Annual Report 2014/15

Local Safeguarding Children Board

For Hammersmith and Fulham, Kensington and Chelsea, and Westminster

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FOREWORD
By the Independent Chair

This is my third annual report as Independent Chair. My role tasks me with ensuring that the Board fulfils its statutory objectives and functions: the coordination of safeguarding work of agencies and ensuring that this is effective.

I am impressed by the dedication and skills of frontline staff and the outcomes for children and young people. Whilst the LSCB (Local Safeguarding Children Board) does not commission services directly, we seek to influence services and practice through the contribution of Board members and our partnerships. We also take challenge very seriously. This often happens in the context within which services are delivered, and through the attitudes, values, and behaviours of staff and frontline managers. It also happens through the Board's discussions and influence. This year an increased focus on Child Sexual Exploitation (CSE) and Female Genital Mutilation (FGM) relates directly to the challenge that we have made to one another to protect children from harm. Early help and engagement with community organisations have been at the forefront of this.

The LSCB members have carefully reviewed progress over the past year and have identified and agreed shared priorities for 2015/16. These priorities are a combination of work that we believe requires ongoing attention to ensure a clearer impact as well as a focus on emerging issues which need to be on our agenda. In agreeing these priorities we have sought to ensure that the work of the LSCB continues to have an impact on the effective safeguarding of the diverse children and young people living in the three boroughs.

Please read this Annual Report. It may help you to understand the work that we do and how it joins up across the agencies. I hope that you will hold the LSCB to account on our plans for next year. We are keen to learn when things don't go as well as they should and when mistakes are made so that we can make the improvements that are needed for children and young people.

Most of the time, work with children and their families goes well and is unnoticed. I want to thank staff for the difference that you continue to make in the lives of those with whom you work.

Jean Daintith
Independent Chair

BACKGROUND TO THE REPORT

Under section 14A of the Children Act 2004 the Independent Chair of the LSCB must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area. The annual report should be published in relation to the preceding financial year and should fit with local agencies' planning, commissioning and budget cycles. 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 Well-being Board.

This report is structured in two parts. Firstly it reviews the activity in the past year to deliver the priorities identified in the LSCB's 2014/15 Business Plan. The second part describes the wider context of the LSCB, who it works with, how it is governed and its membership, with an overview of a number of its key functions. The report concludes with a summary of the LSCB's priorities for 2015/16, as informed by the review of its effectiveness to date and partners' agreement of what needs to happen next.

CHAPTER 1 – PROGRESS ON PRIORITY AREAS 2014/15

The 2014/15 LSCB Business Plan identified four key priority areas for development over the year. These included Early Help and the Prevention of Harm; Child Protection and Looked After Children; Practice Areas to Compare and Contrast; and Continuous Improvement in a Changing Landscape. This section reviews what was done for each of these areas, the impact of the work and what needs to happen next to ensure continuing improvement. There is a particular focus on a number of particular areas for development which were addressed over the year including some high-profile issues which are covered in more detail as "spotlights". Progress on other sub-priorities that were highlighted is reflected elsewhere in this report.

1.1 Early Help and Prevention of Harm

The LSCB has a statutory responsibility to assess the effectiveness of help being provided to children and families, including "Early Help". Early Help means providing help for children and families as soon as problems start to emerge or when there is a strong likelihood that problems will emerge in the future. The 2014/15 business plan priorities therefore reflected a need amongst all agencies to improve early help services and the early identification of and help for children at risk.

The range of early help services is good in all three boroughs. The voluntary sector is funded to make a significant contribution to this. Expectations are high from professionals about getting a response if a referral is made; and there is challenge if the response is not what was expected.

2014/15 Business Plan priorities:

- ✓ Local Early Help arrangements are effective in preventing harm and keeping children safe
- ✓ Early Help services are strengthened in relation to identification and response to parental mental health and substance misuse
- ✓ Work around safeguarding in relation to faith and belief is embedded and evaluated
- ✓ Schools and voluntary sector identify safeguarding needs leading to timely response

Local Early Help arrangements are effective in preventing harm and keeping children safe

What have we done?

An Early Help outcomes framework has been agreed and a single Early Help Offer is now available across the three boroughs. The Threshold of Needs Guidance also incorporates thresholds for early help, including identification and assessment. A recent development is the 'Best Start in Life' project group across Health and the three Local Authorities who are

aiming to integrate a pathway for 0-5 year olds and implement a 'whole system' for early years. Each borough has an Early Help Service which provide a range of services including universal and targeted provision through Children's Centres; teams which carry out casework with families who have levels of need just below the threshold for children's social care; parenting programmes and joint work with schools, health and the police.

The Multi Agency Safeguarding Hub has assisted in establishing where cases should be referred to at the initial stages when they first come into Children's Social Care promoting informed referrals to Early Help Services.

In addition, there have been significant Early Help developments led by a range of agencies including:

- The '**Focus on Practice'** programme started during the year including training from January 2015. The wider aim of the programme is to improve the effectiveness of direct work with families and key anticipated outcomes are reductions in the number of looked after children and reducing referrals to children's social care. Early help workers in local authority services are receiving training in modules in systemic practice, motivational interviewing, and parenting theory and skills. The programme is expected to have a major effect on the way Early Help is provided, its impact in reducing the need to escalate services to statutory services and the need for cases to be re-referred after case closure.
- **Imperial Health Care Trust** (at Queen Charlotte's Hospital and St Mary's Hospital) as well as partners in Westminster Family Services through the Queens Park Project have piloted the National Society for the Prevention of Cruelty to Children (NSPCC's) evidence-based "Coping with Crying" programme to raise awareness of parents about how to cope when their baby cries. A similar programme in the United States was shown to have reduced the number of shaken babies or non-accidental head injuries by 47%.
- **The London Community Rehabilitation Company** (CRC) is now ensuring that all new cases are referred to social services to check whether the person or family are known. This process helps to keep the safeguarding of children at the forefront of staff actions when working with individual offenders.
- The LSCB has continued to hear about the impact of welfare reforms on families who seek help from the **Homeless Person's Service** and considers that, at a local level, the implications are as well-managed as they could be, whilst the national system is one that impacts disproportionately on London thresholds.
- **The Safeguarding in Schools lead** has ensured that guidelines have been circulated on when and how to refer a child missing from Education to Early Help services and the ACE Team (Attendance, Child employment and entertainment and Elective home education). The lead has also promoted awareness in schools of private fostering, and making sure schools understand the interface with the Multi-Agency Safeguarding Hub (MASH). An audit tool has been developed and distributed to schools (including independent schools) to support the evaluation of the degree to which they meet their safeguarding responsibilities. Schools have been prioritised for a comprehensive safeguarding audit including an action plan to address any identified gaps or areas requiring strengthening.
- An LSCB event was held with **the Voluntary Sector** in May 2014 which strengthened their links with the Partnership Groups and LSCB representation within the Voluntary

Sector fora. The voluntary and faith sectors' contacts with a wide range of families means they are well placed to offer 'universal' help, advice or referral on of children and their families to more specialist services. The involvement of the Community Development Worker for Faith and Communities has had a significant role in developing this work over the past year.

- Work initiated by the **Westminster Partnership Group** regarding parental mental health was taken forward by the three Health and Wellbeing Boards who conducted a Task and Finish group on Mental Health leading to a local action to improve services.
- The **Integrated Gangs Unit** (IGU) in WCC have links with other services across the three boroughs and work with young people considered in a short life working group on gangs and CSE two years ago. The IGU focuses on diverting young people from gang involvement, with particular links with Multi-agency Public Protection Arrangements (MAPPA), Police and Children's Services are strong. The IGU has had considerable successes in engaging and safeguarding this difficult to reach group of young people.

What difference has it made?

- ✓ LBHF Early Help services have contributed to reductions in numbers of children with child protection plans and those entering care; improved identification and support of young people subject to child sexual exploitation; reductions in homelessness amongst 16 and 17 year olds; improved identification and support of young carers; ensuring that only small numbers of families referred need to be "stepped up" to statutory social care teams; success in addressing substance misuse amongst young people.
- ✓ RBKC Early Help services have shown an average increase of 11% in school attendance for children they have worked with at the point of case closure and an impact on reducing the need for cases to be "stepped up". Monitoring of outcomes has shown that on average, outcomes have improved across all dimensions for families worked. There has been a particular impact upon meeting emotional needs, education and learning and family routine.
- ✓ WCC Early Help services have identified a significant number of children who have been supported to remain with their families after previously having been identified as being on the "edge of care". A reduction in the percentage of young people not in education, employment or training (NEET) has also been noted following interventions. They have worked with young people who have been arrested by the police and can demonstrate that most of the young people concerned have not gone on to reoffend.
- ✓ WCC Early Help service has also worked in partnership with Save the Children on FAST (Families and Schools Together) which is an evidence based programme to build stronger bonds between parents, schools and communities. This has been delivered in 23 Westminster schools and evaluations have shown improvements of family and parent-child relationships, as well as reductions in difficulties experienced by children in school.
- ✓ Following learning from case reviews, a Children in Need chair has been introduced with the aim that cases held in early help services, where there are emerging concerns, are reviewed independently to ensure that they are managed in the right service.
- ✓ Children missing education referrals have been received from a wide range of agencies including different council departments, health professionals and members of the public. The majority of these referrals are satisfactorily resolved by the ACE team with

cases only concluded as 'untraceable' following extensive reasonable enquiries undertaken.

- ✓ Over the course of 2014/15, 765 evaluation forms were received from parents who had received preventative input and advice through the local pilot of the NSPCC's Coping with Crying programme.
- ✓ The management of cases of young adult offenders and their potential association with children under 18 has been improved by increased co-working by CRC with the youth offending services in the three boroughs and frequent information sharing between the agencies.
- ✓ While the numbers of families in placed in Bed and Breakfast accommodation fluctuated over the year, there were no families living in such accommodation for longer than six weeks. There are examples of good practice from Housing in all three boroughs in helping families early. For instance in Hammersmith and Fulham, households which have medical or social vulnerabilities, as well as those where there are children in critical stages of their education, have been receiving tailored support.
- ✓ Coordinated multi-agency support through the "Team Around the School" approach has been enhanced to better address any increased safeguarding issues such as emotional wellbeing of children. This approach was undertaken with a particular secondary school in Westminster which has resulted in an improved approach including the relationship with CAMHs.
- ✓ A Mental Health Task and Finish Group was initiated by the three Health and Wellbeing Boards but informed by work of Westminster's LSCB Partnership Group. Its action plan includes an expectation that services providing mental health care to adults should be contractually required to ask patients about parental responsibilities and to assess the potential impact of their mental health problems on their children. The numbers of parents and carers identified are submitted in quarterly safeguarding reports. In addition, Chelsea and Westminster Hospital has a Lead Midwife for mental health and she works with mothers to ensure they are supported and referred to appropriate services.
- ✓ All three boroughs have methods and interventions for addressing radicalisation in schools that are innovative and built into the curriculum. There is a significant emphasis on safeguarding (see "Spotlight on safeguarding children from radicalisation" below).
- ✓ The IGU has maintained a significant reduction in violent offences in Westminster.
- ✓ The Section 11[1] reporting format has been revised in response to feedback from the voluntary sector.

Next steps

- Support and challenge all agencies to be able to describe more clearly and evaluate the important contribution that Early Help is making to ensure positive outcomes for children's safeguarding.

[1] Section 11 of the Children Act 2004 place duties on a range of agencies which come into contact with children to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. The LSCB has responsibility to ascertain compliance with this.

- There is regular reporting from the Children's Services performance team on Early Help but the way this is monitored and challenged has been identified as an area for development by the QA subgroup in the 2015/16 Business Plan.
- LSCB to have oversight of and opportunity to challenge initial impact of Focus on Practice on indicators that are expected to lead to better outcomes. These include anticipated reductions in numbers of children entering care, subject to child protection plans or rereferrals. The programme is being independently evaluated by the Institute of Education and the findings will be reported to the LSCB.
- Build upon improved joint working between Community Rehabilitation Company (CRC) and youth offending and other children's services as work takes place with a new cohort of young people becoming 18.
- Recommendations made about parental mental health by the Mental Health Task and Finish Group need to be effectively implemented along with any further actions recommended by a short life working group on parental health being led by both the Mental Health Trusts for the Board in 2015/16.
- Continue to evaluate and report on projects in relation to faith and belief which aim to engage and improve outcomes for children, incorporating this into ongoing activity.

