Local Safeguarding Children Board

Hammersmith & Fulham | Kensington and Chelsea | Westminster

# DRAFT ANNUAL REPORT

# 2015 / 2016



## FOREWORD BY LSCB INDEPENDENT CHAIR

I have been the Independent Chair of the Local Safeguarding Children Board for the three boroughs of Hammersmith & Fulham, Kensington and Chelsea and Westminster since it was established in April 2012. This is my fourth report, covering the year April 2015 to March 2016.

The LSCB is a statutory body and is a partnership comprising statutory partners who are charged with compliance with 'Working Together' (the statutory guidance underpinning LSCBs) and other partners, including lay members. We meet as a Board four times a year; but, the LSCB comprises a number of subgroups and a range of activities. The Board is responsible for the strategic oversight of child safeguarding arrangements by all agencies. It is not accountable for delivering child protection services - but it does need to know how well things are working.

This year the annual report presents information about what we know about children in our area, key partner agencies' activities in relation to safeguarding, the activities of the Board, the governance and accountability arrangements, an overview of serious case reviews and a review of the priorities for the coming year as well as some additional information on budget. The report refers to the 2016 Ofsted review of the LSCB (a judgment of Good') and the impact of resources - a reality for all agencies. The priorities for 2016/17 are included in the report.

An early start is being made to consider future options for making the local arrangements more effective. This needs to align with the changes that will be introduced nationally by government for multi-agency safeguarding leadership. 2016/17 is my final year chairing the Board and so I am working with others towards the handover, anticipating the national changes.

Once again I want to thank staff for the difference they continue to make to the lives of those with whom they work. Safeguarding is at the forefront of all that they do.

**Jean Daintith, Independent Chair**

## Contents

**EXECUTIVE SUMMARY**

This report, as required of the Independent Chair through “Working Together to Protect Children 2015”, provides an overview of the effectiveness of child safeguarding and promoting the welfare of children in the areas of Hammersmith & Fulham, Kensington and Chelsea and Westminster in 2015/16. It includes a self-assessment of the performance and effectiveness of many of the local and regional agencies represented on the LSCB and identifies a number of areas where improvements are required. The report also summarises a number of reports that have been published following reviews of incidents where children have died or been seriously injured and where abuse or neglect is thought to have been involved. The learning that has resulted from such reviews and how these have been communicated to those who work with children is also included.

The Safeguarding Plan for 2015/16 is reviewed with an overview of where progress has been made as well as areas where further work or attention is required. The Report concludes with an Assurance Statement provided by the Independent Chair and outline of the priorities of the LSCB for 206/17.

## LOCAL BACKGROUND AND CONTEXT

The Local Safeguarding Children Board covers three inner London local authority areas. A total of 579,420 people live in the area, of which 110,240 or 18% are children aged 0-18[1].

| **Local Population Profile*** *(mid year 2015 population estimates)* | **LBHF** | **RBKC** | **WCC** | **Total** |
|---|---|---|---|---|
| All ages resident population | 179,410 | 157,711 | 242,299 | 579,420 |
| 0 to 4 years | 11,601 | 8,981 | 13,927 | 34,509 |
| 5 to 10 years | 11,990 | 9,989 | 14,616 | 36,595 |
| 11 to under 19 years | 12,154 | 10,683 | 16,299 | 39,136 |
| Total 0 to under 19 years | 35,745 | 29,653 | 44,842 | 110,240 |

As with many boroughs in London, there are areas with high levels of affluence but also localities where there are significant levels of deprivation. The three boroughs' rates of child poverty after housing costs were (in 2014):

Hammersmith & Fulham 31%
Kensington and Chelsea 28%
Westminster 39%

These figures do not show the variations in levels of poverty within wards. For example, using the Her Majesty's Revenue and Customs (HMRC) measure of child poverty, the ward with the highest rate in London was Church Street in Westminster where 50% of children were classified as being in poverty[2]. 10 wards across the three boroughs have child poverty rates of over 40%.

As with many London boroughs, the three areas covered by the LSCB have highly diverse populations. The 2011 Census identified a BAME (black, Asian and minority ethnic) population of 188,969 people living in the area (58,271 in Hammersmith & Fulham, 46,632 in Kensington and Chelsea and 84,066 in Westminster).

The profile of the most vulnerable children in the LSCB area is summarised below.

**Children subject to a child protection plan at 31 March 2016**
**(and comparative figures since 2011-12)**

| | **2011-12** | **2012-13** | **2013-14** | **2014-15** | **2015-16** |
|---|---|---|---|---|---|
| **Hammersmith & Fulham** | 134 | 142 | 161 | 169 | 133 |
| **Kensington and Chelsea** | 79 | 74 | 92 | 61 | 85 |
| **Westminster** | 97 | 96 | 99 | 113 | 100 |
| **Total** | 310 | 312 | 352 | 343 | 318 |

[1] ONS Mid-Year Estimates 2014
[2] End Child Poverty 2014

Following increases in the numbers of children subject to a child protection plan increased in Hammersmith and Fulham and Westminster in 2014-15, over the course of 2015-16, planned reductions in the numbers of children with plans were achieved in both boroughs. In Kensington and Chelsea, numbers increased by 7%. These changes are linked to fewer child protection plans starting in the year in Hammersmith and Fulham and Westminster and a higher number of plans ceasing. Kensington and Chelsea saw a similar number of plans starting in each of the two years, but fewer plans ended in 2015-16. The numbers of children with plans fluctuated considerably from month to month in all three boroughs.

**Children in care at 31 March 2016**
**(and comparative figures since 2011-12)**

| | 2011-12 | 2012-13 | 2013-14 | 2014-15 | 2015-16 |
|---|---|---|---|---|---|
| **Hammersmith & Fulham** | 224 | 236 | 200 | 185 | 198 |
| **Kensington and Chelsea** | 139 | 98 | 98 | 105 | 105 |
| **Westminster** | 208 | 188 | 176 | 179 | 166 |
| **Total** | 571 | 522 | 474 | 469 | 469 |

The numbers of looked after children have increased in Hammersmith and Fulham, reduced in Westminster and remained constant in Kensington and Chelsea over the course of 2015/16. Over the last three years, the number of unaccompanied asylum seeking children has increased by 73%. This trend has had an impact upon overall numbers of children in care which have otherwise been generally decreasing over time.

## THE OFSTED REVIEW OF THE LSCB

In January 2016 Ofsted reviewed the LSCB as part of its inspection of the three inspections of Children's Services. The LSCB was reviewed as one body and reported on in all three reports on children's services, with the only variation in the three reports being in relation to the borough-based local partnership groups of the LSCB. The overall judgement of the LSCB was that it was 'Good'. This placed the LSCB in the top third of Boards reviewed at that time.

Ofsted commented on the strengths of the LSCB:

- Amalgamation under a single LSCB creates significant benefits for young people and for all partner agencies.
- The tri-borough achieves the right balance between shared and local functions, and this ensures that children are safeguarded effectively.
- Robust links are in place between the LSCB and other statutory bodies and this allows the board to make sure that children's safeguarding stays high on everyone's agenda.
- The Chair promotes safeguarding issues across the partnership and community, and provides appropriate challenge. As a result, extensive engagement by partners has been secured across the full range of safeguarding work. Partners are encouraged and enabled by the Chair to raise issues and challenges constructively.
- Through systematic analysis of audits under Section 11 of the Children Act 2004,

the LSCB has assured itself that safeguarding is a priority for all partner agencies. (but see recommendation 3 below).

- Effective monitoring by the Child Sexual Exploitation/Missing sub-group enables the board to have a robust understanding of missing children and their behaviour across the tri-borough.
- An established case review sub-committee ensures that lessons learnt from reviews are disseminated promptly across the tri-borough (but see recommendation 4 below).
- A clear and detailed learning and improvement framework incorporates the learning from Serious Case Reviews (SCRs), themed audits and performance monitoring by the board. The learning and development sub-group of the LSCB undertakes its role across the tri-borough and ensures that sufficient safeguarding training is provided across all partner agencies.
- A wide range of activity to tackle the board's priorities and any lessons from SCRs is appropriately included in the LSCB annual report. A comprehensive safeguarding plan covers all of the board's priorities.

Ofsted made 5 recommendations for the LSCB

1. Review the extensive dataset to ensure that it is aligned to the board's priorities.

2. Devise a system for ensuring that actions arising from data scrutiny are carried out in the individual boroughs.

3. Ensure that recommendations from multi-agency themed audits are carried out and analyse their impact on improving practice.

4. Develop an overarching SCR action plan to track the progress of work arising from individual case reviews.

5. Devise a system to escalate concerns about infrequent partnership attendance at the board.

Ofsted also noted two changes of Business Manager for the LSCB in the previous year and the need for coordination of activities and work arising from the LSCB so that it is evident to others; the limited time available for the Independent Chair to maintain all the links across three separate boroughs; a need for a formal analysis of the impact of training either across the tri-borough partnership or at borough level; and an annual report that could be stronger on explaining the difference the LSCB has made to children's lives.

All these issues have been fed into the 2016/17 Business Plan and are being monitored during the year.

## THE EFFECTIVENESS OF LOCAL SERVICES

### London Borough of Hammersmith & Fulham

The Borough's Family Services directorate coordinates a range of services for vulnerable children including statutory social work for children and families and early help. A number of services are provided by shared arrangements with the Royal Borough of Kensington and Chelsea and Westminster City Council. This includes specialist support for children involved in the criminal justice system via the local Youth Offending Team which is

managed by a single management team across three boroughs. There is also a single Fostering and Adoption service which recruits, approves and supports foster carers, connected persons and adoptive parents who care for children from all three boroughs. The borough's services for children in need of help and protection, children looked after and care leavers were inspected by Ofsted under its unannounced single inspection framework in January and February 2016. This resulted in a "Good" judgement by Ofsted. The inspection report[3] included a sub-judgement of "Good" regarding the experience and progress of children needing help and protection.

Ofsted made six recommendations following the inspection in relation to children who go missing, access to independent advocates, out-of-hours services for children, care planning, opportunities for care leavers and pathway plans. The local authority has produced and reviewed progress on an action plan to address these recommendations which has been submitted to Ofsted.

**Royal Borough of Kensington and Chelsea**

As is the case with Hammersmith & Fulham, the Royal Borough's Family Services directorate coordinates a range of services for vulnerable children including statutory social work for children and families and early help and also shares the same services. The Royal Borough's services for children in need of help and protection, children looked after and care leavers were inspected by Ofsted under its unannounced single inspection framework in January and February 2016. This resulted in an "Outstanding" judgement by Ofsted, one the first of two authorities to have received this judgement to date. The inspection report[4] included a sub-judgement of "Good" regarding the experience and progress of children needing help and protection.

Ofsted made four recommendations following the inspection in relation to children who go missing, out-of-hours services for children, engaging partner agencies in strategy discussions and access to independent advocates. The local authority has produced and reviewed progress on an action plan to address these recommendations which has been submitted to Ofsted.

**Westminster City Council**

As is the case with Hammersmith & Fulham and Kensington and Chelsea, Westminster's Family Services directorate coordinates a range of services for vulnerable children including statutory social work for children and families and early help and also shares the same services. Westminster's services for children in need of help and protection, children looked after and care leavers were inspected by Ofsted under its unannounced single inspection framework in January and February 2016. This resulted in an "Outstanding" judgement by Ofsted, one of the first two authorities to have received this judgement to

[3] London Borough of Hammersmith and Fulham - Inspection of services for children in need of help and protection, children looked after and care leavers Ofsted 2016

[4] Royal Borough of Kensington & Chelsea - Inspection of services for children in need of help and protection, children looked after and care leavers Ofsted 2016

date. The inspection report[5] included a sub-judgement of "Good" regarding the experience and progress of children needing help and protection.

Ofsted made four recommendations following the inspection in relation to children who go missing, out-of-hours services for children, evaluation of children in need cases and support for care leavers who are in custody. The local authority has produced and reviewed progress on an action plan to address these recommendations which has been submitted to Ofsted.

**Metropolitan Police**

A combination of individual Borough Commands and specialist teams provide policing across the LSCB area. All of these units prioritise children's safeguarding with their wider priorities informed by the Mayor's Office for Policing and Community (MOPAC). MOPAC identified 7 key neighbourhood crime types for particular attention between 2013 and 2016 including violence with injury. The future strategies of the Metropolitan Police will focus increasingly on key risks to vulnerable people, including children, for example, those who go missing, are at risk of sexual exploitation and victims of modern slavery.

The Child Abuse Investigation Team (CAIT) is one of 15 such teams covering all 32 boroughs and has responsibility for providing support, advice and assistance with any serious safeguarding issues relating to children. CAIT also investigate abuse committed within families as well as by professionals and carers. Such investigations take place in cooperation with local authority services and include recent and historical allegations of offences against children. Locally, the Borough police have focused particularly on children who go missing or are at risk of child sexual exploitation, domestic abuse and serious youth violence or gang activity. As more specialist secondary teams often rely upon borough police officers to detect and refer on such crime, it is important that frontline officers have the necessary levels of awareness and knowledge. Therefore, a continuous programme of training is provided to officers on these issues and safeguarding in general. Current pressures for the police service include needing to respond to high levels of children being reported as missing and meeting the needs of people who have significant mental health difficulties. In the LSCB area there are also additional pressures resulting from needing to provide initial responses to significant numbers of young people for whom there are concerns but who are the responsibility of other local authority areas.

The report following a "PEEL" inspection of the Metropolitan Police's effectiveness across London in response to vulnerable people was published in December 2015. It concluded that a good response was provided by the force to missing and absent children and that it had made a good start in ensuring it was well prepared to tackle child sexual exploitation. Meanwhile its response to victims of domestic abuse was good, clear and well understood by officers and staff across the force. However, the overall conclusion was that the force required improvement. There were recommendations to develop understanding of the nature and scale of the issue of missing and absent children through assessment of available data, including that of partner organisations. It was also recommended that it should be ensured that specialist staff receive appropriate training in relation to safeguarding and understanding how to prevent repeat instances which could lead to

[5] Westminster City Council - Inspection of services for children in need of help and protection, children looked after and care leavers Ofsted 2016

harm. In 2016, Her Majesty's Inspectorate of Constabulary carried out an inspection of the Metropolitan Police's response to child protection issues, the results of which are yet to be published

**Multi-Agency Safeguarding Hub (MASH)**

The Tri-Borough MASH acts as the focal point for all police generated safeguarding referrals for both children and vulnerable adults. Excellent partnerships exist across all the agencies represented within the MASH ensuring consistency in the application of thresholds and informed risk based decision making. The team also shares all reports created in relation to missing children maintaining a productive working relationship with the Tri-Borough Missing Persons Co-ordinator. The officers within the MASH now have responsibility for the investigation of Category 1 CSE concerns across the LSCB area. This dedicated response has seen a significant increase in police attendance at strategy meetings and improved oversight of the links between missing children and CSE. Oversight for CSE across the area is managed via the Multi-Agency Sexual Exploitation (MASE) panel which enables a strategic overview of the effectiveness of interventions made with victims and disruption tactics employed with perpetrators. MASE is well attended by a range of partners who are supportive of the aims of the group which reports quarterly to the LSCB subgroup. The work of the MASH, MASE, and overall response to CSE were commended in the reports published by Ofsted following inspections in all three boroughs of services for children in need of help and protection, children looked after and care leavers. Arrangements have also been subject to a recent Her Majesty's Inspectorate of Constabulary inspection the results of which are yet to be published.

**NHS England (NHSE)**

NHS England London Region is responsible for ensuring that the commissioning system in London works effectively to safeguard children at risk of abuse or neglect. One of its outcomes is to ensure that NHS England London Region directorates are aware of their responsibilities with regard to safeguarding and are appropriately engaged with the Local Safeguarding Boards and key partners such as the Metropolitan Police across London.

Key activity for London Region in 2015/16 included carrying out a CCG Safeguarding Deep Dive Assurance and the development of a risk matrix outlining key safeguarding risks across London. This was partly based on the "Section 11 audit" used by LSCBs to assure themselves that agencies placed under a duty to co-operate are fulfilling their responsibilities to safeguard children. While the self assessment concluded that the theme of "The culture of safeguarding within the organisation" was fully met, the outcomes for "A safe organisation" and "Assurance and system leadership" were assessed as "partially met". This has led to planned actions to improve training for staff and to improve linkages between CCGs, local authorities and NHS London in relation to primary care assurance. The need for work with London Councils in relation to the Alan Wood Review (a government initiated review of the role of LSCBs published in 2016) was also highlighted.

Significant challenges for health agencies in London include the recruitment and retention of safeguarding professionals; effective working with CCGs, Care Quality Commission (CQC) and safeguarding boards to recognise and understand key safeguarding risks in primary care; keeping up with the challenge of complexity, particularly in relation to new and emerging risks including Female Genital Mutilation (FGM), Modern Slavery, counter terrorism, unaccompanied asylum seeking children and CSE. Activity in 2015/16 which has specifically impacted upon the area covered by the LSCB includes the implementation of

the Child Protection-Information Sharing project (CP-IS). This is a national system that connects children's Social Care IT systems with those used by in unscheduled care settings across England. The system went live in Kensington and Chelsea in 2015/16 with Hammersmith & Fulham and Westminster due to go live by the end of 2016.

Priorities for 2016/17 include improving training numbers in the region; leading work on FGM and modern slavery; working with partners to understand the impact of the Alan Wood review; and improving the CH-IS roll out and to work on priorities identified from the CCG deep dives.

**Clinical Commissioning Groups (CCGs): West London CCG, Hammersmith and Fulham CCG and Central London CCG**

CCGs are statutory NHS bodies with a range of statutory duties – including the safeguarding of children. They are membership organisations that bring together General Practices to commission services for the registered populations and unregistered patients who live in their area.

CCGs as commissioners of local health services need to assure themselves that the organisations they commission have effective safeguarding arrangements in place. They are responsible for securing the expertise of Designated Professionals on behalf of the local health system. These professionals undertake this role across the health economy and actively participate in the work of the LSCB. During 2015-16 Designated Professionals played an integral role in all parts of the commissioning cycle, from procurement to quality assurance, ensuring appropriate services are commissioned that support children at risk of abuse or neglect, as well as effectively safeguarding their well-being.

During 2015 the three CCGs undertook an NHSE Assurance Safeguarding "Deep Dive" exercise. The CCGs were assessed against four components namely: Governance, Systems and Processes; Workforce; Capacity Levels; and Assurance

The table below details NHSE's assessment of the CCGs against these components.

| | Safeguarding Deep Dive Review Components | Outcome |
|---|---|---|
| 1 | Governance / Systems / Processes | Assured as Good |
| 2 | Workforce | Limited Assurance |
| 3 | Capacity Levels within CCGs | Assured as Good |
| 4 | Assurance | Assured as Good |

Beneath these four high level components are a number of more detailed areas. The CCGs were assured as being **Outstanding** on the following areas:

- Engagement around FGM.
- The work being undertaken with Buckinghamshire New University to develop an educational tool to support practitioners in the application of the Mental Capacity Act (2005).

Components that were rated as providing Limited Assurance are being addressed at a CCG level. These predominately relate to the uptake of training.

**Imperial Hospital NHS Trust**

Imperial College Healthcare NHS Trust has a well-established children's safeguarding service led by a Designated Doctor, Nurse and Midwife. Specialist staff are based in maternity, children's services and the A&E department and a quarterly safeguarding children meeting is held. Strong links have been established with organisations and charities, to provide joined up support in areas such as domestic violence (Standing Together) and youth gang violence and child sexual exploitation (Red Thread). Red Thread workers are based in the A&E department and sexual health clinic at St Mary's Hospitals. Close working has also been developed with adult safeguarding services to ensure that children are protected in situations where there are adult safeguarding concerns. An extensive programme of training and supervision has been established to ensure that staff are prepared and supported when dealing with safeguarding issues.

**Chelsea and Westminster Hospital NHS Foundation Trust**

Within Chelsea & Westminster Hospital there is a full safeguarding children's team – liaison health visitor, Designated Nurse, Midwife and Doctor, supported by an administration post. The Designated Doctor for the area works within the Trust and offers additional support. Quarterly Children's Safeguarding Boards are chaired by the Director of Nursing, and there is also an annual Joint Adult and Children's Safeguarding Board within the Trust. A social work team based within the hospital supports children's safeguarding. Child Protection medicals are undertaken within the hospital, and there is good attendance at case reviews by the safeguarding team along with the lead nurse for paediatrics.

The team has worked with the Designated Nurses and Tri-borough safeguarding leads in a number of SCRs with learning shared across the organisation and with other agencies. The relationships developed through the LSCB enable the organisation to provide best practice, up to date safeguarding training, supervision, and care to children and families. Domestic violence continues to be a theme within SCRs and training within this area has been a priority, led by our Domestic Violence lead. We are delighted to have an Independent Domestic Violence Advocate in post to offer support and advice to families and staff.

Child and Adolescent Mental Health Services (CAMHS) are an ongoing concern due to the lack of tier 4 beds (specialist in-patient care for children who are suffering from severe and/or complex mental health conditions), but senior staff within the hospital are working with the CCG, mental health providers and NHSE to bring about improvements for patients within this area.

The Director of Nursing is a member of the LSCB and this is an essential partnership to enable sharing of learning, best practice, and support across agencies.