Spotlight on safeguarding children from radicalisation

The LSCB recognises that young people are best safeguarded from 'radicalisation' through the creation of networks that engage young people with life-enhancing, respectful ideologies; challenging casual prejudice in families; creating communities where there is a shared language of non-militancy; and diverting young people from peer groups who share extremist world-views. These are all activities that need to be joined-up with other partnerships - especially with schools, youth, community and faith organisations, young offender and prison institutions, as well as through direct work with families.

What we have done?

- There have been significant developments regarding engagement of key agencies in the Prevent agenda. The Safeguarding Lead for education has been a longstanding member of the local Channel Panels (there are two panels, one for Hammersmith & Fulham and Kensington and Chelsea and another panel for Westminster). In the past year, membership of the LBHF/RBKC panel was expanded to include a Team Manager from Family Services to provide children's social care perspective as well as representation from the Tri Borough Youth Offending Service.
- The Prevent agenda has been included in the rolling training for designated teachers and governors. In addition, Prevent training has been provided for over 1700 staff in 140 schools across the three boroughs with an ongoing programme planned for 2015/16.
- Information about the Prevent agenda has been shared with the significant number of schools in the independent sector.
- There has been effective multi-agency support for schools and colleges in managing the repercussions in local communities when cases involving individuals (usually young adults) have attracted significant publicity.

- Building upon existing knowledge of and links with Supplementary Schools, the LSCB Community Development Worker and Prevent leads have been mapping Madrassas in all three boroughs with a view to improve communication and provide active support to raise the profile of the Prevent agenda along with wider safeguarding issues.
- CLCH is fully compliant with prevent duties as outlined 2015 guidance. It has a Prevent policy in place and has continued to cover the issues involved as part of their mandatory training offer. It is covered through Safeguarding Adults Level 1 training (90% compliance) and 50% of all staff have so far received Prevent training.

What difference has it made?

- ✓ The overall impact of local developments has been that emerging concerns are being consulted on earlier, with referrals made to the Channel panel where required. This means interventions can take place prior to any crime being committed.
- ✓ Although data in relation to this cannot be published, there are anecdotal indications that a greater proportion of Channel Panel referrals now come from schools or are regarding a child or young person.
- ✓ The agenda of Channel panels has widened to include more intelligence from schools rather than a sole focus on information from the police about individuals who are a cause for concern. This has led to a broader understanding of links between individual young people and has enabled a more preventative approach on some cases. Schools now actively take part in Channel discussions about individuals who are linked to children who are on their roll.
- ✓ Younger siblings and other extended family have been safeguarded and supported to continue to go to school and access other services following high profile cases involving other family members.
- ✓ There have been specific examples of successful interventions to address concerns about behaviour and developing attitudes of individual children which suggested that they were becoming radicalised. This has included work with children who have special educational needs.
- ✓ Independent schools have started to request specific advice and input about the Prevent agenda.
- ✓ Prevent leads have become an established and significant point of consultation for schools.

Next steps

- Embed developments by engaging members of the Tri-borough Prevent Steering Group in relevant LSCB sub-groups.
- Replicate practice in LBHF and RBKC to engage a Family Services Team Manager in WCC’s Channel Panel.

- Continue to raise the profile of the Prevent agenda in schools and colleges through training, tailored input and awareness raising, with a particular focus on the independent sector.
- Provide information and workshops for representatives from Madrassas and Supplementary Schools to improve communications signpost access to the existing multi agency LSCB Training programme.
- Ongoing analysis of referrals to and outcomes from Channel to ensure it is effective, particularly in response to children at risk of radicalisation
- Develop support for children where there is evidence that their parents have become radicalised
- Continue to develop our awareness of links with the e-safety agenda to safeguard children from the risks of internet and social media as a means of radicalisation.

1.2 Better Outcomes for Children Subject to Child Protection Plans and those Looked After

2014/15 Business Plan priorities:

- ✓ All child protection plans are relevant to the risks and needs of the child and lead to effective support that improves their outcomes and life chances.
- ✓ Learning from case reviews improves the quality of practice and service that children, young people and families receive.
- ✓ Staff working across all agencies are better able to identify and support children who are at risk of neglect.

Child protection plans are relevant to the risks and needs of the child and lead to effective support that improves their outcomes and life chances.

What have we done?

- The Quality Assurance function within local authority Children's Services maintains an oversight of children with child protection plans. Numbers of children becoming subjects of a plan and numbers where their plan has ended are monitored through reports to the QA sub-group. Where the LSCB has noted changes in local trends, this has been highlighted and challenged at the LSCB. This happened in April 2014 in relation to LBHF when it was noted at the LSCB meeting that there had been an increase in children subject to plans. This prompted more analysis of data and cases to review whether different thresholds were being applied. There have also been frequent care and contrast exercises across the three boroughs to understand trends and take action to ensure thresholds are consistently applied.

- When actions have been taken to address increases in numbers of child protection plans, these have been discussed at partnership group meetings to develop a consensus on thresholds and the degree to which different agencies are aware of and agree with these.

- The Signs of Safety model has been introduced into child protection case conferences in in all three boroughs with all social workers receiving two days of training to use the techniques in practice. The model aims to work collaboratively and in partnership with families and children to conduct risk assessments and produce action plans for increasing safety, and reducing risk by focusing on strengths, resources and networks that the family have.

What difference has it made?

- ✓ The increased number of child protection plans in LBHF during 2014/15 prompted an external audit in the form of a 'Safeguarding Stocktake' which examined cases and child protection practice, leading to a set of recommendations. The numbers of children in LBHF with child protection plans have since declined.
- ✓ The introduction of Signs of Safety/Strengthening Families approaches has led to an increasing focus on reducing risks to children rather than plans which are lists of tasks that must be completed.
- ✓ The majority of children who have been subject of child protection plans do not require such plans in the future.

Next steps

- ✓ Continue to review and challenge how the Board can be most effectively informed about trends and outcomes in relation to children with child protection plans including through reports provided by Child Protection Conference chairs and data reviewed by the QA subgroup.

Learning from case reviews improves the quality of practice and service that children, young people and families receive.

One Serious Case Review was published in 2014/15 and a second completed SCR has not yet been published owing to ongoing legal proceedings but initial learning has been shared across agencies. Multi-agency themed audits in 2014/15 covered cases where there were issues of domestic abuse, neglect and child sexual exploitation. It is important that recommendations and outcomes of such audits are communicated and lead to better practice or outcomes for children. Individual agencies continue to be responsible for ensuring that recommendations from the audits are followed through.

What have we done?

- Learning Events have been held to disseminate key learning from the reviews, including when it has not been possible to publish final reports from SCRs.
- A new 'Quality Assurance Manager' role has been developed, partly to improve engagement of other agencies with audits such as schools as well as maintaining an overview of audit outcomes.
- A quarterly *Learning Review* has been published which summarises learning from case reviews at both the local level and further afield as well as providing details of additional information or resources to support practice. This has been cascaded to staff via Board members and is used at training events.
- A practice note has been published regarding processes that should be followed when Children in Need move between authorities.

What difference has it made?

✓ Local protocols have been developed to improve multi-agency engagement in strategy discussions

✓ Improvements have been made to Health case transfer protocols and linking of patient records

✓ Action has been taken place to ensure frontline staff have a good understanding of welfare rights and that local thresholds do not operate in relation to families in particular situations;

✓ Findings from Serious Case Reviews led to a number of new tools to better understand neglect as described in "Raising the Profile of Neglect" below.

Next steps

- Review the impact of improved communications about learning from reviews, including sampling the awareness of relevant multi-agency practitioners.
- Continue to ensure that clear action plans result from ongoing case reviews and that actions agreed are completed with the impact tracked over time.

Raising the Profile of Neglect

What have we done?

- There has been a particular focus this year on learning from reports about neglect of younger children and teenagers. Awareness of the consequences of neglect of children in the first two years of life had a higher profile following a multi-agency audit in December 2014. This led to the initiation of a Neglect short life working group which will report in 2015/16. Other developments included new tools to help front line staff to identify cases of neglect and evidence the referrals they make to statutory child

protection services. The tool includes a check list and template for evidence recording based on templates used in schools but to be rolled out more widely across agencies such as early years providers. Another tool is being trialed which assists in recording evidence of the child's experience relating to neglect with the aim of avoiding drift where neglect is identified.

- The MASH has revised its case rating system to ensure that signs of neglect are more readily recognised including where multiple referrals have been made on the same child. Such cases are then escalated to an early help social worker.
- The Neglect Short Life Working Group (SLWG) also focused on situations where families miss important appointments for their children, drawing upon individual agency work, particularly that undertaken by Health. Following learning from a SCR carried out in Greenwich, there has been a focus on Health, schools, Housing and social care considering their respective responses to families moving in and out of the local area.
- A Neglect strategy and action plan has been agreed by the LSCB Board. LSCB Neglect training has been reviewed and individual agencies asked to reconsider the content of internal training in light of local and national case reviews and the Ofsted Thematic report in 2014.
- The Independent Chair has worked with the DCI for the Child Abuse Investigation Team (CAIT) to follow up concerns that resource constraints on the CAIT were having implications for joint investigations and police attendance at strategy meetings. The Board has also reviewed the Metropolitan Police Service policy on changes to the practice of police not carrying out "welfare checks", introduced in 2014 to ensure that police do not attend premises when they have no legal power to enter.

What difference has it made?

The impact of the significant number of developments outlined above will be evaluated during 2015/16 and beyond.

✓ The Independent Chair was given an assurance by the DCI of the CAIT that despite resource constraints, the Metropolitan Police Service audited the performance of the CAIT and that it was well case-managed at a local level. The Board has also been assured that children would not be left unprotected, and there is no evidence that this has happened locally. Locally the police have stated that whenever there are sufficient grounds to suspect a child is at risk, an officer will attend and take appropriate action.

Next steps

- Ongoing evaluation of recent developments to improve responses to neglect.
- Continue to develop and publish learning materials.

- Each agency to identify and agree a specific action to improve the identification of neglect with the LSCB to facilitating the coordination of action to ensure that it is directed to where it is most effective.
- Further testing of the Threshold of Needs Guide to ensure it continues to provide appropriate indications of neglect (as well as other issues such as CSE, missing children and risk of radicalisation). It will also be updated in light of the publication of Working Together 2015.
- Continue to review the degree to which social workers are accompanied by Police colleagues when carrying out 'joint' investigations and reporting in to the police.

1.3 Practice areas to compare, contrast and improve together

Since 2012, organisations working across the three boroughs have sought to take advantage of the opportunities afforded through a single LSCB covering three boroughs by using a compare and contrast process to identify and learn from the best practice. This approach has been applied to priority areas of the LSCB's Business Plan in 2014/15.

2014/15 Business Plan priorities:

- ✓ Improve practice in respect of children and young people at risk of child sexual exploitation (CSE)
- ✓ Improve practice in respect of children who are subject to or at risk of female genital mutilation
- ✓ Improve response to domestic violence and abuse
- ✓ Develop a co-ordinated approach to e-safety.

Spotlight on child sexual exploitation

What have we done?

- There has been a significant level of activity overseen by the LSCB to address CSE which has gathered momentum over the course of the year. The shared CSE Strategy and action plan is overseen by the MASH, Missing and CSE sub-group and reported to the Board. An agreed risk assessment tool is in place which has been developed over time to make it more user-friendly to assess all children and young people who may be at risk. The MASH has developed systems to identify all resident children receiving services or subject to referrals who meet the criteria for being at risk of sexual exploitation as determined through Metropolitan Police CSE Operating Protocol. Each local authority has a nominated CSE coordinator who provides a point of contact, advice or consultation for any professional who is concerned that a child may be at risk of or experiencing CSE.
- The Multi-Agency Sexual Exploitation (MASE) panel was set up in early 2014 and provides a strategic overview of the identification, support and protection of children and young people at risk of CSE. It meets monthly with good representation from

relevant agencies and all three boroughs. The MASE has also developed its overview of interconnections between victims, perpetrators, and potential locations of concern which may require a planned and coordinated response.

- There have been ongoing developments in terms of use of information which is matched with other data to map perpetrators and locations of exploitation. Problem profiles have been developed and shared with the sub-group.
- Regular reviews of trends in relation to CSE identified some concerns about the quality of data regarding children and young people at risk, particularly in relation to differences between the reported number of cases by the local authorities compared to the Police in WCC and perceived low numbers of Category 1 cases overall. This was audited by the MASH Detective Inspector. He found that Police data included children who were not residents of WCC but were victims of CSE within the borough boundaries and included young adults who were making historical allegations. Otherwise, Police and the local authority were recording information about the same children. It was also concluded that the local authority CSE Co-ordinators were appropriately screening and applying thresholds so cases were only classified as Category 1 when there was clear evidence that the case should be deemed a CSE concern.
- The publication of the report of the Independent Inquiry into CSE in Rotherham (1997-2013) has led to additional local scrutiny by Chief Executives and elected members in all three boroughs. This also contributed to a more multi-departmental approach across the councils. A particular initiative resulting from was the Metropolitan Police's Operation Makesafe programme which will be implemented in 2015/16 with the involvement of departments responsible for Licensing, Environmental Health and Community Safety as well as local business communities.
- The LSCB offers specialist CSE training. Signs and indicators of CSE as well as signposting to CSE leads, the MASE and details of learning from case reviews are now included in the core multi-agency safeguarding training programme. Train the trainer programmes have been provided for all Designated Teachers for Child Protection in maintained schools across the three boroughs, including CSE as a key area. In CLCH the named Nurses for Child Protection attend the MASE and share any concerns and information relating to children at risk of CSE. CLCH staff have received training on the signs and indicators of CSE and so are aware of this form of abuse. Where they have concerns they seek advice from the CLCH Safeguarding team to make the appropriate referral into children's services.
- Multi-agency meetings take place in all three boroughs to plan interventions and responses for both victims and perpetrators. Probation, the Police, Community Safety and Anti-Social Behaviour Teams use innovative approaches to disrupt perpetrator activity and improve safety in emerging locations of concern. Over the past year, a number of children have been moved out of the area for their own protection, either through an identified care placement or through work with the Housing Department.

What difference has it made?

- ✓ There has been significant review of how CSE is recorded to ensure that as well as cases which meet Metropolitan Police thresholds, children who are at risk of CSE are also monitored and tracked by the three local authorities with oversight from the MASE. This approach will be rolled out, monitored and developed in 2015/16, in particular ensuring that a consistent threshold is being applied where children are thought to be vulnerable. Cases where risks have been effectively addressed are also being tracked to gain a better overview of the "journey" of individual children and interventions which have made a difference.
- ✓ A multi-agency LSCB audit of CSE cases showed a general improvement in the way that multidisciplinary work was carried out with young people at risk of CSE, compared with a previous audit in 2013. Effective communication between agencies in relation to plans and interventions was noted as well as good multidisciplinary working between police and local authority services to achieve short term safety for children.
- ✓ A police audit of perceived differences between police and local authorities data identified good levels of multi-agency working on all cases reviewed.
- ✓ There have been examples of schools receiving coordinated support with concerns about potential CSE from more than one borough, addressing the complexities of providing services for children attending school outside of their home borough. Schools have engaged in mapping of CSE and Serious Youth Violence and their interrelationships. This mapping has informed "Team Around" approaches coordinating multi-agency support for schools, in particular those providing alternative educational provision. There is now wider multi-agency information sharing about vulnerabilities and risks for individual young people before they are placed in such provision, including liaison with MASH and the Youth Offending Service.
- ✓ A contract for Barnardos to provide specialist services in LBHF has been reviewed and now includes a greater focus on outcomes and a role in the training of foster carers. Barnardos worked directly with 10 young people throughout the year. There has also been a good impact from work undertaken by specialist sexual health workers who work intensively with young people and build key relationships in the borough.
- ✓ Frameworks to support multi-agency information sharing and mapping have led to the identification of "locations of concern" or hotspots. One example was where mapping of victims and alleged perpetrators led to a park being identified as a location where CSE activity was taking place. This led to cross-departmental work to improve lighting, CCTV, cutting back hedges, and additional police patrols. Since then there have been no further referrals to MASE about CSE cases involving the park and as a result it is not currently considered a location of concern.
- ✓ Partnership working between police, local authority and parents led to child abduction notices being served regarding two victims of CSE in one of the boroughs.

Next steps

- The shared risk assessment tools will continue to be revised to ensure they can be used to screen children at the earliest stage, linking them to the Integrated Children's System to ensure relevant cases are flagged consistently.
- Develop plans to better identify, monitor and support children and young people for who there are concerns about potential CSE but who don't meet the threshold for Category 1 interventions.
- Ensure plans by MASE to develop strategic responses continue to be effective, including oversight of the success of disruption and intervention strategies; ongoing integration with serious youth violence panels; communicating the themes of strategic intelligence with practitioners e.g. mapping of local "locations of concern", information about emerging patterns of activity and links with work with gangs.
- Ensure that Operation Makesafe is implemented and that the impact of the programme is evaluated.
- Ensure protocols are further developed and refined to ensure detailed assessments of risk take place in relation to vulnerable young people placed in alternative educational provision. Also ensure that staff working directly with these young people receive training on current safeguarding issues including CSE.
- Further develop links with Adults' Services to ensure young people who are victims and/or perpetrators of CSE are supported through the transition into adulthood.

Spotlight on Female Genital Mutilation (FGM)

What have we done?

- An LSCB standing group was established to improve practice regarding FGM and with an initial aim to improve information sharing between Maternity services and children's social care.
- There is now a designated Child Protection Adviser for FGM in each borough providing consultation to partner agencies and overseeing cases, tracking referral activity and outcomes. A dedicated post has also been introduced who has shared good practice identified locally at both the London LSCB Chairs' meeting and the National Association of Chairs Group.
- FGM has been incorporated within the MASH threshold framework, rated as AMBER status when a woman has been identified as affected by FGM and she has a female child. This rating means that inter-agency checks will be undertaken without the requirement for family consent. There has also been work in partnership with the Metropolitan Police London wide strategy and assisting the London LSCB in updating risk assessment guidance for front line staff.
- A pilot project at St. Mary's Hospital took place in 2014 through a partnership between Children Services, Maternity Services and Midaye, a community organisation. Through

this, women referred to the clinic are jointly assessed by Health and Social Services with parallel support from a community based Health Advocate. Once a family has been identified, MASH checks are undertaken and then the cases are reviewed at a multi-disciplinary meeting where plans are made to offer support and assess the family circumstances in a holistic way. Where a woman has or is expecting a female child this will include a social work assessment. The emphasis of this project is on early identification and prevention so that time can be taken to work with families, to help them to understand the health and legal consequences of FGM, and to empower parents to keep their child safe in the face of social and familial pressure to conform to tradition. Following the pilot, the DfE awarded an innovation grant to enable the roll out across the three boroughs by extending the pilot at the hospital.

- A second pilot has started but focusing instead on children and young people who have suffered FGM. This builds upon on a partnership between Imperial College NHS Trust and Children's Services, planned in conjunction with the Police. Children who have been victims of FGM will receive a joint examination by a Consultant Paediatrician and Consultant Gynaecologist, as well as immediate access to a child psychologist and specialist social worker. This will be available to all children and families across the three boroughs and will be piloted for six months.
- The Safeguarding in Education Lead has carried out targeted work to increase awareness among school staff about the indicators of and responses to FGM and highlighting specialist support and advice. In Westminster, FGM is now routinely considered as part of the Team Around the School model.

What difference has it made?

- ✓ Over the last year, referral numbers have increased which is seen as an early indicator of improved practice. However, referrals in relation to FGM remain low, suggesting that under-reporting remains a concern for all three Boroughs as is the case elsewhere in London.
- ✓ As raised awareness is a key element of better identification and response to families and children who may be at risk of FGM, the significant amount of training for relevant staff will increase impact.

Next steps

- Finalise the LSCB FGM strategy and embed it across agencies.
- Confirm the draft information sharing protocol to clarify when information about an adult survivor of FGM should trigger information sharing between agencies in order to consider the safety of the child. This is informed by pilot work which is already demonstrating the ability of agencies to work together.

- Refine best practice models in cases where a child protection investigation is initiated, such as how medical examinations, interviews and legal proceedings are most effectively conducted.
- Monitor and review the extension of the FGM Clinic project into Queen Charlotte's hospital and support a further extension to Chelsea and Westminster Hospital as well as additional resources such as a male worker and psychological support for survivors.
- Continue to engage schools serving communities which are likely to have high levels of FGM prevalence in a trial approach which will involve a targeted multi-agency meeting to share information about cases where there is a worry or concern.
- Review and develop the pilot working with children and young people who have suffered FGM

Spotlight on Missing children

What have we done?

- The appointment of a Missing Children Officer located within the MASH in September 2014 has supported ongoing improvements in practice in line with a Tri-borough Missing Protocol and new government guidance. The post was introduced following a review of the numbers of missing children within the QA subgroup which identified differences across the three boroughs which were found to have resulted from different recording expectations. The Officer had a role in identifying vulnerable 'missing' and 'absent' young people and coordinating responses which would reduce long-term risk. Local authority case management systems have been developed to enable online recording of missing of absent "episodes". The Officer receives daily Missing notifications from the Police (Merlins) and notifications from practitioners and checks compliance with the protocol ensuring relevant follow up actions take place. Quarterly reports have heightened our understanding of each borough's compliance with the protocol and provided more of an understanding of the profile of each borough's children who go missing.
- A Missing Review is held every three months for all stakeholders with developments and required being discussed at the MASH/CSE/Missing Board. Two practice audits have been conducted in the past year which highlighted strengths and gaps within practice which are then followed up by the Missing Children's Officer.
- Meetings with Police have occurred on a regular basis to raise the Police awareness of the importance of Children's Services receiving all Missing Merlins.
- Information provided to RBKC's Care Planning group enables a regular review of the highest risk missing cases leading to management oversight and clear actions being identified.

- Because of the known links between children going missing and risks of CSE, the Missing Officer attends the MASE Panel to ensure intelligence regarding missing children is also considered.

What difference has it made?

- ✓ There is now an increased the awareness of the number of children and young people who go missing within the three boroughs. There are higher levels of understanding amongst frontline staff of the significance of being 'missing'/'absent' as a risk factor and links with other risks such as CSE and gang involvements.
- ✓ Meetings with the Police have increased the number of Merlins being received by Children's Services and their timeliness.
- ✓ There is improved recording of missing episodes on case management systems and Strategy Discussions are held according to statutory requirements.
- ✓ Outcomes from Return Home Interviews are informing on-going reflection and analysis of casework.

Next steps

- Develop practice targeting children who go missing most frequently.
- Continue to provide training in relation to the protocol and any updates as well as the risks associated with going missing including support and advice for professionals from all agencies who may conduct "return home interviews".
- Carry out further audits, including one on the experience of young people who previously went missing, to identify what they found helpful to inform future practice.
- MASH/CSE/Missing Board to receive performance reports including the identification of patterns and themes for individual children as well as for individual boroughs, to inform future multi-agency responses and challenge.

Domestic Violence and Abuse

What have we done?

- A short life working group for domestic violence was established in 2014 to gain a mutual agreement and understanding of the direction of travel for reducing the risks of harm to children from domestic abuse. The group endorsed work carried out by the Early Help Board to provide guidance to frontline social workers in recognising and responding to signs of domestic abuse and proposed that the LSCB should agree to the Tri-borough Violence Against Women and Girls (VAWG) Partnership taking forward and coordinating future work to reduce the impact of domestic abuse. This was agreed in April 2015 with the LSCB to receive regular updates on progress from the VAWG Partnership.

- The VAWG strategy and action plan has been agreed for 2015/16 informed by the views of focus groups of children and young people, facilitated by the LSCB's Community Development Worker. It incorporates a more coherent approach to commissioning and decommissioning voluntary sector services across the three boroughs to ensure a more consistent approach with victims and perpetrators.
- Learning from a SCR in LBHF last year has contributed to new ways of working with families where domestic violence is a feature. In RBKC for example, the significance of domestic violence and abuse has been further emphasised in Practice Week findings and ensuring more meaningful work with men and fathers.

What difference has it made?

- ✓ There has been improved working with the three boroughs' Community Safety Partnerships and a strengthening of the quality assurance and training links with VAWG group.
- ✓ Findings from recent case reviews regarding "disguised compliance" and working with men have influenced the content of systemic training for the Focus on Practice programme, therefore informing future practice of all local authority children's social care and early help staff.
- ✓ In all three boroughs, clinicians are being used to help understand family dynamics and how to change patterns of behaviour. In LBHF, three specialist posts have been created and split case conferences now take place where the father and mother both want to attend and sharing information in the presence of the other would be a problem.