**Central and North West London NHS Trust (CNWL) and West London Mental Health Trust**

Both Trusts have continued to work closely with children's social care across the three local authorities, referring cases appropriately whilst responding to MASH or Front Door enquiries as to whether parents are known to mental health services when safeguarding is a concern. There has been good feedback about the service provided by Trust link staff. We have worked hard to promote the "Think Family" agenda within adult mental health

services and this has contributed to a demonstrable increase in referrals from adult mental health services to children's social care.

An audit on the joint protocol was included in our Commissioning for Quality and Innovation (CQUINs) payments framework. This showed good joint working across the partnership, but with no room for complacency. We have also tried to stress that mental health is not just about mental health services and this year have encouraged primary care to explain to service users the services that they provide to those with minor mental health problems or stable severe conditions.

In 2015/16 both Trusts were subject to CQC Inspections and there were no actions that were identified in relation to safeguarding children arising from either inspection.

CNWL has undertaken work in relation to the two Serious Case Reviews that it was involved with and is now in the process of implementing the action plans and embedding the learning across its services. This has also been shared with West London Mental Health Trust so that both Trusts can learn from incidents.

New reporting guidance on FGM has been implemented. New guidance on modern slavery has also been promoted and used effectively with a specific case so that a vulnerable adult was kept safe. The Prevent agenda also continues to be promoted with both agencies having internal targets to contributing to a three year target which is on track to be achieved. Both Trusts have been involved with a Mayor's Office for Policing and Crime (MOPAC) funded project. This includes join work with Standing Together to run sessions for mental health staff on raising awareness of domestic abuse and to improve compliance with procedures.

**Probation**

The National Probation Service (NPS) London continues to work with partner agencies to safeguard children within the three boroughs. NPS contributes to MASH, the Multi-Agency Risk Assessment Conference (MARAC), MASE and Multi-Agency Public Protection Arrangements (MAPPA) to ensure that issues of child safeguarding are at the forefront of all our work with service users. NPS undertakes an audit of a sample of cases every month and safeguarding aspects of casework are always considered when appropriate. Court teams are currently developing closer links with safeguarding agencies to ensure more effective and faster sharing of information to protect children of those who appear in our local courts. All staff are trained and are encouraged to take part in the opportunities for further learning provided by the LSCB training programme.

**Community Rehabilitation Company (CRC)**

Since December 2015, London CRC's offender managers have adopted a new approach which works with groups of offenders who have similar rehabilitation needs. The aim of this new way of working to deliver tailored services that tackle the underlying causes of offending. Young people receiving services are now assigned to one of six cohort groups including those who are 18 to 25 year old males, those who have mental health and learning disabilities (as the primary presenting need) and those who are women. Through this model, operational staff can spend more time working face-to-face with offenders. The CRC also continues to fulfil its Community Safety (Integrated Offender Management) and Safeguarding (MASH) responsibilities. The CRC has re-launched its performance framework which monitors the volume of responses and whether someone is known to

children's social care. Meanwhile staff in the separate Rehabilitation, Partnerships and Stakeholders directorate are focusing on developing partnership relationships. This work is led by a Head of Stakeholders and Partnerships who attend this and other LSCBs.

**Children and Family Court Advisory and Support Service (Cafcass)**

Cafcass is a non-departmental public body, sponsored by the Ministry of Justice. It works in the family courts in circumstances where children have experienced or are at risk of experiencing abuse, neglect or trauma. Cafcass also work with families in circumstances where there is a dispute about where a child should live or with whom they should spend time, often following divorce or separation. The role of Cafcass is to make recommendations to the court about the right courses of action for children and young people. Cafcass was inspected by Ofsted in 2014 and judged to be good with outstanding leadership and management. Since then Cafcass continues to prioritise safeguarding activity and internal audit reveals that the organisation is making good progress. Cafcass's recent annual report detailed work with 116,104 children and young people across England. Cafcass's key performance indicators were met 2015-2016 despite a 10.3% increase in demand in private law and a 14.2% increase in public law cases.

**Community Safety**

Across the three local authority areas, Community Safety provides significant focus around prevention and a range of activity in support of safeguarding. Through the Channel and wider Prevent safeguarding processes, the Prevent Team works closely with different Council departments across the three local authorities and with other agencies to support and safeguard individuals potentially vulnerable to extremism or radicalisation.

Channel is a statutory, early intervention, multi-agency process designed to safeguard vulnerable people from being drawn into violent extremism and/or terrorism. Channel works in a similar way to other safeguarding partnerships such as case conferences for children in need. It is a pre-criminal process that is designed to support vulnerable people at the earliest possible opportunity, before they become involved in illegal activity. Safeguarding leads from within child protection and Children's Services also sit on the panel. Alongside this, other multi-agency partners, including all those involved in any specific case, are brought together to collectively assess the risks in relation to an individual and decide whether a support package is needed. If the panel feels that an individual would benefit from support; a bespoke package will be developed, based on their particular needs and circumstances. The value of this work across the three boroughs was recognised in the early 2016 Ofsted inspection of services for children in need of help and protection, children looked after and care leavers.

Significant work has taken place to address youth violence within and across the three boroughs. Westminster's Integrated Gangs Unit (IGU) has also delivered multi agency work to safeguard young people. Examples include the provision of intensive support for those involved in gangs (100 referrals per year), prevention in schools (3074 pupils took part in sessions in 2015), joint workshops to support women in the BAME community (Prevent and IGU) and work to safeguard those at risk of being exploited by potential child sexual exploitation perpetrators.

**Housing and Housing providers**

The range of housing services across the three boroughs is very broad comprising the provision of tens of thousands of homes owned and/or managed by the three councils with similar numbers of affordable housing properties owned by Registered Providers (Housing Associations). Advice is provided to thousands of households in housing need and across the three boroughs. Accommodation is also provided for over 6000 homeless households and supported housing services to care-leavers and other vulnerable young people to support them to live independently. High priority has been given to ensuring front-line staff across all types of housing service have an excellent understanding of safeguarding, are able to identify risk and know the appropriate action to take. There has also been a strong focus from the LSCB on ensuring that the most vulnerable homeless families are prioritised for suitable housing within their home borough and that the use of non-self-contained bed and breakfast accommodation for households in need only happens in emergencies. At any one time there have not been any more than 10 such placements across the three boroughs. Reviews of young people's hostel accommodation have included a significant focus on safeguarding and the findings of such reviews were very positive with the overwhelming majority of young people feeling safe and knowing action to take following any incidents.

**Voluntary / Faith Sector**

The LSCB has benefited from a Community Development Worker post working closely with key safeguarding agencies from across the three boroughs, such as Prevent, the safeguarding in schools lead, and the FGM lead. In 2015-16, joint safeguarding sessions have been delivered to community groups, Imams, supplementary school teachers, and community forums. This joint working has helped to safeguard children more effectively in an LSCB area of significant diversity because of the increased face-to-face contact enabled with key community leaders who are often gate-keepers to the communities themselves. We have provided such leaders with key safeguarding contacts, an enhanced understanding of what safeguarding is, and some insight into signs and symptoms of abuse. This increased awareness amongst communities and groups can only strengthen safeguarding arrangements of children and young people. The Ofsted inspection in early 2016 provided very positive feedback regarding the work carried out with male members of FGM practising communities, particularly in reference to the support provided for key community leaders, including an Imam, in addressing this challenging issue amongst the wider community.

**Schools**

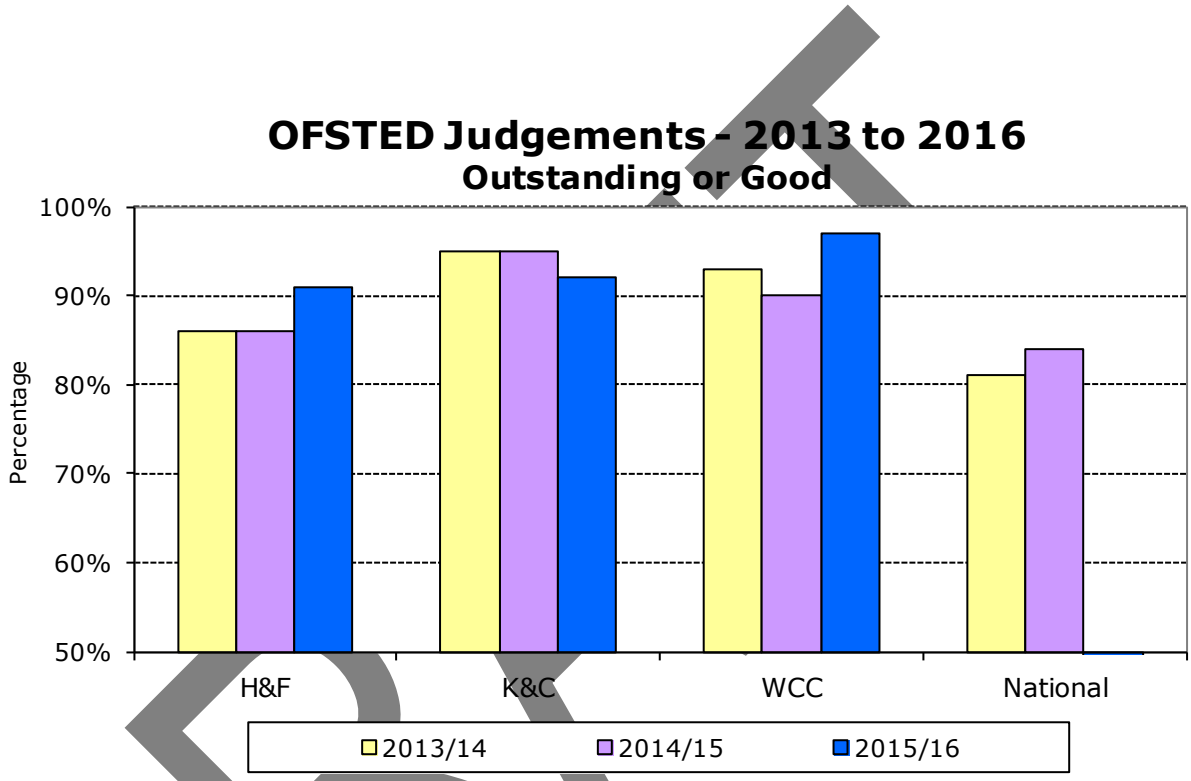
As at January 2016[6], there were there was a total of 255 schools across the three boroughs. 160 of these were state funded including 12 nursery schools, 104 primary schools, 30 secondary schools, 9 special schools and 5 settings which were either pupil referral units or alternative provision. 43 of these schools were academies or free schools. There is a significant independent sector across the three boroughs. In all there are 94 independent schools, 21 in Hammersmith & Fulham, 44 in Kensington and Chelsea and 29 in Westminster.

**Ofsted Inspections of Schools 2015/16**

[6] DfE "Schools, pupils and their characteristics: January 2016"

The percentages of schools in the tri-boroughs which are rated outstanding or good by Ofsted inspectors have remained consistently high during the last three academic years. Only three schools are currently judged inadequate (Hurlingham Academy and Phoenix, in Hammersmith & Fulham, and Wilberforce in Westminster) while seven of the 155 schools are judged to require improvement.