Next steps

- Review progress with the VAWG strategy ensuring improvements are made to services that work with perpetrators and with children impacted by domestic violence.
- Ensure an improved system and directory of services is available by the end of 2015 which is easier for professionals and survivors to access and navigate.
- Use and develop VAWG data to enhance the work of the LSCB and vice versa.
- Work with the VAWG to understand whether we have the right services in place in the three boroughs in the face of reducing resources.

E-Safety

What we have done?

- A Short Life Working Group was established to identify best practice and co-ordinate multi-agency practice regarding e-safety, reporting to the LSCB in January 2015. The group reviewed existing policies, practice and training to identify any gaps to promote a better understanding of the issue for all agencies including safe practice by

professionals. This was informed by the views and suggestions of children and young people and aimed to increase clarity across the multi-agency network in responding to e-safety concerns at a strategic and individual child level. A multi-agency preventive strategy was developed involving training and other practice initiatives.

- Strong links have been developed with 3BM (an employee mutual which provides information technology support to many schools across the three boroughs) who have been an important partner in helping to share information with schools about e-safety. E-safety information will also be included on the LSCB website which will be a helpful resource for schools.
- "Team around the school" approaches have enabled coordinated support and advice (including mental health services) being made available to schools in response to emerging issues which are affecting young people on roll where the medium of social media can be a contributory factor, e.g. self-harm, eating disorders and gender identity.

What difference has it made?

- ✓ E-safety guidance and information has been circulated to all schools including independent schools) via schools' circulars. Information has also been distributed to schools to circulate to children and families.
- ✓ E-Safety has been incorporated into training for Designated Leads for safeguarding in schools, including designated governors, and further specialist training has been commissioned for Designated Leads and specialist staff to commence in September 2015.
- ✓ An e-safety audit tool has been developed and reviewed by the LSCB and circulated to all schools as well as policy templates to be incorporated in school safeguarding and child protection policies.

Next steps

- ✓ Monitor take up of e-safety training as well as identification of e-safety "champions" in schools.
- ✓ Share learning from safeguarding audits carried out from schools where good practice in relation to e-safety is identified.

1.4 Continuous improvement in a changing landscape

2014/15 Business Plan priorities:

- ✓ Work with Health and Wellbeing Boards, and other partnerships, to promote safeguarding as everyone's business
- ✓ Improve the engagement and representation of children, young people and families in the work of the Board
- ✓ Improve the feedback to families in relation to child death overview panel findings
- ✓ Strengthen the role of the borough Partnership Groups in championing local safeguarding practice and improvement
- ✓ Ensure that the LSCB's governance arrangements are fit for purpose and deliver improved local safeguarding practice
- ✓ The LSCB has adequate Business Support to facilitate effective working of the Board
- ✓ The LSCB's training and development programme evaluates its effectiveness and impact on improving front-line practice and the experiences of children, young people and families

Work with Health and Wellbeing Boards, and other partnerships, to promote safeguarding as everyone's business

What have we done?

- We have sought to develop stronger links with the Adult Safeguarding Board and held a joint event in November 2014 to establish areas of common interest. Forty four members attended and took part in two exercises concerning shared themes such as domestic violence and young people going through transition. It was agreed that the respective Independent Chairs would attend each other's Board annually with plans for further joint events. The Chairs continue to meet regularly and to strengthen the linkages with other bodies together, such as the Violence Against Women and Girls Strategic Partnership.
- The LSCB has provided safeguarding input and expertise into a Health and Wellbeing Board (HWB) Task and Finish Group on child and adolescent mental health and has now established terms of reference for a short life working group focusing on parental mental health. Links with the Health and Wellbeing Boards (HWBs) have been strengthened through the LSCB Chair meeting the HWB Chairs and the annual report being presented to HWB meetings. Each borough-based HWB has priorities for children with links to safeguarding and several LSCB members are also members of the HWBs.

What difference has it made?

- ✓ LSCB members have attended training on the implementation of the Care Act and the Adult Safeguarding Board was invited to have representation on the LSCB's short life working group on parental mental health.
- ✓ The agenda at individual Health and Wellbeing Boards has been informed by input from an LSCB perspective. The RBKC HWB requested follow up reports on FGM, CSE and Neglect following presentation of the LSCB Annual Report and actions were agreed, for example to review information sharing and communication in relation to FGM by health agencies.

Next steps

- Where appropriate, the LSCB will now work more closely with the Adult Safeguarding Board on Serious Case Reviews, sharing learning and training events.

Engagement and representation of children, young people and families in the work of the Board

What have we done?

- A safeguarding survey of 134 children and young people across the three boroughs sought views on what they thought safeguarding was and the ways in which professionals, agencies and services should communicate with them. 51% of young people said they had not been asked their views on safeguarding before while 24% could not remember or did not know if their views had been sought. Three key areas were then identified to focus on more widely:

    1. Are young people being asked about safeguarding?
    2. Is there a feedback loop?
    3. Which professionals are young people talking to?

- There have been five meetings with young people between October 2014 and February 2015 one of which was attended by the Independent Chair and other Board members. At least six young people have attended each session. So far the young people have learnt what the LSCB is, what its priorities are and the types of professionals who sit on the board.
- The LSCB Communication Map has been developed which charts the way information can be shared to and from the Board, regarding participation and engagement. Professionals have nominated themselves to be the named person for their respective sector. This means any safeguarding issues, comments or suggestions that young people may want to communicate with the Board on can be collated by those individuals, fed

back to the community development worker and then shared with the Board and vice versa.

- In December 2014, a group of six young people identified 16 safeguarding priorities that they would like to focus on for 2015/2016. Over the last few months other young people across the three boroughs have been invited to select their top two from this list, with a description of what needed to change and how the LSCB can seek to bring about those changes. The recommendation following this piece of work is that the children and young people's chosen top three priorities be incorporated either into the work of the Board or the work of the Community Development Officer for the financial year 2015/2016. The three areas are:

    1. Bullying (including online and in school)
    2. Self harm
    3. Employment, training and education

- The community development worker created a model for a young person's version of the VAWG strategy and is now working with the VAWG partnership to collect feedback from children and young people.
- The community development worker has also developed a working-group with Somalian men from the White City area of Hammersmith & Fulham, who are viewed as "community leaders" in an isolated community. The group was set up in response to a perception from the community that Somalian children were over-represented in the cohort of children with child protection plans and a feeling that they were being responded to unfairly. There have been three safeguarding workshops since December 2014 with six members of the group attending a "Safeguarding Awareness Raising Session" provided for supplementary school teachers including those working from Mosques and Madrassas. While the group is predominantly male, a Safeguarding Awareness Raising Session has also been provided for Somalian mothers in the White City Estate.
- Workshops on Safeguarding have also taken place with members of the Arabic speaking community in RBKC. In addition 18 community groups took part in a workshop on the key Safeguarding requirements for community and youth groups with "Safe Network".

What difference has it made?

- ✓ A cohort of young people is becoming both more informed about the work of the LSCB and more involved in it.
- ✓ Young people contributed to the safeguarding messages communicated locally during Safer Internet Day (February 2015).
- ✓ Members of local communities have engaged with the LSCB including groups who have concerns about safeguarding practice

Next steps

- Build on opportunities to communicate with wider groups of children and young people, e.g. through facilitating workshops at young people's conferences and other events.
- Review the effectiveness of individual schools' plans to raise awareness of safeguarding topics amongst their pupils and share good practice with other schools across the three boroughs.
- Continue to develop more effective ways of ensuring that the views of children and young people influence and inform the priority work of the LSCB.

LSCB website development

What have we done?

- Progress has been made in developing a standalone LSCB website to replace the three single borough LSCB sites. This will support a stronger identity for the shared LSCB which effectively communicates the local 'safeguarding story'. The new LSCB website has been launched in summer 2015 with sections for professionals, children and young people and parents and carers. It includes signposting to relevant resources, information on training, policies and procedures and where to get help and advice relating to safeguarding.
- In other areas of communication, the LSCB has improved. The previously mentioned 'Learning Review' is complemented in Children's Services Departments by bulletins summarising recent LSCB work and by regular communications from Directors of Family Services and the Director of Children's Services. There is also a monthly Policy Digest which includes a section on safeguarding.

What difference has it made?

✓ More staff are aware of the LSCB and there are plans to improve the number of channels through which the Board communicates with them and the wider community in the forthcoming year.

Next steps

✓ Launch and continue to develop the LSCB.
✓ Review and improve the LSCB's communications to reach a wider audience more effectively.

Strengthening the role of borough Partnership Groups in championing safeguarding

What have we done?

- There continue to be positive relationships in all three boroughs across a wide range of partnerships and openness to hearing from others both in meetings and outside. The LSCB has ensured that partners can continue to focus on specific local issues through the borough-based partnership groups whilst retaining oversight.
- All three Partnership Groups now have lay members and good representation from across the agencies. Any weaknesses in representation are being followed up.
- Each Group has developed a local agenda, however it has been acknowledged that they have not consistently taken forward the wider LCSB Safeguarding Plan.

What difference has it made?

✓ The 2015/16 LSCB Safeguarding Plan will inform the annual plans of the Partnership Groups which will include local issues but with stronger linkage to wider, shared priorities. The Chair has strengthened the groups' work by being more rigorous in specifying the outcomes that are to be achieved.

Next steps

- Ensure that ongoing review of the LSCB Safeguarding Plan includes oversight of the degree to which the activity of the three Partnership Groups is supporting and informing the overall aims of the LSCB.

Review of governance arrangements

What have we done?

- Governance arrangements have been reviewed to ensure the LSCB is fit for purpose to deliver improved local safeguarding. We aim to ensure that agendas reflect issues raised by all agencies. There has been particularly strong engagement of Health with the LSCB agenda. The lay members continue to bring active independent thinking to the Board as well as input to subgroups.
- Business planning processes have been reviewed in order to streamline Board priorities and specify outcome measures while ensuring that ongoing work is completed.
- A more robust culture of challenge has been developed with one element of this being the establishment of a 'Challenge Log'. Challenges are raised in a number of ways with major ones submitted to the Chair who may then table them at the following LSCB meeting for discussion. The log records details of the challenge, the date, the agencies involved and the outcome for a child or group of children or wider practice. Challenges are submitted by all agencies and concern a wide range of topics such as FGM, teenage

mental health, information sharing between agencies and the impact of housing benefit caps. Other opportunities for agencies to challenge partners include through the multi-agency case audits, conducted by the Quality and Assurance Subgroup. These are brought to the Board for scrutiny, and development sessions about the learning from case and serious case reviews.

- In May 2014 a peer review was commissioned to assist with assessing the effectiveness of the LSCB. It was led by the Independent Chair of another local authority area with experience in improving LSCBs' functions and led to a number of recommendations where improvements could be made.

What difference has it made?

- ✓ Partners have raised issues for detailed consideration of the LSCB such as the Violence Against Women and Girls Strategy, new Police policies on welfare checks, neglect during the first two years of life and how effectively the health needs of Looked After Children are met, especially those placed out of borough.
- ✓ A more streamlined annual Safeguarding Plan was agreed at the start of 2015/16 which specified outcome measures.
- ✓ Challenge identified the need for a more strategic response regarding FGM to ensure that agencies were joined up. As a result, of this, a short life working group was established and this has led to outcomes specified earlier in this report.
- ✓ The peer review exercise led to recommendations which have been acted upon including the improvement of communications, development of smarter LSCB targets and a review of the support allocated to the LSCB.

Next steps

- Take steps to widen the range of LSCB partners who lead sub-groups or short life work groups.
- Develop the profile of the Board and its activities through key messages communicated to all staff via newsletters and the website.
- Improve the logging of escalations to tie in with the "challenge log", to ensure that LSCB has oversight and can make links to future learning and improvement.

Ensuring adequate Business Support to facilitate effective working of the Board

The business support provided for the Board was reviewed in 2014/15 and a revised support structure has been agreed to be implemented. This includes a full time Business Development Manager who will take a project management approach to the day to day running of the Board as well as developing its activities and evaluating progress in the longer term. The Board will also be supported by a Development Worker who will support the

management of the LSCB and its sub-groups, as well as developing and coordinating strategic plans and initiatives, service improvement and overall administration of the Board.