The percentages ranked outstanding or good at the end of the last three academic years is shown below; overall judgements for all three boroughs were considerably above the national average.




During 2015/16 to date there have been twelve full inspections of schools across the three local authorities. There have also been short inspections of a further four schools.
The reports from such inspections include specific commentary from Ofsted regarding the effectiveness of safeguarding arrangements in individual schools and these reports are all publicly available.

**Children's Homes**

The Royal Borough of Kensington and Chelsea maintains two children's homes in the area (Olive House and St Marks). St Mark's has a current Ofsted rating of Good following an inspection in June 2016. Olive House received a rating of Good with "declining effectiveness" in an interim inspection in February 2016. No recommendations were made for specific actions for Olive House and the "declining effectiveness" issue was linked to the registration status of the home's manager. An application for registration has subsequently been submitted to Ofsted.

Both Olive House and St Mark's continue to provide detailed risk assessments for all the young people placed with them. These identify areas of concern and actions taken to address them. All staff undertake relevant training including bespoke training as the needs arise. Specific training was commissioned to support staff around working with CSE and to

respond more effectively to those people who go missing. St Mark's Ofsted inspection did note the lack of opportunity for young people to be seen by an independent person when returning after going missing and an action plan is in place to address this.

The Haven in Hammersmith & Fulham is a local authority children's home registered for up to seven children with learning disabilities and physical disabilities. The home mainly provides short breaks, but can also provide interim emergency and longer-term placements. It was last inspected in July 2016 and judged by Ofsted to be "good" across all three sub-judgements. An area identified for improvement was the "safeguarding knowledge" of staff. Managers advise that this refers particularly to temporary staff which have been needed to meet demands for longer-term placements. This demand has resulted from a planned strategy to ensure more children with complex needs can be placed locally with good access to their family networks and local support services. Managers have provided assurance that permanent staff have a good understanding of safeguarding and that these staff take lead responsibility for each shift. Further actions are being taken to increase recruitment to permanent positions and to ensure training needs of all staff are identified and met.

**HM Prison Wormwood Scrubs**

Safeguarding comprises a significant part of the work carried out by HM Wormwood Scrubs Prison with families and children of inmates. A lead officer, who is also an attending statutory member of the LSCB, is in place for safeguarding. Her role includes liaison with social workers, schools and families regarding children's visits to the prison and discussing any safeguarding issues. There are also links between the prison and external Multi-Agency Public Protection Arrangements (MAPPA).The officer has attended Level 3 multi-agency safeguarding training provided by the LSCB and the Academy of Justice and. Furthermore she provides a basic training to the officers who supervise visits and there are plans to recruit a family officer.

The prison's Visitor Centre has provided safeguarding training for the staff working there and can make referrals or consult with the lead officer where there are any safeguarding issues for families attending the centre.

A recent Justice Inspectorate inspection in December 2015 noted that public protection procedures were adequate and that applications for contact with children were assessed appropriately and suitable levels of contact approved where possible.

**Section 11 Audits**

Section 11 of the Children Act 2004 details the responsibilities that agencies have for safeguarding children. The LSCB carries out bi-annual audits of all member agencies. In 2015-2016, a working group, including one of the LSCB lay members, reviewed the pan-London audit tool in use and revised the questions in it to make it both more user friendly and helpful for agencies completing it. The audit tool questions were also updated to include new and emerging safeguarding concerns such as radicalisation and child sexual exploitation. The audit tool is now accessed online and once completed in full, allows users to generate an action plan to address any areas that need improvement. Following the development of the revised audit tool, a small number of agencies were selected to

complete it at the end of the year. A wider range of agencies, including schools and voluntary sector providers are expected to complete it in 2016-2017.

## ANNUAL REPORTS

### Child Death Overview Panel (CDOP)

The 2015/16 Annual Report for CDOP provides analysis of the child deaths reviewed during 2015-16 in the boroughs of Westminster, Kensington and Chelsea and Hammersmith and Fulham, rather than those deaths notified during the same period. Between April 2009 and March 2016 there have been 226 child death reviews completed with 25 reviews in 2015- 16.

The panel has focused on reviewing all child deaths that have occurred across the 3 boroughs identifying factors that may have contributed to the deaths along with any modifiable factors.

The panels are themed to enable more effective learning from cases and do not review unexpected deaths until other forms of investigations or Serious Case Review has been undertaken.

In addition, the timing of reviews is subject to:

- The information available from agencies involved
- Other processes such as police investigation, serious case review or inquest
- Number of cases relation to particular themes

Of the 25 deaths of children, reviewed by the Child Death Overview Panel (CDOP) 10 were assessed as unexpected. The key themes for the unexpected deaths were related to life limiting disease and perinatal events. As a consequence, the main category of death has been those with life limiting disease.

The Clinical Commissioning Groups have continued to lead on the work of CDOP on behalf of the LSCB. Quarterly updates are given to the Board and progress has been made in strengthening links with other subgroups in particular the Case Review Subgroup.

The panel is chaired by the Deputy Director of Public Health for Westminster. A Specialist Nurse is being recruited to take responsibility for the management of the CDOP process working alongside the Designated Doctor for Child Death.

A number of recommendations were made for the work of CDOP in 2016/17 including

- To improve the communication process between CDOP and the parents of children who have died. Parents should receive a letter to inform them of the CDOP process along with appropriate leaflets.
- Identification of topics for research and to develop a work stream to support this.
- To work with the LSCB to develop web pages on the LSCB website so that families and professionals have access to information and resources in relation to the child death process and how to access support.
- To establish links with the Learning and Development subgroup secondary and primary care, education and the police to ensure that learning from the child

death reviews is disseminated and that agencies are aware of the CDOP process.

- The learning from CDOP to inform the Joint Strategic Needs Assessment for the three boroughs.

**Local Authority Designated Officer (LADO) – Safer Organisations**

The LADO has provided a report regarding the management of allegations against adults working with children across the LSCB over the course of the past year.

The procedures used for managing allegations are as set out in the London Child Protection Procedures. The procedures are invoked when there is an allegation (whether historic or current) that a person who works with children has:

- behaved in a way that has harmed a child, or may have harmed a child;
- possibly committed a criminal offence against or related to a child; or
- behaved towards a child or children in a way that indicates they may pose a risk of harm to children

These behaviours should be considered within the context of the four categories of abuse (i.e. physical, sexual and emotional abuse and neglect). These include concerns relating to inappropriate relationships between members of staff and children or young people. If concerns arise about the person's behaviour to her/his own children, the police and/or children's social care must consider informing the employer or organisation in order to assess whether there may be implications for children with whom the person has contact at work / in the organisation, in which case this procedure will apply.

All staff should be made aware of their organisation's whistle-blowing policy and feel confident to voice concerns about the attitude or actions of colleagues; learning from Serious Case Reviews indicates that early reporting of low level concerns around rule breaking and boundary keeping can help to prevent the abuse of children.

In 2015/16, the local LADO service has been strengthened and developed. Child protection advisors in each of the boroughs handle incoming cases on a duty basis with support from the Safe Organisation manager /LADO lead. The majority of Child Protection Advisors are now permanent members of staff which means practice is embedded and there are opportunities to take advantage of discussing emerging themes and thresholds across the three boroughs. This is particularly important where there have been similar changes in the arrangement in place for the Child Abuse Investigation team.

**Safe Recruitment and leaning from Serious Case Reviews**

The LADO has continued to offer accredited safe recruitment training as part of the LSCB training programme. This has been well attended as have sessions on learning from SCRs and ‘meet the LADO’ events.

**Raising the profile of the LADO role**

The LADO has worked closely with the Safeguarding Lead for Schools and Education officer and the LSCB Training Officer to raise the profile of the role with schools and in particular in the independent school sector (in part prompted by the learning from the Southbank International School SCR). There is further work to be done academies, particularly those which belong to larger trusts and where in-house HR services for such schools do not have specialist knowledge of safeguarding.

**Origin of Referrals**

Overall the volume of cases reported to the LADO service is increasing – this appears to be reflected across the London boroughs. More organisations are making contact for consultation and reassurance on risk assessment. The majority of cases still emanate from early years settings and schools.

It would appear that more historic cases are coming to light and this could partly reflect the influence of the Independent Inquiry into Child Sexual Abuse at a national level. All LADOs have been instructed to retain and secure records of previous concerns and it is possible that a local case will be called in during the course of the Inquiry.

It is notable that there has been a decline in the number of referrals from the voluntary sector. Whilst acknowledging that this is not a homogenous group of organisations, some consideration should be given to further outreach work to raise the profile of safeguarding and to ensure that the sector is well-supported amongst the wide range of organisations in this sector.

In contrast there has been an increase in referrals from a broad range of sports organisations. Whilst some bodies like the Rugby Football Union do have a regulatory role, many other such bodies are membership organisations, meaning that anyone can pay their fee and join. This can give users the false impression that sports providers are accredited and vetted and it can be very difficult to hold some small scale providers to account in these circumstances. A similar situation applies to other service providers – for example therapists who do not need to be registered with the Health Care Professionals Council (HCPC).

**Private Fostering**

The social worker responsible for the coordination of private fostering arrangements across the LSCB area provided a report to the LSCB in October 2015. The report showed an increase in notifications of such arrangements at that point of 2015/16 compared with the previous year. Notifications tended to come from agencies such as school admissions, the Benefits Agency, schools, local authority Children's Services and self-referrals. A programme of awareness-raising had taken place including with GPs, Health Centres, and Youth Hubs with some initial indications of this having an impact upon referrals. Other publicity and guidance had led to an increase in queries and consultations. The effectiveness of this coordinating role including awareness raising and impact on referrals was confirmed in the reports following the Ofsted inspections in all three boroughs in January and February 2016.

The report notes that a high number of private fostering arrangements had recently ended, largely because children and young people had either returned to the care of close family members, made the transition into adulthood or moved to other areas. Appropriate referrals have been made to the relevant boroughs to inform them of the likelihood that children were moving into their area subject to private fostering arrangements. Support had also been explored with carers of young people as they reached the age of 16, and appropriate referrals made where required.

Further work was planned including a formal communication and awareness raising strategy across the LSCB area including a single website; engagement with external special interest groups to ensure access to best practice; development of a local, shared

Private Fostering Protocol and improvements to common recording and assessment processes.

**Independent Reviewing Officers (IRO)**

Independent Reviewing Officers chair reviews for individual looked after children and have an important role in the care planning and safeguarding of such children. They therefore hold significant information regarding the overall experiences of children in the care of the three local authorities covered by the LSCB.

Over the course of 2015/16, the IROs have been working as part of a unified service. The teams have remained relatively stable, with caseloads within the recommended limits set in the IRO Handbook. This allows IROs to know their children well, and to monitor cases between reviews. They have continued to work in collaboration with the social work teams to resolve issues and concerns about children's care plans in an informal manner wherever possible. There is a positive working relationship between IROs and front line teams across the three authorities, and this has kept the need for recourse to the formal Resolution Protocol to a minimum.

The role of the IROs was noted in the inspections of the three local authorities by Ofsted in 2016 with commentary including "Outstanding services for children looked after are characterised by robust arrangements in place for reviewing care plans by a dedicated team of independent reviewing officers", "Independent reviewing officers know children and young people well, and provide positive support outside of the reviewing process. There is a culture of informal and formal challenges to care plans" and that IROs "have manageable caseloads ..., enabling them to drive permanency planning vigorously. They routinely attend permanency planning meetings and are committed, knowledgeable and passionate about their work. They know the young people well."

51% of the children looked-after at 31st March 2016 had been in the care system for less than 12 months. This indicates a continued high turnover of children in the care system over the 12 month period. 78% of looked-after children across the three authorities are aged ten and over. This presents particular challenges for achieving stable and permanent placements for some of these young people, as their needs are likely to be more complex as a result of their late entry into the care system. 22% of looked-after children were placed outside of the London area. Progressing permanent and stable placements for these children close to their home authority wherever possible remains a challenge and the LSCB has reviewed the reasons behind children being placed at distance from a perspective of being able to provide consistent health services for them.

Across the three local authorities 91% of looked after children reviews were held within statutory timescales. Over 97% of looked after children participated in their review meetings over the year. They have also been involved in key service development initiatives through their Children and Young People's Panel / Children in Care Councils. These included engagement activities as part of the development and implementation of the Looked After Children and Care leavers Strategy, recruitment of senior Officers, and a number of events to celebrate key achievements

**Violence Against Women and Girls (VAWG) Partnership**[7]

The three local authorities covered by the LSCB established have maintained a shared services response to VAWG commissioning, governance and strategy since 2014. Mayor's Office for Policing and Crime (MOPAC) London Crime Prevention Funding, matched by Council funding has been used for this purpose from 2013 with the current funding due to end in 2017. From April 2015 to March 2016 the three previously sovereign borough Domestic Violence/VAWG arrangements were brought within a single governance structure with a Strategic Board, chaired by the Tri-Borough Executive Director of Children's Services, and supported by six operational groups. Joint working protocols have been established with the partnerships including the LSCB in recognition of the cross cutting range of harms included in the scope of VAWG.

The VAWG strategy is configured around seven priorities including one which focuses on children and young people. The priority is that children and young people are supported if they witness or are subject to abuse and understand healthy relationships and acceptable behaviour in order to prevent future abuse. The Partnership prioritises both prevention of violence and abuse and direct provision of support for Children and Young People.

Specialist VAWG professionals within eight different children's services settings were co-located through the Partnership in 2015/16. Professionals in specialist services now work alongside colleagues from children's services to strengthen pathways and knowledge-sharing between them to support high risk families in the short term but also to undertake longer term work to prevent future abuse and increase safety in families.

Priorities for 2016/17 include a focus on whole school and whole family approaches and networks of lead professionals across the children's sector. Additionally, there is a plan to roll out the #SpeakSense campaign for young people alongside the young person's version of the VAWG Strategy.

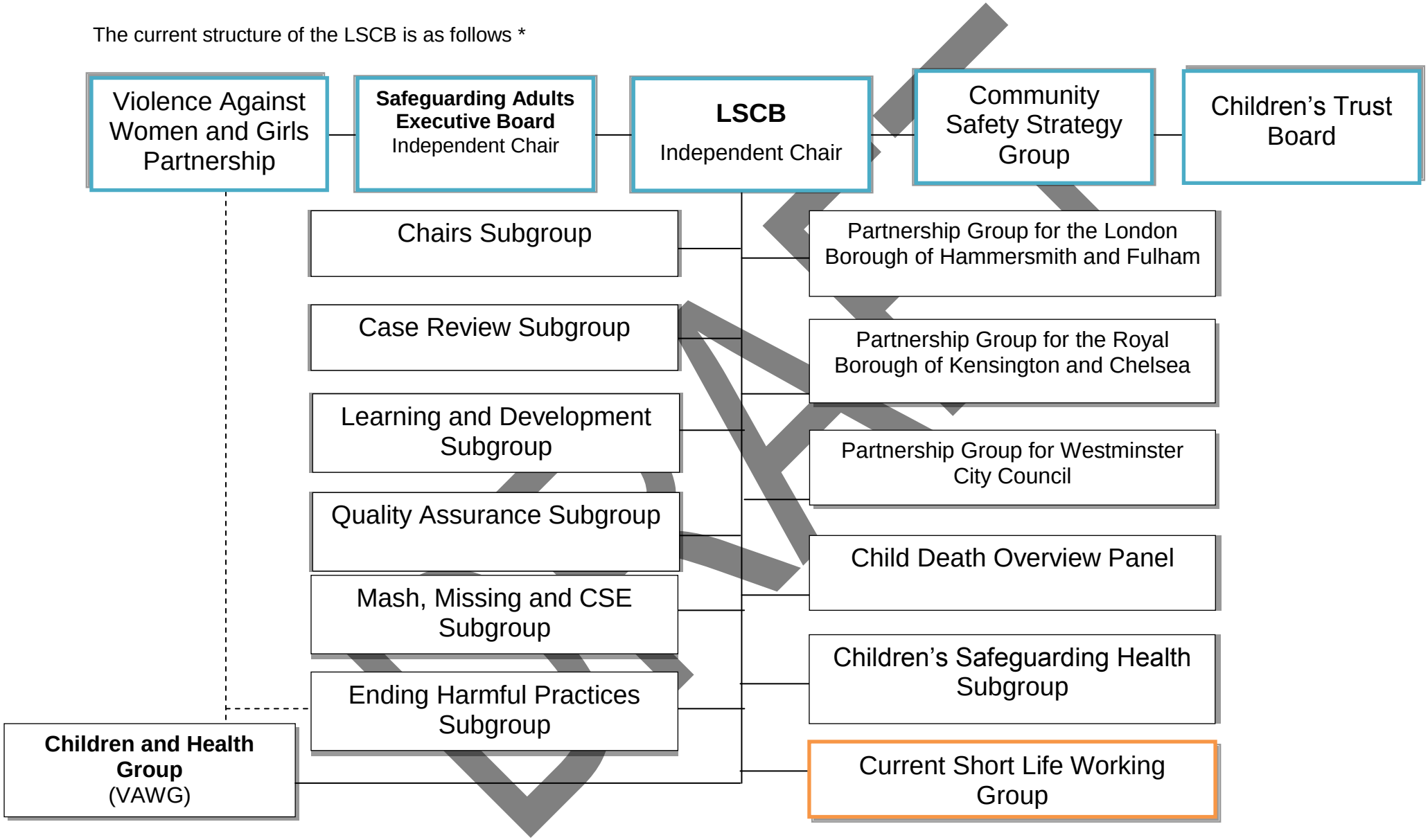
Specialist support for children remains a significant gap in all three boroughs. There is no specialist advocacy support for children and young people under 13 years old who have been affected by domestic abuse in any of the three boroughs. The Partnership aims to address this gap with a needs assessment and joint commissioning strategy.



[7] https://www.rbkc.gov.uk/pdf/Violence%20against%20women%20and%20girls%20Partnership%20Annual%20Report%202015-16.pdf

## GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS

The current structure of the LSCB is as follows *

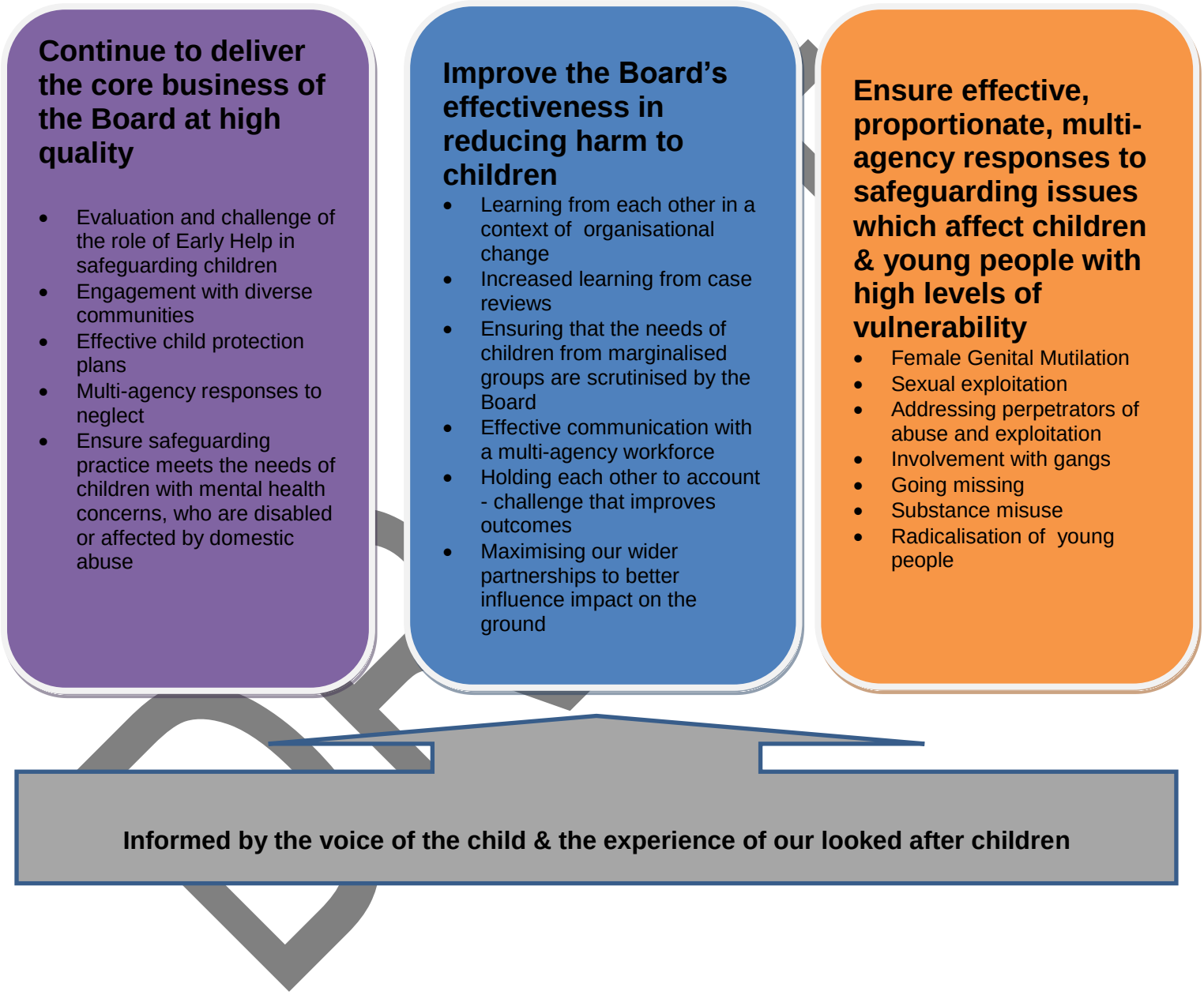



* LSCB membership on LSCB website https://www.rbkc.gov.uk/sharedservices/lscb/aboutus/boardmembersandadvisers.aspx

Version 6 20/10/16

**PRIORITIES OF THE LOCAL SAFEGUARDING CHILDREN BOARD – 2015/16**

The headline priorities of the Local Safeguarding Children Board for 2015/16 were as follows**:**



**Summary of outcomes and progress made**

The Safeguarding Plan was developed to identify a series of outcomes through which progress could be measured. The following section lists the outcomes and evidence of activity that supports each of the outcomes.