Ensuring the LSCB's training and development programme evaluates its effectiveness and impact on improving front-line practice and the experiences of children, young people and families

The LSCB benefits from a well-trained workforce in the three boroughs with a focus on practice and resources for early help as well as child protection. Safeguarding is regarded as 'everyone's business'. LSCB training is well regarded across the workforce and is attended by a wide range of agencies. Police attendance is low but they do attend their own safeguarding training. The LSCB trainer has excellent links with Commissioning, Education and Early Years colleagues and therefore has frequent access to conferences or briefing events in order to promote training courses where take up is low.

The Learning and Improvement Framework (LIF) aims to ensure that that the LSCB fulfils its statutory obligations; that the multi-agency workforce is suitably skilled and provided with suitable support to learn and improve; that services improve through developing the workforce; that expectations of member organisations and the LSCB are clear; that single and inter-agency training and learning is of adequate quantity and quality; that a standard is set for professional knowledge, skills and values (via the LSCB Training Strategy).

A summary of the training commissioned by the LSCB in 2014/15 is in Appendix C.

What we have done?

- The Learning and Development (L&D) Group has overseen the LSCB multi-agency training programme which has been publicised through a newsletter to staff across the children's workforce. This year's offer has included Core Training as well as a wide range of specialist courses addressing specific safeguarding issues and training for managers and supervisors. Partner agencies share the delivery of the LSCB training offer although the main contributors continue to be Health and Children Services who delivered 19.8 % and 54.2% of the training respectively. Training courses are also delivered in schools by the Safeguarding in Schools lead which are tailored to schools' specific needs.
- The training offer is informed by learning from case reviews, audits and short life working groups as well as focus groups to review the training offer. Training content has also been revised to reflect national developments, for example Neglect training incorporated lessons from the 2014 Ofsted thematic report. Meanwhile changes were made to training provided by health providers to incorporate FGM and CSE. Corporate 'Prevent' training has been promoted across LSCB members and this will continue into 2015/16.
- LSCB-commissioned training has been subject to quality assurance including observations of trainer delivery and course content and mystery shopping exercises.

- Another action this year was for the LSCB's training and development function to better evaluate its effectiveness and impact on improving front-line practice and the experiences of children, young people and families. A revised process commenced in September 2014, focusing on pre and post course evaluation. It included self-assessment of knowledge and competency with a longer term plan to undertake a longitudinal evaluation from delegates three months and six months afterwards to assess the impact of training on practice.

What difference has it made?

✓ Training provided has reached significant numbers of staff. There have been 13 'Introduction to Safeguarding' workshops training 242 delegates; 34 'Multi-agency Safeguarding and Child Protection' workshops training 673 delegates. Specialist and managerial workshops have delivered training to a further 670 delegates:

  - Voluntary sector organisation delegates made up 31% of attendance at 'Introduction to Safeguarding' workshops.
  - Attendance rates for core training remain high at 96.2%
  - Delegate feedback was positive regarding course content and impact on the delegates' knowledge, skills and practice.

✓ Feedback from staff in 2014/15 has led to changes to the 2015/16 training programme including the offer of half-day refresher safeguarding training (Level 3) for delegates who have already attended a whole day workshop in the past. Courses are also being offered at different times to increase accessibility as well as more access to e-learning and external links to Virtual College for FGM and CSE training.

Next steps

- Review and develop the Learning and Improvement Framework.
- The L&D subgroup will collate and analyse information emerging from Section 11 audits to inform assessment of training effectiveness.
- Revise the LSCB training programme to make it leaner and enable us to respond to new and emerging priorities. For example through working alongside the VAWG group to promote CSE training and Harmful Cultural Practices training from the innovation bid to the DfE. There will also be efforts to make links to Adult Services training and sign post where necessary.
- Identify and respond to lessons from the new process of pre and post course evaluation in terms of what forms of training have the best impact upon professional practice and outcomes for children.

CHAPTER 2 – THE LOCAL AREAS' SAFEGUARDING CONTEXT

Local Demographics

- Between the 2001 and the 2011 Census the population of Hammersmith and Fulham and Westminster has risen. The population of Kensington and Chelsea has declined. The population is LBHF: 182,500 (+10%), RBKC: 158,600 (-0.2%), WCC: 219,400 (+21%).
- Kensington and Chelsea is the country's second most densely populated area.
- Hammersmith & Fulham is sixth and Westminster is seventh.
- The population turnover (churn) is high in all three boroughs: Westminster is the highest in London, Hammersmith and Fulham is the fourth and Kensington and Chelsea is the sixth.
- In Hammersmith & Fulham 20% of the population are aged 0 to 19 years, 19% in Kensington and Chelsea and Westminster.
- There are an estimated 86,600 children under 16 living in the three boroughs with recent increases in this population in LBHF (+9%) and WCC (+33%) and a decrease in RBKC (-2%).
- 23% of all households in LBHF contain dependent children; 19.5% in RBKC and 19% in WCC.
- 15,000 (46%) children in LBHF are from Black and Minority Ethnic (BAME) group; 10,300 (38%) in RBKC and 20,500 (57%) in WCC.
- WCC has seen a 73% increase in the non-Christian under 16s population; 41% in LBHF and 2% in RBKC.
- 17% of LBHF children have other (non-British) national identities; 28% in RBKC and 23% in WCC.
- Foreign-born children made up 14% of all children in LBHF; 21% in RBKC and 19% in WCC.

2.1 Vulnerable Children and Young People

This section reviews trends and progress with safeguarding children with high levels of vulnerability. This includes children who need to be supported by a child protection plan and those who need to be in the care of the local authority to keep them safe. It also looks at other cohorts of children and young who have been identified as a priority by the LSCB.

2.2 Children with a child protection plan

Following a child protection case conference which concludes that a child or young person is at risk of abuse, he or she becomes a 'child subject of a child protection plan'. The plan identifies tasks for different agencies to ensure that such children are safe.

At the end of 2014/15, there were **343 children who were subject to child protection plans across the three boroughs**. This included 169 children in Hammersmith and Fulham, 61 in Kensington and Chelsea and 113 in Westminster. Compared with previous years, this is an increase in numbers, except for Kensington and Chelsea which saw a reduction. Compared with most recently available national and London rates (children with child protection plans per 10,000 population, 2012/13), rates were higher in LBHF and lower in RBKC and WCC. Significant work has taken place in LBHF to understand these trends and review practice where required.

2.3 Children in Care

Children in care are “looked after” by one of the three local authorities. Children usually only enter care after significant work which seeks to protect children so they can remain at home with their families. Children can only become looked after either with a parent’s consent or following a court decision.

At the end of 2014/15, 469 children were in care across the three boroughs, 185 were looked after by LBHF, 105 by RBKC and 179 by WCC. Numbers of children in care have reduced since 2012 across the three boroughs, although RBKC and WCC saw a slight increase between 2014 and 2015. Rates of children in care are lower in all three authorities compared to national measures (children looked after per 10,000 population 2012/13) and slightly higher than London rates in LBHF.

The three local authorities have agreed a Strategic Plan for Looked After Children and Care Leavers which sets out the vision and intended outcomes for Looked After Children and Care Leavers in the three boroughs from 2014-17. Individual children in care have regular reviews which are chaired by Independent Reviewing Officers (IROs) to ensure their needs are met over time.

Work with Looked after Children is scrutinised at a borough level by the relevant local authority committee but the LSCB also receives an annual report which gives assurances about different stages of the looked after arrangements. The LSCB has a particular interest in the interfaces with CSE, children missing from care, the stability of care leavers’ lives, the risks that may arise from children being placed away from the local authority area and the risk and impact of neglect.

2.4 Children who are privately fostered

Privately fostered children are those who live away from home following an arrangement with extended family or friends made by their parent or parents. The ongoing challenge is to raise awareness about these children and their needs so that the local authority is notified

and able to assess situations where private fostering appears to be taking place. A Senior Practitioner was employed during 2014/15 to lead on this work with responsibility to coordinate awareness raising across agencies, and to assess and monitor the children concerned. Most children we are aware of are aged 10 or older. Most referrals tend to originate from the UK Border Agency, school admissions or self-referrals. There is a local trend involving young people, usually aged 14 or older living in the local area with host families to attend international schools and colleges. Additional activity to highlight the needs of these children has led to increased levels of referral in 2015/16. LSCB will review t during the forthcoming year.

2.5 Disabled Children

During 2014/15, of the Children in Need who received a service from children's social care, 6% in LBHF, 5% in RBKC and 11% in WCC were children with disabilities. The proportions of children with these needs have remained broadly constant over the past three years although in WCC the percentage has increased from 5% in 2012/13 to 11% in 2014/5. At the end of the year it was noted that of the children receiving services from Children with Disability social care teams, 3% had child protection plans, 5% were looked after children and the rest were Children in Need. During the review of the LSCB's work in 2014/15 it was agreed that a greater focus on the safeguarding of disabled children and young people was needed and has been identified as a key priority in the 2015/16 Safeguarding Plan.

2.6 Young people at risk of offending

The number of young people across all three boroughs starting to receive interventions from the Youth Offending Service reduced to 444 in 2014/15 from 469 in the previous year. However, numbers starting to receive a service in WCC increased by 10. Those who were subject to remands also reduced from 46 young people to 39 although numbers remained the same in LBHF (18 young people). The number and rates of young people receiving custodial sentences increased in LBHF and WCC although numbers decreased from 13 to 4 young people in RBKC. National rates of young people receiving custodial sentences decreased between 2013/14 and 2014/15.

2.7 Young people with mental health issues

Use of mental health services by children and young people is recorded for each of the three CCGs covering the three boroughs. 2,451 referrals were made to Child and Adolescent Mental Health Services (CAMHS). Although the highest number of referrals was recorded for West London CCG, the highest rate of referrals was seen in Hammersmith & Fulham CCG. For all three CCGs, 104 children were admitted to hospital with a primary diagnosis of mental or behavioural disorder in 2014/15 with the admission rate per 10,000 children being the highest in Hammersmith & Fulham CCG (13.4 admissions per 10,000 children). While there has not been a specific focus on the safeguarding needs of children with these needs in 2014/15, there has been significant activity carried out through the Health and Wellbeing Boards and the Children's Trust Board. The Safeguarding Plan for 2015/16 prioritises ensuring that safeguarding practice meets the needs of children with mental health concerns.

CHAPTER 3 – GOVERNANCE AND ACCOUNTABILITY

3.1 What is the LSCB?

The Local Safeguarding Children Board (LSCB) is a statutory body which agrees how relevant agencies work together to help make children and young people safer through promoting the welfare of children and making sure that work taking place is effective. The work of the LSCB during 2014/15 was governed by statutory guidance in *Working Together 2014 (Section 13)* and from March 2015 *Working Together 2015* (Chapters 3-5).

Since April 2012 a single LSCB has been in place to represent the three local authorities of Hammersmith and Fulham (LBHF), Royal Borough of Kensington and Chelsea (RBKC) and the City of Westminster (WCC). A LSCB across three boroughs works well for many partners, particularly as it reduces the duplication of senior managers having to attend three different LSCBs and enables greater engagement. This is particularly the case for some Health leads and the CAIT representative who have regional responsibilities which cover multiple boroughs. There has also been a positive impact on attendance and strength of input. There are complications for some locally-run services such as Police, Housing and Schools at Board level, as representative Board members do not work in arrangements that cross the three boroughs. The communication burden for such partners is challenging but this is partly addressed through the work of the borough-based Partnership Groups.

There is a significant advantage in having best practice, learning and resources from the three boroughs shared, compared and contrasted across agencies. Three geographically small boroughs would be challenged in having the resources to run three boards with the attendant costs of having specialist posts to take forward some of the work of the Board. For example, it is probable that three single LSCBs would not have the funding to support the part-time development workers for faith and voluntary sector, and children and young people's participation. An LSCB for three boroughs has also enabled shared structures and processes to develop, for example in relation to missing children and child sexual exploitation. This is of benefit for agencies operating in a part of London where children often go to school or receive services in neighbouring boroughs which can otherwise lead to confusion over pathways to services and their thresholds.

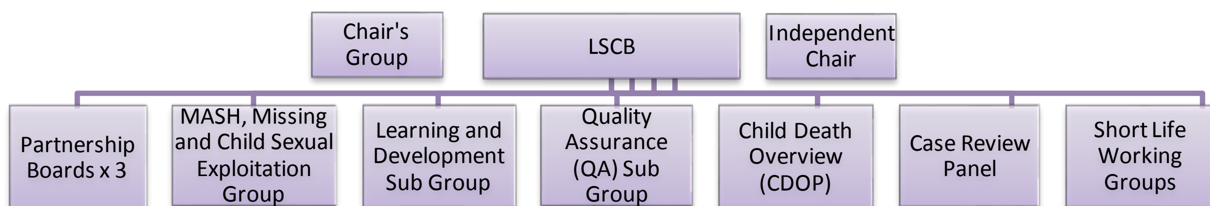
The shared Board is numerically large and the Independent Chair therefore needs to be active and visible across a number of key service areas. Governance arrangements need to ensure that the Chief Executives of each local authority are accountable for the arrangements being made. These arrangements are in place with a protocol agreed with the Chief Executives in 2013. The Scrutiny Committees in each borough receive and consider this Annual Report (as do the three Health and Well-being Boards). The time required to meet these demands is significant but through this the Board benefits from significant review of and feedback about its work.

VISION OF THE LSCB

The LSCB for the three boroughs aims to be 'excellent' in its role in ensuring agencies work effectively together to help make children and young people safer and promoting their welfare. We will make a proportionate response to national issues. A focus on what works best for children means we will support early help and promote family-based care wherever possible. We will work with partners to encourage and challenge a range of organisations to raise their profile to ensure that safeguarding is everyone's business. We will continue to have short-life focus groups to learn and improve and to disseminate learning and knowledge. All of our work will be informed by the voice of the child and the experience of our looked after children. We will manage within our resources but continue to raise any additional requirements where resource limitations impact on our ambition to fulfill our function well.

3.2 LSCB Structure

The structure of the Board and it's subgroups in 2014/15 was as follows:



3.3 Key roles

Independent Chair

The LSCB has been led by Jean Daintith, Independent Chair for three years since its inception in 2012. The Independent Chair is directly accountable to and meets regularly with the Chief Executives of Hammersmith & Fulham, the Royal Borough of Kensington and Chelsea and Westminster City Council. She also works closely with the Executive Director of Children's Services.

Local Authorities

All three local authorities are required to establish a Local Safeguarding Children Board under Section 13 of the Children Act 2004. The leaders of the three councils are responsible for the effectiveness of their respective LSCB arrangements with the Chief Executives accountable to their Leaders.

There is a Lead Member for Children's Services in the Cabinet of all three councils. The Lead Members are responsible for ensuring that their respective councils meet their legal

responsibilities in relation to safeguarding children. All three Lead Members are members of the LSCB with the status of "observers" as defined through Working Together 2015. They also receive regular briefings in relation to safeguarding developments and concerns from the Executive Director of Children's Services and the relevant borough based Family Services Director.

Partner Agencies

Section 13 of the Children Act 2004 sets out which partners must be represented on the LSCB. The representatives of these partners are at a level in their organisation at which they are able to commit to agreed developments in local policy or practice as determined by the LSCB as well as being able to hold their agency to account. There are examples of where the Independent Chair has challenged the level of representation provided by particular agencies which have led to improvements.

Designated Professionals

There are two Designated Doctors, one for Central London Clinical Commissioning Group (CCG) (Westminster) and a second for Hammersmith & Fulham CCG and West London CCG (Kensington and Chelsea). There are also two Designated Nurses covering the same three CCGs. The Designated Professionals' role is to work across the local health system to support other professionals in their agencies on all aspects of safeguarding and child protection. They provide advice and support to health commissioners in CCGs, the local authority and NHS England, other health professionals in provider organisations, quality surveillance groups, regulators, the LSCB/SAB and the Health and Wellbeing Board. They also quality assure the Governance and Accountability arrangements of Provider agencies through their Section 11 audits.

3.4 Organisation of the LSCB

The Board is chaired by an Independent Chair and meets four times a year. In addition to the quarterly meetings, the Board has two half-day development sessions or extra-ordinary meetings and holds special events to provide opportunities for active learning from the findings of case reviews. Much of the business of the Board is taken forward by its subgroups which meet between Board meetings. Each borough also retains a partnership group which has an important role in channeling issues up to, and disseminating messages from, the main Board. Partnership groups also ensure an ongoing focus on specific local issues with oversight from the Board.

A list of LSCB members as at May 2015 can be found in Appendix A. There has been a focus on increasing the participation of key partners and their attendance at the main Board is recorded in Appendix B. An increased representation at the LSCB from schools has been noted although it has been a challenge to have all three school representatives at the Board at the same time. The link with education has been strengthened by the School Improvement Service regularly participating in the QA sub-group. The three Borough Police services are represented at the Board by one Chief Superintendent who is then responsible

for communicating key messages to colleagues in the other two boroughs which can be a challenge.

Communication with local schools about safeguarding outside of LSCB meetings has improved significantly. The LSCB's Safeguarding in Education officer has established active links with schools' safeguarding leads. The officer along with the Local Authority Designated Officer (LADO) have also made progress with engaging the significant number of private and international schools in the three boroughs. An Independent Schools forum has been established with a focus on Safeguarding and Child Protection. This is well attended and feedback from schools is positive with an increase in requests for advice or support being noted. The Director of Education and the Safeguarding in Education Officer have regular mechanisms for communication with schools about relevant matters, including private and independent schools and the Independent Chair of the LSCB has attended the Head Teachers Executive meeting to discuss safeguarding.

The Independent Chair has intervened where there have been concerns about communication between related agencies, levels of representation at the Board or the impact of changes in resourcing. This has included challenge of the Child Abuse Investigation Team (CAIT) regarding regional levels of resourcing for investigations and strategy meetings and raising this issue with London Councils. There are examples of where other partners have responded to challenge about their level of representation which have led to new arrangements which have improved the contributions made to discussions and debates as well as the quality of joint working between meetings.

3.5 Key relationships

Health and Wellbeing Boards

There is a Health and Wellbeing Board in each of the three boroughs. The Boards are chaired by the Lead Member for Adults Services and members include representatives from local authority services (including the Executive Director of Children's Services), the Lead Members for Children's Services, the NHS and the voluntary sector. A protocol for working arrangements has been agreed between the LSCB and each of the three Health and Wellbeing Boards which has enabled the Independent Chair to present the LSCB Annual Report to each Board as well as the identification of shared priorities in relation to safeguarding children.

Children's Trust Board

A single Children's Trust Board was established for all three boroughs in 2014/15. It is chaired by the Executive Director of Children's Services who is also a member of the LSCB. In its first year, the Children's Trust Board has focused on developing multi-agency approaches to key commissioning developments including child and adolescent mental health and sexual health. The Independent Chair has presented the LSCB's priorities to the Children's Trust Board which informed the CTB's initial workplan.

Clinical Commissioning Groups (CCGs)

There are three CCGs covering the LSCB's area but the CCG collaborative group represents these at the LSCB with the Director and Assistant Director of the collaborative being members of the Board.

In addition, all relevant health organisations attend a Health Sub-group which is chaired one of the Designated Nurses. This was set up at the end of the 2014/15 and will be absorbed into the overall governance structure in 2015/16.

In 2014/15, Child Death Overview Panel (CDOP) work was led by the Clinical Commissioning Groups on behalf of the LSCB. The CDOP has continued to report to the LSCB and strengthen the links with the other subgroups to ensure that safeguarding issues are fully addressed and learning achieved to prevent future deaths.

3.6 Quality Assurance

The Quality Assurance (QA) subgroup takes a lead role in fulfilling the LSCB's scrutiny functions. The Quality Assurance Framework, launched in 2013, provides the LSCB with an opportunity to scrutinise key information from agencies across the partnership, incorporating quantitative data, information about the quality of services, and information about outcomes for children, asking: How much? How good? and What difference? Exceptions are escalated through relevant reporting mechanisms for discussion and decision, with the results fed back down and action followed up by the QA subgroup or individual agencies.

The data set examined by the subgroup has identified patterns, changes and early warning signs within interagency safeguarding work (see sections on Child Protection Plans and Missing Children for examples). Some agencies which collect information regionally or with alternative boundaries have had difficulties providing data specific to one or three boroughs and there are some logistical issues with collating a data set from such a wide range of sources to enable all emerging issues to be responded to in a timely way. However, management information has improved this year: better information from the Police has allowed the group to examine conviction rates while information from Housing has fed into the Domestic Violence Strategy. An area for development will be to find ways to use the large amount of data more meaningfully and selecting particular themes for analysis.

The QA subgroup has carried out a number of multi-agency themed audits of front-line practice concerning specific Board priorities. In 2014/15 this has included domestic abuse, neglect and child sexual exploitation. These were led by officers independent and external to the LSCB usually reviewing up to 15 cases from the three boroughs. In the last year, additional resource has been created for audit arrangements by putting in place a new 'QA Manager' role, in order to ensure improved agency engagement, such as with schools and to enable more robust reporting on the impact of audits on front line practice and outcomes for children. Audit findings are presented at LSCB meetings and agencies are tasked to take action as required. The new QA Manager role will follow up recommendations to ensure

learning is widely disseminated and impact is measured. Recommendations from past multi agency audits will be reviewed at Board meetings.

In 2014/15, the pan-London template for Section 11 reporting was reviewed and revised, based on Working Together guidance and to make the audits more evidence based. The new template will also encourage an improved partnership approach for the identification of strengths and weaknesses and offering mutual support, rather than an approach which previously may have been viewed as criticism or scrutiny by the Local Authority. Audits will be conducted electronically so that results can be collated and analysed and presented to the QA subgroup for scrutiny. The final draft will be trialed during the summer of 2015. Further to a Voluntary Sector Safeguarding event in May 2014 there has been a strengthening of links with partnership groups and LSCB representation at Voluntary Sector fora. The key focus is Section 11 responsibilities and liaison with the Commissioning Directorate concerning services commissioned by the local authority to work with children and young people.

In addition, the LSCB has considered findings from new Local Authority Ofsted reports and paid regard to issues relating to safeguarding and child protection which have emerged from Ofsted School inspections. Consideration has been given to carrying out a JSNA on children's safeguarding although Public Health advice has been that a JSNA may not be the right tool for this purpose. The three HWBs have commissioned a number of JSNAs, including one on child poverty and this will inform the Board's work.

A peer review of the LSCB recommended that the Board should monitor the impact of restructured front line services. In the last year, the relevant Assistant Director presented a report to the LSCB following the development of a number of services for looked after children and care leavers which were shared by all three boroughs. A report with a similar focus is anticipated on the progress of the restructured Adoption and Fostering service. The Board has been updated on Focus on Practice, a significant transformation programmes across Children's Services, and Partnership Groups have also discussed any emerging pressures on front-line services. In addition the Chair of the LSCB introduced a standing item at the Board meetings for agencies to update on organisational changes that impact on service delivery. The opportunity to challenge agencies about practice is explicit both in meetings and by professional contacts between Board members outside meetings.

Again this year, each of the boroughs has conducted a 'Practice Week' through which managers undertook practice observations and case file audits, as well as providing coaching and feedback sessions with staff and supervisors. Common themes are subsequently written up to inform learning, development and follow up discussion. This also gives staff an opportunity to talk about work they are proud of and any barriers that may exist to getting the best outcomes for children. In particular, managers look at the journey of the child and evidence which clearly communicates purpose of interventions. Results of the practice weeks include a focus on the quality of return home interviews for missing children which also informed the development of the new Missing Children Co-ordinator role.

3.7 Local Authority Designated Officer (LADO)

A well established LADO service continues to develop strong working relationships across children's services within the three boroughs and with external statutory partners. This builds a coordinated and consistent approach to allegations management, facilitates the dissemination of guidelines in respect of safe working practice and aids the development of organisational cultures which facilitate safeguarding. Strong links have also been established with the regulators and inspectorate and with LADOs both across London and nationally; the LADO lead co-coordinates the pan-London LADO group and this year organised the second National LADO Conference which was hosted by shared Children's Services of the three boroughs.

During 2014/15 there were 148 allegations referred to the LADO across the three boroughs (LBHF:68, RBKC:21, WCC:59) from a wide range of agencies and relating to both professionals and volunteers who work with children.

The LADO lead sits on the Learning and Development subgroup and delivers nationally accredited safe recruitment training which is open to all agencies. A separate refresher course is also available taking learning from Serious Case Reviews and a 'meet the LADO' session has also been added to the LSCB. Explicit reference to the arrangements for managing allegations in the three boroughs is also made in all multi – agency training and there is emerging evidence that this has led to an increase in reporting and consultation.