1. **We know the impact of our early help framework in identifying and supporting children and young people who are at risk of neglect and/or have high levels of vulnerability.**
    - The LSCB was provided with an assessment from each borough of measured impacts of council early help services upon children and families.
    - A Focus on Practice impact report was provided showing initial indications of the positive effects of the programme on rates of children becoming looked after, those with child protection plans and re-referrals.
    - The LSCB Neglect Strategy was published which is now informing a series of tools and awareness raising developments across the three boroughs.
    - An integrated ante-natal offer and 2 year old check has been implemented across all three boroughs with Information Sharing Agreements in place.
    - Schools are increasingly engaged with addressing eSafety issues, including through linking with parents.

2. **Our performance framework identifies areas of concern which are challenged and addressed through the Board.**
    - The Board has consistently received performance reports with exceptions identified. There have been challenges which have been discussed at the Board including in relation to the numbers of looked after children placed out of borough.

3. **Partners have a shared overview of the effectiveness of safeguarding of disabled children and agree actions to address any concerns.**
    - Learning in relation to the specific needs of disabled children from relevant Serious Case Reviews has been reviewed and shared across the multi-agency workforce.

4. **We have reviewed the structure of the LSCB to maximise the contribution of our partners and the Board's impact upon wider practice.**
    - Ofsted's Review of the LSCB found the shared structure created significant benefits for young people through the rationalisation of time and secure involvement of senior representatives from partner agencies. The balance achieved between shared and local functions ensured that children are safeguarded effectively. Additional points of relevance to this outcome included:
        i. Although Ofsted recommended that the Board should devise a system to escalate concerns about infrequent attendance at the board by

partners, there has been effective follow-up in relation to this by the Independent Chair and others. There has also been effective action to ensure departing members are replaced. The sub-groups are chaired by leads from a range of agencies. The LSCB now includes stronger input from Public Health, Health, Adults Services and Prevent.

ii. A Health Overview sub-group has been meeting since April 2015.

iii. A new system has been implemented to enable Section 11 audits to be carried out virtually with a phased programme to make this accessible to different agencies.

5. **A Communications Strategy is agreed which reflects the views of children and young people on how best to raise their awareness of our priority safeguarding issues; successfully disseminates key learning to practitioners in all partner agencies; identifies missing stakeholders/partners and strategies to engage them.**
    - A shared website went live in 2015 and has been regularly updated with further developments planned. A Twitter feed is driving visits to the site.
    - The "Young Humans" project regarding feelings of young people about being Muslim in West London has been hosted on the website.
    - The LSCB worked with young people during Youth Takeover Day to design anti-bullying resources.
    - Our communications are encouraging increasing numbers of independent schools to seek advice about safeguarding issues.

6. **Our training programme is targeted to reflect the priorities of the LSCB and address current challenges for frontline workers.**
    - The annual training programme was published with a plan in place to measure the impact on delegates at intervals after training was completed, as well as mystery shopping exercises.
    - Feedback from consultation has influenced training content, e.g. a VAWG consultation of young people led to key messages being stressed in LSCB core training. LSCB has facilitated advertising of Prevent WRAP training to increase uptake by the children's multi-agency workforce.

7. **LSCB members have a clear understanding of the role and challenges of other partner agencies including the impact of ongoing significant change.**
    - LSCB member agencies have publicised changes to service offers via the Board with challenges where it is felt that such changes could have an impact on safeguarding. This aspect of the Board's activity will be formalised through LSCB meeting agendas in 2016/17.

8. **All partner agencies are effective in identifying children and young people affected by gangs and serious youth violence and refer them on for effective support.**
    - There have been effective services and processes in all three boroughs as follows:

i. Hammersmith & Fulham: Street Outreach Service operating as an autonomous service with referrals from police, children's services and probation following concerns about serious youth violence or emerging tensions.
ii. Kensington and Chelsea: Good working relationships between key agencies concerned with serious youth violence facilitate information sharing and effective meetings following London Child Protection guidelines. The local police gangs team work with all agencies on managing individual or groups of young people.
iii. Westminster: The multi-agency Integrated Gangs Unit located in the MASH meets daily to share information with strong partnership working with schools, Redthread and Child and Adolescent Mental Health Services.

9. **Frontline practitioners are aware of the signs of child sexual exploitation and are confident in supporting children who are affected.**
    - There is a high level of assurance about the effectiveness of a wide range of strategies to tackle CSE in the three boroughs. Ofsted noted a "robust and well-coordinated response…informed by the effective sharing of information and intelligence between all key agencies." The Review of the LSCB noted that "Effective monitoring by the child sexual exploitation and missing sub-group enables the board to have a robust understanding of missing children and their behaviour across the tri-borough partnership."
    - LSCB general and specialist training courses address CSE with additional training provided for Family Services staff by CSE leads. Training has been reviewed and revised where appropriate e.g. to make some generic training more specific to local situations. Staff from local authority Children's Services, health, the voluntary sector and probation have participated in the training offered.
    - Training and awareness videos have been published on the LSCB website.
    - Profiles of CSE activity have been produced and shared with partners through the MASH/Missing/CSE sub-group.

10. **The wider community has an increased awareness of young people vulnerable to sexual exploitation, gang activities, domestic violence and female genital mutilation.**
    - Operation Makesafe has been implemented across the three councils with a Stakeholder Group led by the Director of Children's Services reporting to the LSCB. This has engaged businesses including hotels, licensed premises and taxi companies in awareness of and responses to CSE
    - Awareness of CSE amongst young people has been addressed through the Healthy Schools Partnership and School Improvement Team which promotes this in schools through the Personal, Health and Social Education (PHSE) curriculum.

- Young people in targeted schools have received training from the Integrated Gangs Unit and the police on consent and rape as well as additional training from Barnardo's and VAWG.
- Ofsted noted the effectiveness of awareness-raising regarding FGM which had led to referrals to children's social care increasing along with the effective role of the tri-borough female genital mutilation project in engaging fathers and husbands and from particular communities.

**11. Multi-agency planning addresses the behaviour of perpetrators of CSE and Domestic Abuse.**

- Ofsted noted the role of information sharing through the Multi-Agency Sexual Exploitation panel (MASE) and other local panels and mapping arrangements in ensuring a focus on both victims and perpetrators.
- Reports to the MASH/Missing/CSE Sub Group now include summary information about perpetrators and locations of concern.
- There is reciprocal attendance at key risk management groups such as MAPPA and Serious Youth Violence panels with good examples of "mapping" meetings in the boroughs sharing information about perpetrators from different agency perspectives.
- Anonymised examples of effective action to disrupt perpetrators and address locations of concern have been shared with the LSCB and the Sub Group.
- All three boroughs have well performing MARACs that safety plan for families where there is high risk domestic abuse

**12. Agencies are aware of and able to respond to young people affected by domestic abuse perpetrated by peers**

- A report has been presented by VAWG representatives to the LSCB with a commitment to regular updates going forward.
- Professionals from specialist services are now working alongside colleagues from children's services to strengthen pathways and knowledge-sharing between them to support high risk families and to provide longer term work to prevent future abuse and increase safety in families.
- Parenting Programmes have been introduced which support wider relationships and their impact on child well-being, in addition to developing additional components to early intervention parenting programmes that offer VAWG support. This includes *Talking Without Fear*, which focuses on offering extra support to non-abusive parents post separation as they are recovering from the trauma of abuse, and the *Healthy Relationships Healthy Babies* pilot, both of which have happened in Westminster.
- Children and young people have been identified as a priority in all of the VAWG's operational groups

13. **Practitioners are increasingly able to identify children at risk of female genital mutilation and respond appropriately to safeguard them.**
    - A pilot project involving local authority and health services has introduced an innovative approach in identifying and working with potential and current FGM victims. A specialist social worker co-located and embedded within a health setting has contributed to strong multi-agency working which is enhanced by joint development work with Midaye, a Somali Development Network.
    - The project has led to a substantial increase in the number of families where FGM has been identified to be an issue, enabling a proportionate response at an early help stage or Child in Need or Child Protection services where required. From May 2014 to March 2016, 77 women from the three boroughs have been referred and seen in both clinics. All women who have daughters or are going to give birth to girls have agreed to social work visits.
    - At St Mary's weekly FGM clinic, the team see approximately 10-12 women per clinic. 3-7 of these are residents of the three boroughs. At Queen Charlotte's Hospital where an FGM clinic operates fortnightly, the team sees 5-10 women per clinic, with 4-5 women of these from the three boroughs.
    - The LSCB provides FGM training to a range of practitioners who have contact with girls across different age groups. "Learning Events" have been planned to support schools with addressing FGM.
    - The LSCB community worker has built strong links with Mosques and Madrassahs to build capacity to recognise and respond to safeguarding issues

14. **The LSCB has identified how best to work with other key partnerships to better address safeguarding issues resulting from the radicalisation of some young people.**
    - A major conference took place involving local schools and including presentations on responding to threats of radicalisation,
    - The Channel Panel has been expanded to include safeguarding representatives from Children's Services in all three boroughs and specific schools, determined by what is on the agenda.
    - Following training and awareness raising, an increasing number of schools and colleges are raising the issue through school councils, PHSE, assemblies and using the support and advice available from Prevent.

15. **The LSCB has ensured that local multi-agency responses to national safeguarding issues are proportionate and target the communities or localities most affected.**
    - There are good examples of tailored support being provided to specific communities, raising awareness of safeguarding in response to local needs while ensuring an appropriate range of other issues are addressed through this contact.

## Conclusions following the review of the 2015/16 Safeguarding Plan

1. While there have been significant developments in many service areas and improved processes, in some areas of LSCB activity, there is an ongoing need for a greater emphasis upon outcomes and clearer indications of impact upon children which result.
2. While we are now clearer about the impact of local authority Early Help services, there is less clarity about preventative services provided by other sectors and their contribution to effective safeguarding.
3. There is a need for the Board to consider the safeguarding needs of disabled children. While the recent Ofsted review and the simultaneous inspections of the three local authorities did not identify any specific concerns about disabled children, there is still a need for the LSCB to consider their safeguarding needs in more detail.
4. While there have been initiatives to involve young people in the work of the board and consult them about safeguarding, this has involved limited numbers of children. A more comprehensive understanding of how we assess the impact of safeguarding upon the lives of children and young people and how the Board has acted upon their views is required.
5. While we have made progress with communicating more regularly and in different ways, we are not always clear about the degree to which key messages are received and responded to by the large multi-agency workforce. Further developments could also be considered as to how the LSCB might best receive feedback from frontline staff about how safeguarding is working in practice.
6. There is an ongoing need for the LSCB needs to continue to develop its links with a range of partnerships with which we share a common agenda or priorities.

## VIEWS OF CHILDREN AND YOUNG PEOPLE

With support from the LSCB Community Development Officer for Children and Young People we undertook a range of activities this year. In July, we hosted a workshop for school children aged 9-10 years old for the Children's Choice Conference for schools in Hammersmith and Fulham, and Kensington and Chelsea where we asked children to tell us about what worried them most. The children were asked 1) what worried them about a particular safeguarding topic, 2) how they could keep themselves and their friends safe and 3) what adults could do to keep them safe.

One of the main themes identified was bullying at school, and we subsequently planned an activity around this and e-safety for Youth Takeover Day in November. For this event, we challenged a number of young people from Phoenix High School in Hammersmith and Fulham to produce with a short stop motion film about keeping safe online which was used on the LSCB Twitter feed to promote Safer Internet Day in February.


In 2015 we also worked with a group of young people in Westminster who formed our Young People's Panel. They identified 'sexting' and staying safe online as two issues they wanted to explore further during our workshops with them.

**KEY ACHIEVEMENTS FROM LSCB SUBGROUPS**

**Hammersmith and Fulham Partnership Group**

The Partnership Group has continued to develop strong partner relationships. There has been good and consistent attendance and contribution by a wide range of agencies. Key issues such as child sexual exploitation, domestic abuse, substance misuse and adult mental health have remained high on the agenda and are standing items for discussion. The Partnership Group has continued to engage the community and voluntary sector and has sought to strengthen collaboration and partnerships by bringing them into the core of safeguarding work. A range of voluntary sector partners have engaged with the partnership group, including Queens Park Rangers Football Club to develop relationships and strengthen their understanding, knowledge and response to safeguarding issues.

The Partnership Group now has a representative from education as a permanent member, which provides an essential link to the head teachers' forum and ensures that key education issues are brought to the attention of the LSCB.

The Partnership Group has routinely sought to encourage challenge between partners in a measured and proactive way. The LSCB is kept informed about all challenges that are raised. Challenges are recorded on the "challenge log", which is regularly reviewed to measure outcomes and the impact of any action taken. This has led to changes to protocols, pathways and responses. For example, a review led to improvements to the protocol and pathways in relation to pregnant refugee women presenting at maternity units for delivery who are homeless and have no recourse to public fund.

'What are you concerned about' remains a standing agenda item of the Partnership Group. This facilitates the raising of key safeguarding issues which can then be escalated to the Board. Members consider safeguarding in the wider context and can prompt particular actions, e.g. sexual health clinics noted a rise in CSE concerns in schools and younger children engaging in sexual activities. A multi-professional meeting was arranged to explore the concerns and developed a more robust approach to the assessment of the safeguarding concerns for each child, an assessment of the response of schools and a strengthening of communication pathways between agencies.

The Partnership Group has been central in maintaining the link between front line services and the LSCB. Feedback has been actively sought from front line practitioners across all services through questionnaires or team/service discussions. The group has led on the dissemination of information to front line staff, including the LSCB newsletter and Learning Review. Exercises have also taken place to measure the impact of the Partnership Group on front line staff's knowledge, understanding and practice following the dissemination of information about referral pathways, thresholds and Early Help and child sexual exploitation.

**Kensington and Chelsea Partnership Group**

The Partnership Group has a committed and long standing core membership. Members seek to investigate proactively safeguarding issues of relevance to local need and issues, reflect and debate, and take action where required to improve the quality of interagency working and the quality of service provision to the children, young people and families in Kensington and Chelsea.

The group has met formally on a quarterly basis, with additional work taking place as required. This is supported by a comprehensive Business Action Plan which guides the group's focus and promotes the opportunity for reflection on local safeguarding issues.

Over the course of the year the Group considered a range of thematic subjects of relevance to local children, families, communities and professionals working at the frontline. These included; ending harmful practices such as FGM, early help services, organisational change and its impact, learning from serious case and management reviews, private fostering, child sexual exploitation, serious youth violence and gang activity. The Group members contribute to the delivery of information through papers, research and presentations on a range of issues. The opportunity to discuss and debate is actively pursued.

A range of speakers were invited to broaden the knowledge and the agenda. Guests discussed thematic issues, e.g. the Asian Resource Centre have presented their partnership work on ending harmful practices. Annual reports have been presented including those of the Child Death Overview Panel, Local Authority Designated Officer, Private Fostering, Multi Agency Risk Assessment Conference (MARAC) report considering domestic abuse, and the Multi Agency Public Protection Arrangements (MAPPA) report of the London Probation Service.

Guidance and signposting to specialist tools have been disseminated through members including FGM and CSE vulnerability assessment tools, and guidance

resulting from the Southbank Serious Case Review in understanding the 'grooming' of the environment and how to ensure a positive safeguarding culture and leadership in organisations.

Organisational changes and the impact upon local safeguarding arrangements have continued to be a theme with opportunities to provide updates, ask questions, raise challenge and debate safeguarding issues and implications. A significantly beneficial aspect has been to focus on collectively how we may support colleagues and promote a positive interagency working arrangement, promoting the opportunity to form professional relationships and address the emergence of issues at the earliest stage. This has had direct benefits for effective working together arrangements and safeguarding matters in relation to children and their families.

The partnership group remains committed to the Board's work on Neglect and a number of members are committed to the continuing partnership with the NSPCC to deliver the Neglect Campaign across the three Boroughs into 2016-2017.

**Westminster Partnership Group**

The partnership group has had a productive year including the Ofsted inspection of children's services which took place in January 2016. The final report included a Review of the LSCB which was positive about the contribution and quality of Westminster's Partnership Group.

Achievements this year included the collation and dissemination of a comprehensive list of Westminster supplementary schools. These are education establishments that may not be registered with Ofsted because they offer homework clubs, religious studies and other provision out of usual school hours and therefore are not subject to a regulatory framework. The Community Development Worker undertook some effective relationship building to enable input with those running schools and institutions. This has meant the profile of issues such as FGM, child sexual exploitation, private fostering and the safeguarding aspects of the 'Prevent' agenda are raised directly with communities who may be affected.
The Community Development Worker has offered advice about making referrals to children's social care and therefore this work had a direct impact on the well-being of young people. She enabled discussions about the issues listed above to take place within the institutions which would not have happened otherwise. The list of supplementary schools was compiled with input from the group to ensure a comprehensive gathering of intelligence across the multi agency safeguarding spectrum.

The Children's Services and Housing Panel was promoted at the partnership group to ensure agencies are aware of the referral pathways and the work that can be done to intervene early, preventing homelessness for children and families.
The Partnership Group identified a low take up of training from multi agency staff about how to use interpreters, which led to a discussion about interpreters' understanding of safeguarding and the complications that can arise when using interpreters with families where there are safeguarding concerns. Subsequently the interpreting and translation contract for children's services is being re-commissioned and this feedback was incorporated into the new specifications, ensuring that

interpreters and users of the service will have clear expectations and quality standards.

The Group heard challenges about the quality of the emergency out of hours social work service, and this was subsequently recognised through self-assessment and the Ofsted inspection. The challenges raised by our Lay Member and Appropriate Adult volunteer resulted in a number of detailed meetings and examination of the processes. The position now is that although further work is required, additional social work resource has been agreed for the out of hours service in Westminster to improve its quality.

The Partnership Group also identified the need for young carers to receive a better service this year. The Young Carers contract with a voluntary sector provider subsequently came to an end with the decommissioning decision influenced by the partnership group. The service is now provided in-house by Westminster Children's Services. There is now a target within Westminster City Council to report on the numbers of young carers identified as a proportion of early help cases. Such cases will therefore have significant multi agency input.

A series of themed workshops were planned to address the priorities the partnership group identified for itself at the start of 2015-16. These were informed by the wider Safeguarding Plan of the LSCB as follows:

- Serious Youth Violence
- Child Sexual Exploitation
- Female Genital Mutilation
- Radicalisation and Prevent

This led to a number of examples of the direct, positive impact of the partnership group on outcomes for children:

A workshop was held with group members and additional invitees on each of the themes outlined resulting in actions to be taken in each area. For example, Redthread attended and gave a presentation at the serious youth violence workshop about their work in hospitals with young people who have been the victim of violence. This was at the suggestion of a safeguarding health lead and led to actions including Redthread attending a safeguarding briefing for GPs. The Tri-Borough Alternative Provision (TBAP) schools were also invited to the Integrated Gangs Unit meetings in order to create better information sharing and closer working as some young people attending such provision would be at risk of or perpetrating serious youth violence.

The workshop on CSE resulted in increased input at the Multi Agency Sexual Exploitation Panel from probation and housing, and a commitment from colleagues in the Safeguarding, Review and Quality Assurance section in Children's Services to ensure that child protection plans for children who were considered at risk of CSE contained specific actions that would increase their safety.

The FGM workshop ensured a greater profile for FGM prior to the summer holiday break in 2016, which we know is a crucial time to identify girls who may be at risk.

Finally the Prevent workshop enabled an overview of the 'reach' of the current training offer for Prevent, offering reassurance that staff across the partnership have accessed the training and are making referrals where appropriate.

**Case Review Subgroup**

The Case Review Subgroup considers new child care incidents (of serious injury or death to children) and makes recommendations to the chair of the LSCB on whether a decision on holding a formal Serious Case Review (SCR) or another type of review should be held.

The sub group also receives completed reports commissioned within the three boroughs so that learning can be identified and disseminated to the LSCB workforce. The sub group considers national or other local authority review reports where there are potential lessons for our local services.

**New child care incidents: Recommendations from Case Reviews**

During the year two SCRs have commenced, one initiated by the shared LSCB and another by Luton LSCB involving a family which had prior involvement from services in Hammersmith & Fulham. Both reports will be completed in 2016/17.

The case initiated by the shared LSCB (known as "Baby Rose") involved a young mother who gave birth abroad and returned to the UK four months later with the intention of taking the baby to Moorfield Eye Hospital for an operation. The mother informed her parents, who lived abroad, that Children's Services had removed the baby from her care, and they were so concerned that they came to the UK immediately and took their daughter to the Police to report the baby missing. Following a police investigation the mother was charged and convicted of murder. Police advised that she had accepted that she suffocated and disposed of the body.