Nationally the successful prosecution of high profile perpetrators of abuse has enabled further victims to come forward with confidence. This has been reflected locally by an increase in referrals and of referrals of a historic nature in particular. In addition the number of referrals relating to conduct outside the workplace has increased particularly with regard to adults who work with children who have accessed and/or are in possession of child abuse images. The LADO works closely with HR departments in the three boroughs and with those providing Human Resources services for partner agencies. Organisations also regularly ask for LADO advice relating to the suspension of employment , matters relating to disciplinary procedures and referrals to the Disclosure and Barring Service and professional bodies.

The introduction of new arrangements relating to disqualification by association has also led to an increase in contact with LADOs for advice in terms of assessment of risk and the application to Ofsted for waivers relating to those involved.

There has also been an increase in referrals and consultations relating to adults, working in various sectors, who have not been appropriately trained and supported to work with children and young people, some of whom have complex needs. Often these cases do not reach the threshold for criminal investigation or intervention by children's services but evidence a need for adults working in this sector to be clearly briefed about conduct and expectations relating to their work with children and young people. It is also becoming evident, when cases are investigated, that early signs of offender behaviour are not always recognised as a cause for concern; staff may not be equipped to recognise these concerns or are not confident to report them.

The following areas have been identified for development by the LADO service:

- Continue to raise the profile of the service with all partner agencies to ensure that referrals and consultations continue to be timely and appropriate.
- Review key contacts with partner agencies in order to provide a directory for all those who hold the LADO function.
- Increased liaison with Adults' Services on the development of the role of designated allegations' management leads.
- Continue to roll out lessons learned from Serious Case Reviews to reinforce best practice.
- Brief teams and organisations on safe working practice including revised national guidance is expected later this year.
- Increase understanding and awareness for those in the children's workforce regarding the modus operandi of offenders.

3.8 Complaints

Complaints regarding the conduct of Child Protection Conferences are dealt with under the LSCB Complaints Procedure. The complaints procedure has two stages with a strong emphasis on resolving complaints at the first stage. From 1 April 2014 to 31 March 2015, 9 complaints were recorded at Stage One of the complaints Procedure. The LSCB successfully resolved 7 complaints at Stage One and 2 were escalated to Stage Two.

Learning from complaints is an important part of the LSCB's philosophy and managers responding to complaints are encouraged to identify any shortcomings within the service and to inform the service user of any actions which will be taken to prevent a recurrence of the event which led to the complaint. Examples of learning during the last year are:

- Following the consideration of a complaint at Stage Two, the LSCB agreed to undertake a review of the way information is recorded for Review Child Protection Conferences. This had a particular emphasis on accuracy so that information provided from previous conferences has a review date, and where the information is no longer accurate, it should be updated in the conference minutes.

- A review of the management of split conferences was also undertaken, including the information provided to families in order to improve practice and enhance parent participation.

3.9 Financial arrangements

The total budget for 2014/15 from partner contributions was £250,241. £167,591 was contributed by the three local authorities with additional contributions totalling £82,650 from the Metropolitan Police, Probation, CAFCASS and the CCGs. Additional expenditure during the year was covered from LSCB reserve funding.

Budget Summary Table

	LBHF	RBKC	WCC	FORECAST
Contributions received in 2014/15				
Sovereign Borough general fund (BUDGET)	-65,951	-49,340	-52,300	**-167,591**
Partner Contributions in 2014/15				
Metropolitan Police	-5,000	**-5,000**	-5,000	**-15,000**
Probation	-2,000	**-2,000**	-2,000	**-6,000**
CAFCASS	-550	**-550**	-550	**-1,650**
CCG (Health)	-20,000	**-20,000**	-20,000	**-60,000**
Total Funding excluding reserves 2014/15	**-93,501**	**-76,890**	**-79,850**	**-250,241**
Forecast Expenditure in 2014/15	**LBHF**	**RBKC**	**WCC**	**FORECAST**
Salary expenditure	89,195	84,582	82,099	**255,876**
Independent Chair	9,319	9,319	9,319	**27,957**
Training	11,221	13,321	13,321	**37,863**
Peer review	1,891	1,891	1,891	**5,673**
Multiagency Auditing	9,303	9,303	9,303	**27,909**
SCR expenditure 1415	18,714		14,581	**33,295**
Other LSCB costs	3,794	6,879	4,569	**15,242**
Total expenditure	**143,437**	**125,295**	**135,083**	**403,815**
Outturn variance in 2014/15 including SCR	**49,936**	**48,405**	**55,233**	**153,574**
LSCB RESERVES as at P9				
	LBHF	**RBKC**	**WCC**	**FORECAST**
Reserves at start of year	-29,050	-116,240	-145,812	**-291,102**
Adjustments in year	5,000	-5,000		

DD in 201415	18,550	48,405	55,233	**122,188.00**
Reserves to take forward into 2015/16	**-5,500**	**-72,835**	**-90,579**	**-168,914**
	CONFIRMED	*CONFIRMED*	*CONFIRMED*	
LSCB final outturn	**31,386**	**0**	**0**	**31,386**

CHAPTER 4 – WHAT HAPPENS WHEN A CHILD DIES OR IS SERIOUSLY HARMED?

4.1 Child Death Reviews

A Child Death Overview Panel (CDOP) is in place covering the three boroughs. It considers circumstances relating to the deaths of children including any implications for future practice and strategic planning.

Twenty three deaths were reviewed by CDOP during 2014-15. These related to children who died between 2011 and 2015. Of the 23 cases, 9 were unexpected. The key themes for the unexpected deaths related to life limiting disease and sudden unexplained death of infants. Unexpected deaths led to a rapid response investigation led by the Designated Paediatrician for Unexpected Child Deaths to ensure there were effective multi agency investigations carried out and that the families were supported through their bereavement.

The main category of death continues to be perinatal events. This is consistent with the national trend and has led to intensive scrutiny of neonatal deaths by the Designated Paediatrician for Unexpected Deaths in conjunction with a Consultant Neonatologist. The Panel consists of a lay member who advises and ensures that the support that parents receive is adequate and of a high standard. A thorough review of cases has revealed that the standard of care is good. Due to the small number of deaths in the three boroughs there is limited learning arising from the reviews. This is not inconsistent with what is reported by other CDOPs.

What difference has it made?

- Developing LSCB training to include awareness of responsibilities regarding child deaths has led to increased consultation of the Designated Paediatrician for Child Deaths by other Trusts across the three boroughs, neonatal units and Paediatric Intensive Care Units as well as improved links with the Designated Paediatrician for Child Death in neighbouring Brent.
- CDOP reviewed and confirmed the effectiveness of feedback and support for those where the child has died within local NHS hospitals.
- Databases and information gathering processes have been developed to ensure that better information is now available about the ethnicity of children who have died is included.
- A registrar's review of sudden unexpected deaths in infants concluded that many babies who die have factors which put them at risk such as adverse social, environmental and medical factors. As the death of a baby should be described in terms of all the factors present in his or her life and not just the post-mortem findings, the study has demanded that data about child deaths is collected in a more rigorous way going forward.

Next Steps

- As part of a CDOP case in April 2015, the CDOP subgroup reviewed the feedback provided to families regarding Panel findings. The review indicated that information cannot always easily be automatically fed back to families due to third party information and inappropriate information such as criminal investigations. This area requires further development. However, the review highlighted work that needs to take place with childminders ongoing registration requirements. Also, that where a case is subject to coroner's inquest, the inquest findings will be available to the family.
- During 2015-16, links will be made with some of the other CDOPs across North West London to identify how learning from a wider number of cases can be shared.
- More work is required to ensure that those dying in Private Hospitals or outside of the boroughs are receiving effective feedback and support.
- Strengthen the contribution of Public Health to the Panel to support better identification of the extent to which socio-economic factors impact on the deaths of local children and to ensure that the learning from the reviews is incorporated into the Joint Strategic Needs Assessment.
- Strengthen links to local Coroners to support a more effective response to deaths abroad
- Review the Rapid Response Protocol and ensure appropriate linkages between Rapid Response, CDOP and the Case Review Sub Group.

4.2 Case Reviews

A "serious case" is where abuse or neglect of a child is suspected and either the child has died or has been seriously harmed and there is cause for concern about how organisations or professionals worked together to safeguard the child. Locally the LSCB case review sub group considers new child care incidents and makes recommendations to the LSCB Chair on whether a serious case review (SCR) or other type of review should be held.

What have we done?

- In 2014/15, the sub-group oversaw the commencement of two new serious case reviews and received one completed serious case review report. In addition, one new "case review" started, four completed review reports were received along with three Individual Management Reports that contributed to a serious case review in another Local Authority.
- The first SCR initiated was referred to as 'Sofia'. A report was completed and the learning from the review was presented at an LSCB meeting with the Board agreeing a response. A learning event was then held to share findings with the three boroughs and

other Boards who had involvement with the case. This SCR report will be published once criminal proceedings are concluded, so that learning can be disseminated more widely.

- The second SCR initiated was in response to abuse at an international school, based in Westminster. This case attracted national publicity because of the extent of the abuse and the suicide of the alleged perpetrator. The review is ongoing and is likely to report in the autumn 2015, following which it will be published. It is likely to be of national interest and the learning will be disseminated widely.
- The sub group considers national or other Local Authority review reports where there are lessons for local services. This is consistent with the Learning and Improvement Framework.

Key learning points from reviews identified by the sub group include:

- The need to avoid a “mindset” approach to cases, where they become compartmentalised as types of cases which require a particular response, e.g. “an adoption case” or “an education case”. Compartmentalising cases in this way was seen to have hindered thinking about other relevant issues e.g. links to gangs or parenting issues in the two cases reviewed.
- The importance of effective reflective supervision and its role in encouraging a more holistic approach to meeting children’s needs has been stressed.
- There has also been learning around working with mobile families, handover of cases, the chairing of Child in Need reviews, working with adoptive families, emotional attachment disorders, best practice in permanency planning, concealed pregnancy and the role of schools in deciding appropriate responses to drug use.

- The Case Review subgroup produces a quarterly ‘Learning Review’ newsletter to ensure that learning improves the quality of practice. This is circulated to Children’s Services and key contacts from partner agencies. In 2015/16 the new website for the LSCB will be a place where all practitioners can access the newsletter and between now and then the LSCB is disseminating the newsletter to front-line staff at safeguarding courses. It is also sent as a link to GPs via CCGs. The Chair of the L&D Subgroup has held two learning workshops as part of the LSCB training offer this year, based on lessons from recent case reviews.

What difference has it made?

Please see sections on Learning of Case Reviews, Domestic Violence and Abuse and Neglect for information about impact of specific SCRs.

Next Steps

- Provide more 'bite-size' courses on learning from current case reviews so that practitioners can attend sessions more easily within busy work schedules.
- A current SCR regarding abuse in an international school in Westminster has highlighted a major learning point at a national level: that the abuser had a previous conviction in the United States but when he was recruited, there were not comprehensive overseas checks. Reviewing how agencies undertake checks for people who have worked or lived abroad may be a national issue for agencies well beyond the LSCB. The LSCB will consider requesting partner agencies to review their own agency and report to the LSCB. The LSCB could also lobby central government for assistance in this area.

CHAPTER 5 – STATEMENT OF SUFFICIENCY AND FUTURE PRIORITIES

5.1 Statement of Sufficiency (LSCB Chair)

Information submitted and presented in this annual review demonstrates that the LSCB for Hammersmith & Fulham, Kensington and Chelsea, and Westminster fulfills its statutory responsibilities in accordance with Children Act 2004 and the Local Safeguarding Children Board Regulations 2006. This Review is evidence that the LSCB has coordinated the work of agencies represented on the Board, for the purposes of safeguarding and promoting the welfare of children in the area. It also captures the mechanisms the LSCB has in place to ensure and monitor the effectiveness of what is done by agencies to safeguard and promote the welfare of children across the three boroughs and to challenge agencies to improve coordination and learn from review and audit.

5.2 Priorities for 2015/16

It has been noted that our previous plans have consisted of a long list of actions and we may be criticised for trying to do everything rather than focusing on a few matters. However, we are committed to doing well across all our areas of responsibility. While we aim to be aware of and responsive to the emerging themes of the national and local safeguarding agenda, we are also keen to continue to develop our approach to longer term priorities until we are satisfied that sufficient progress and impact has been made. This is reflected in a number of actions identified in this report where we want to improve still further. We are also conscious of the need to balance priorities to ensure that responses to significant risks to comparatively small numbers of children and young people are progressed while not losing sight of wider safeguarding issues which affect a larger cohort.

For 2015/16 we have sought to design smarter objectives. **The LSCB's Safeguarding Plan for 2015/16** has been signed off by the LSCB. Following a review of the previous year's Business Plan, consultation with partner agencies and discussion with the Board, the headline priorities are as follows:

Continue to deliver the core business of the Board at high quality

- Evaluation and challenge of the role of Early Help in safeguarding children
- Engagement with diverse communities
- Effective child protection plans
- Multi-agency responses to neglect
- Ensure safeguarding practice meets the needs of children with mental health concerns, who are disabled or affected by domestic abuse

Improve the Board's effectiveness in reducing harm to children

- Learning from each other in a context of organisational change
- Increased learning from case reviews
- Ensuring that the needs of children from marginalised groups are scrutinised by the Board
- Effective communication with a multi-agency workforce
- Holding each other to account - challenge that improves outcomes
- Maximising our wider partnerships to better influence impact on the ground

Ensure effective, proportionate, multi-agency responses to safeguarding issues which affect children & young people with high levels of vulnerability

- Female Genital Mutilation
- Sexual exploitation
- Addressing perpetrators of abuse and exploitation
- Involvement with gangs
- Going missing
- Substance misuse
- Radicalisation of young people

Our developments and action in relation to these priorities will be informed by the voice of the child & the experience of our looked after children. We have also indicated how we would expect to measure the impact of our work and will report on our progress with this in our next Annual Report.

Essential Information

Authorship Jean Daintith (Independent Chair of the LSCB) and Children's Policy Team, Westminster, Kensington and Chelsea and Hammersmith and Fulham

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APPENDIX A BOARD MEMBERSHIP

(Membership as at May 2015)

Surname	Forename and title	Role	Borough or area (if relevant)	Agency
Armotrading	Lavinia	Designated Nurse for Safeguarding Children Central London and West London CCGs		Health - CCG
Ashley	Dr Louise	Chief Nurse and Director of Quality Assurance, CLCH		Health - CLCH
Brownjohn	Nicky	Associate Director for Safeguarding (CWHH) CCGs		Health - CWHHE CCG
Bywater	Steve	Policy and Performance Manager	Hammersmith & Fulham	Children's Services
Campbell	Cllr Elizabeth	Cabinet Member for Family and Children's Services, RBKC	Kensington and Chelsea	Councillor
Caslake	Melissa	Operational Director of Children's Services (WCC)	Westminster	Children's Services
Chaffer	Denise	Director of Nursing NW London Area Team NHS England		Health - NHS England
Chalkley	Cllr Danny	Cabinet Member for Children's Services, WCC	Westminster	Councillor
Chamberlain	Clare	Director of Family Services (RBKC)	Kensington and Chelsea	Children's Services
Christie	Andrew	Executive Director of Children's Services		Children's Services
Daintith	Jean	Independent LSCB Chair		Independent Chair
Dehinde	Tola	LSCB Lay member	Kensington and Chelsea	Lay person
Dodhia	Hitesh	Head of Operations (Gate / Visits) Wormwood Scrubs		Prisons
Flahive	Angela	Joint Tri Borough Head of Safeguarding Review and Quality Assurance (WCC, RBKC, H&F) Children's Services		Children's Services
Goddard	Andrea	Designated Doctor for Central London CCG		Health - Imperial
Grant	Patricia	Designated Nurse for Safeguarding Children Hammersmith and Fulham CCG Health Adviser to LSCB	Hammersmith & Fulham	Health - CCGs
Hargreaves	Paul	Designated Doctor for Hammersmith & Fulham and West London CCGs	Hammersmith & Fulham	Health - Chelwest
Heggs	Ian	Tri-borough Director for School Commissioning		Education
Hillas	Andrew	Assistant Chief Officer, London Community Rehabilitation Company		Probation

Hine	Coretta	MPS CAIT		Police - Met
Hrobonova	Eva	Consultant in Public Health Medicine		Health - Public Health
Jackson	Sally	Partnership Manager, Standing Together		Voluntary Sector
Jones	Will	Assistant Chief Officer National Probation Service		Probation
Knights	Catherine	Associate Director of Operations, Central North West London Mental Health Trust		Adult Mental Health
Leeming	Wayne	Head Teacher Melcombe Primary School	Hammersmith & Fulham	Education - School
Maclean	Caroline	Director of ASC Ops		Adult Safeguarding
Macmillan	Cllr Sue	Cabinet Member for Family and Children's Services	Hammersmith & Fulham	Councillor
Meyrick	Olivia	Executive Head of QEII and College Park School	Westminster	Education - School
Miley	Steve	Director of Family Services (H&F)	Hammersmith & Fulham	Children’s Services
Raymond	Debbie	Head of Combined Safeguarding & Quality Assurance		Children’s Services
Redelinghuys	Johan	Director of Safeguarding and Named Doctor WLMHT		Adult Mental Health
Riley	Belinda	Interim LSCB Business Manager		LSCB
Roberts	Greg	Supporting People and Homelessness Strategy Manager (WCC)	Westminster	Housing
Royle	Liz	Head of Safeguarding, CLCH		Health - CLCH
Scott Plummer	Poppy	LSCB Lay member	Hammersmith & Fulham	Lay person
Sloane	Vanessa	Director of Nursing and Quality. Chelsea and Westminster Hospital		Health - Chelwest
Springer	Gideon	Chief Superintendent Borough Commander Hammersmith and Fulham	Hammersmith & Fulham	Police - Met
Steel	Senga	Deputy Director of Nursing		Health - Imperial
Taylor	Adam	Head of Commissioning		Community Safety Team
Taylor	Alan	Head of Safeguarding, London Ambulance Service		Health - London Ambulance
Virgo	Elizabeth	LSCB Lay member	Westminster	Lay person
Webster	Dr Jonathan	Director of Quality, Patient Safety and Nursing CWHH CCG Collaborative		Health - CWHHE CCG
Whyte	Sally	Head Teacher of Lady Margaret Secondary School	Hammersmith & Fulham	Education - School
Yilkan	Zafer	CAFCASS		Cafcass

APPENDIX B LSCB MAIN BOARD ATTENDANCE

Role	16th April 13	16th July 13	15th Oct 13	14th Jan 14	15th Apr 14	15th Jul 14	14th Oct 14	13th Jan 15	21st Apr 15	14th July 15
LSCB Chair	y	y	y	y	y	y	y	y	y	y
Executive Director of Children's Services	y	y	y	y	y	y	y	y	y	y
Director of Family Services (H&F)	y	y	y	y	y	y	y	y	y	y
Director of Family Services (RBKC)	o	y	y	y	x	y	y	y	y	x
Director of Children's Services (WCC)	y	y	y	y	y	y	y	y	y	y
Director of Schools	y	y	y	y	y	y	x	x	y	y
Head of Combined Safeguarding & Quality Assurance	y	y(2)	y	y	y	y	y(2)	y	y	y
LSCB Business Manager	y	x	y	y	y	y	y	y	y	y
Director of Adults Safeguarding	x	y	y	x	y	x	y(2)	y	y(2)	y
Housing	y	y	y	y	y	y	y	y(2)	y	y
Borough Command	x	y	y	y	y	y	y	x	y	y
CAIT	y	y	x	x	y	y	y	y	y	y
Probation	y	y	x	y	y	y	y	x	y	x
Community Rehabilitation Company	o	o	o	o	y	x	x	y	y	y
CAFCASS	y	y	x	y	x	x	x	y	x	x
Prisons	o	o	o	y	x	x	y	y	y	x
Ambulance Service	o	y	y	y	x	y	x	y	y	y
Voluntary Sector	y	y	y	y	x	y	y	x	y	y
Lay member	o	y(2)	y(3)	y(2)	y	y(2)	y(2)	y	y	y(2)
NHS England	x	x	x	x	x	x	y	x	x	x
Health CCGs	y	y	y(2)	y	y	y	y	y(2)	y	y
Designated Doctor INWL/Designated Doctor Chelwest	y(2)	y(2)	y	y(2)	x	y	y(2)	y	x	y
Designated Nurse	y	y	y	y	y	y	y	y	y	y
Head of Safeguarding,	y	x	y	y	y	y	y	y	y	y

CLCH										
CLCH Director of Nursing	x	y	x	y	x	x	y	x	x	y
Imperial Director of Nursing	y	y	y	y	y	y	y	y	y	x
Chelwest Director of Nursing	y	x	x	y	y	x	y	x	x	y
WLMHT	y	y	y	y	y	x	x	y	y	y
CNWL	y	y	y	y	y	y	y	y	y	y
Public Health	y	y	x	y	y	y	y	y	x	y
Community Safety Team (Commissioning)	o	o	o	o	y	y	x	y	y	y
Policy Team (Commissioning)	o	o	o	o	o	o	o	o	y	y
Head Teachers	o	o	o	y(3)	x	x	y	y(2)	x	x
Cabinet Member for Children's services, H&F	o	y	y	y	x	y	x	y	x	x
Cabinet Member for Family and Children's Services, RBKC	y	x	x	y	y	x	y	x	y	y
Cabinet Member for Children's Services, WCC	y	y	y	y	x	x	x	x	x	x

APPENDIX C LSCB TRAINING OFFER 2014/15

The training offer has been as follows:

Core training:

- Introduction to Safeguarding
- Multi-agency Safeguarding and Child Protection

Specialist Training:

- Domestic Abuse and Safeguarding Children
- Parental Mental Health and Safeguarding Children
- Parental Substance Misuse and Safeguarding Children
- Working Effectively with Interpreters
- Abuse and Young People's Relationships
- Girls, gangs and sexual violence
- Awareness of cultural practices (FGM and honour based violence)
- Be wise to Sexual Exploitation
- Safeguarding Children with Special Needs
- Safeguarding Children who may be involved with gangs
- Safeguarding Children: The Impact of Neglect
- Safeguarding Neglect: Identifying and intervening
- E-safety
- Fabricated and Induced Illness
- Working with Difficult and Evasive Families
- Working Effectively with Interpreters
- Forced Marriage and Honour Based Violence (Karma Nirvana Roadshow)
- A whole programme on Joint Investigation – well attended by Children's Services staff but not attended by health or police so it has been removed from 15/16 programme

Managerial Training:

- Safer Recruitment
- Supervision in relation to Safeguarding Children
- Serious Case Review: What do we have to Learn?
- Advanced Skills Workshops for Supervisors: Assessment and Analysis
- Advanced Skills Workshops for Supervisors: Safeguarding young people and gangs.

The LSCB training offer is continually reviewed to ensure that it responds to local priorities and demands. The L&D team has convened a number of focus groups with training participants, managers, subgroup members, trainers and safeguarding specialists to review the training offer. The LSCB training team hosted some of the national Karma Nirvana roadshows to update the workshop on changes to legislation on forced marriage. Other developments and progress against 2014/15 priorities included:

- Neglect Training. This was as a result of individual agencies asking to review internal training in light of local and national case reviews and the Ofsted Thematic Report of 2014.
- Level 3 Safeguarding. The programme includes learning from recent national and local case reviews. It has been updated, with new programmes in place and plans to ensure all LSCB trainers are competent to deliver.
- E-Safety. Following the report and recommendations from the e-safety short life working group, e-safety has been incorporated into training for Designated Leads and further specialist training has been commissioned for Designated Leads and specialist staff to commence in September 2015. There is also signposting to support available from CEOP, NSPCC and Internet Watch Foundation, among others.
- Safeguarding in Schools. From January 2015, the Lead for Safeguarding in Schools has been using a new audit tool to support schools evaluate their effectiveness in meeting safeguarding responsibilities. Evaluation and feedback has been used to inform training on Safer Recruitment including management of allegations in 2015/16.
- Signposting to Prevent workshops.
- Ensuring all agencies have the highest standards in safer recruitment of staff. A revised scenario in multi-agency safeguarding Level 3 course was also included about the role of the LADO to raise awareness and signpost to safer recruitment training.
- The promotion of training amongst community and voluntary sector organisations to increase take-up. The LSCB's Community Development Worker co-ordinated an event for the faith and voluntary sector where the LSCB training programme was promoted.
- A focus on diversity issues (FGM and forced marriage).