In the Luton case a baby died of severe physical injuries when cared for by a young mother and her new partner; the use of drugs by both parents influenced the care they provided for the baby. Hammersmith & Fulham Children's Services were involved at the time of the baby's birth, before the family moved out of the area. Children's Services and Hammersmith & Fulham's Housing Department are both engaged in the serious case review.

**COMPLETED REPORTS RECEIVED AND REVIEWED**

A number of completed reports were received by the sub group and the key lessons reported to the LSCB and to the wider multi agency workforce through training, learning events and the Learning Review newsletter.

The key reports and lessons were as follows:

**CD – Case Review**

CD was a 21 year old care leaver who died as a result of drug misuse. She had a long history in care with multiple placements. The review noted that the services she was offered were provided by highly committed staff; despite the high level of input

the services did not sufficiently change her pattern of substance use or other life choices

The report identified the following lessons:

a. The LSCB should note the need for the care leavers' teams to have and/or have access to specialist substance misuse knowledge and should ask the Tri Borough Assistant Director for looked after children to review the position in the three care leaver's services and take appropriate action as necessary.

b. The borough's care leaver service should consider how to make available a drop-in opportunity for young people not able to keep to regular appointments.

c. Peer mentoring should be made available to engage hard to reach young people.

d. Pathway plans for young people leaving care should have a wider multi agency input into them.

e. Consideration should be given to a career pathway for personal advisors to ensure that the more complex young people can be allocated to the most experienced staff.

**Sofia – Serious Case Review**

In December 2015, the LSCB published the serious case review regarding baby Sofia. Sofia was a 13-month old baby who died as a result of neglect. Her mother had a history of moving between boroughs. As far as can be ascertained, Sofia and her mother lived in seven different areas prior to the baby's death.

The report identified the following lessons:

a. There was a pattern, particularly across London, whereby the complex nature of housing and benefits legislation (as it applies to foreign nationals) meant that professionals are ill-equipped to explore all options open to families.
b. There was a pattern in Westminster Children's Social Care at the time not to assess the needs of pregnant women where housing needs were the primary problem. This potentially placed unborn children at risk
c. Systems to share information between GPs and Health Visitors need to be more robust so that reliable oversight of babies' health is not undermined.
d. There was a pattern in London whereby strategy discussions had become diluted to a brief telephone communication between Police and Children's Social Care, which resulted in other agencies not being included in the discussion, even where they have the greatest knowledge of the family.
e. There was a pattern of professionals over-focusing on physical manifestations of neglect, such as weight loss and failing to identify more complex, less visible indicators.
f. There was a tendency to assess risk from the parent's perspective and not to focus on the child's experience. This meant that destitution, and resulting transience, were not seen as potential child protection issues.

g. Children's Social Care being unable to complete an assessment because a family is 'avoidant' at point of transfer may lead to children inappropriately being described as 'in need' rather than 'in need of protection'.

**JJ – Serious Case Review**

In January 2016, the LSCB published the serious case review for JJ. JJ was a 3-year-old boy who lived in Westminster with his mother. He died in the care of his father while having overnight contact in another local authority area. The post mortem outcome was that this was an unexplained tragic accident; further specialist medical advice concluded that the injuries did not match the reported description of events and suggested force had been used. Because the child had died and abuse or neglect was suspected, a serious case review was held.

The review could not identify any information regarding what had happened the evening JJ died – this had been carefully investigated by the police. No agencies were involved in any plans for JJ's overnight stays with his father; this was organised informally between his parents. However there were lessons which emerged for agencies which arose from the interactions his mother had had with health agencies.

The report made the following recommendations

a. The health visiting service should review the assessment and recognition of support needs when mothers are presenting with low level mental health issues or anxiety.
b. Communication needed to be stronger to primary health services regarding presentations of children to Accident & Emergency services. This should include not just the transmission of information, but the aggregation of patterns of presentations and understanding the potential issues that might lie behind them.
c. Agencies should ensure that fathers are an important part of their thinking, assessments and intervention.

**Southbank International School Serious Case Review**

The sub group received the report on the abuse at Southbank International School, which occurred over a period of four years, perpetrated by a teacher, William Vahey, who is now known to have been a prolific sex offender.

The report concluded that: "William Vahey, an American citizen, joined Southbank School from the international school in Venezuela, having worked in several countries during his teaching career. It is significant that he had a conviction for sexual offences against young boys in California in 1969 and this conviction resulted in a 90-day jail sentence and five years' probation with a condition that he should be supervised in the company of males younger than 16 during that time. This conviction was not picked up at the point he qualified as a teacher in the United States or by any subsequent employer."

Recruitment processes which were not compliant with expected standards resulted in his appointment as a teacher at Southbank International School. Vahey had quickly established himself as a teacher who had an informal, unconventional teaching style but was popular with many pupils. He specialised in residential trips

and ran the ‘travel club’ which involved him selecting pupils and teachers to accompany him on overseas trips.

The review has found that “aspects of Vahey’s behaviour should have alerted senior staff at the school to the possibility that he was sexually abusing pupils; at no point was this given any formal consideration”.

The key recommendations identified were:

a. There is a need to ensure that all staff in the multi agency workforce are able to use the report resulting from the SCR to further develop their understanding of the modus operandi of sex offenders.
b. The LSCB to consider how it can promote learning in agencies regarding the establishing and maintenance of a safeguarding culture that restricts opportunities for offenders, promotes identifications and ensures effective follow up when issues are raised.
c. The need for effective recruitment practice, and where possible, overseas checks to be implemented in all agencies so as to minimise the chances of offenders gaining access to employment and to children.

**Family C - Serious Case Review to be published in 2016-17**

In February 2015, the mother of two young children aged 4 and 18 months, killed her oldest child as well as the children’s father and also seriously injured the youngest child, whilst she was experiencing an acute psychiatric disorder. The family had been known to local statutory agencies but had never met the criteria for any formal child safeguarding interventions. The mother was seen by adult services but left before formal assessments could be completed.

The SCR findings will be published in a full report, alongside the publication of a domestic homicide review (DHR), commissioned by the Community Safety Partnership. The timescale for publication of the SCR has not delayed sharing learning from it with practitioners and introducing some service changes in adult health services in order to improve communications.

**External Serious Case Reviews**

The sub group also considered two serious case reviews from other LSCBs where children had been harmed in other local authority areas. In one case a local authority foster carer had sexually abused children placed in his care over a 10 year period. Another SCR focused on a teenager who had suffered severe neglect over a long period of time. Local review of these cases and learning led to actions to ensure this was shared with relevant groups (e.g. the local Fostering Panel, services responding to school attendance concerns and Early Help services) as well as informing the content of training and conferences.

**Communication of the Lessons**

As a matter of routine all three local partnership groups in the three local authorities take the review reports to their meetings to ensure there is wide dissemination of the lessons. The LSCB’s Learning Review newsletter includes a summary of the

lessons. The LSCB training offer is amended where required to incorporate learning. In addition, all LSCB members are expected to communicate and cascade lessons back to their agency networks as appropriate.

**Quality Assurance Subgroup**

The Quality Assurance (QA) subgroup takes a lead on the LSCB's role in examining information including quantitative data, information about the quality of services, and information about outcomes for children. This is done by examining performance data from a number of key agencies, multiagency audits, section 11 audits and informal exception reporting. This is scrutinised to consider any unusual patterns or themes and compared with local and national data where possible. The subgroup has met quarterly to explore the above drawing conclusions and potential recommendations relevant for each sector.

In 2015/16 there were a number of achievements led by the QA subgroup. Section 11 audits are now completed using a virtual tool and the questions redesigned to ensure the document is user friendly and to increase agency participation. This has been trialled by several agencies with positive results tracked by the LSCB.

Multi-agency audits are now led by the local authorities' Quality Assurance Manager where previously an independent consultant was commissioned. In this period the subject chosen by the subgroup for audit was 'Safeguarding and Parental Mental Health' and the report was completed in January 2016. The process included agencies across a number of services completing individual case audits followed by a workshop to consider the findings. The information was analysed and contributed to a final report which was communicated to the LSCB meeting themed around mental health. The following findings cover a number of recommendations in the full report:

**1) Challenges Associated with Information Sharing**
This report has highlighted different examples of where information sharing has worked and where it is hindered. This ranges from parental consent/openness with practitioners to information sharing barriers between agencies. This is inclusive of private providers. The importance of taking a curious and proactive approach to safeguarding is essential.

**2) The Importance of Robust and Purposeful Planning and Interventions**
The inclusion of families and the importance of multiagency working is an important aspect of achieving good outcomes for families. There were examples where well attended network meetings had led to good discussions and planning to support families. However, there were examples where network meetings had not taken place and were therefore recommended within the audits.

**3) Relationships**
Relationships are central to working with families and the professional network to achieve positive outcomes and change. How we strengthen these relationships and utilise them is essential to continued development across services.

In November 2015, in response to a challenge from a voluntary sector partner agency, the Local Children Safeguarding Board was requested to review Children's

Services use of the Barnardo's Domestic Violence Risk Identification Matrix (DVRIM) where domestic abuse is identified in the home. The audit also explored the other types of tools that may be contributing to the Social Work assessment of risk and also made wider observations related to the quality of practice.

Whilst use of the Risk Identification Matrix was not evident on any of the cases reviewed, the audit identified evidence of multi agency approaches to assessments and interventions with families. Social Workers had a good understanding of risk to the child or children and parents and considered these in detail. The drive of systemic practice across Children's Services in the three local authorities was also being utilised in a number of these cases both with Social Workers that were on the 'Focus on Practice' course and those who had not yet started demonstrating that this too is becoming embedded.

Planned multiagency audits will now occur twice a year with the flexibility to complete further audit work where agencies raise potential practice challenges as demonstrated above.

**CSE, Missing and MASH Sub-group**

The subgroup met on three occasions over the course of the year. As a multi-disciplinary partnership it considered strategic plans to deliver on LSCB safeguarding priorities in this area. The membership of the group continued to represent the wider spectrum of partnership agencies working with children and their families affected by child sexual exploitation, children who are missing from home, care and education. It also reflected the systems in operation through the Multi Agency Safeguarding Hub (MASH) to effective identified and manage the information flow when assessing risk for some of the most vulnerable families.

The MASH has now been in operation for a number of years, and its activity has been overseen by this sub-group. This included the regular scrutiny of activity data as well as an exploration of practice issues and workload demands. The communication flow back to agencies which have been consulted as part of the initial checks made by MASH remained a challenge for the Hub and professionals. This led to a clear statement which noted that professionals and agencies will not be contacted following initial checks unless there was a concern that needed to be communicated. The sub-group acknowledged that the MASH would not have capacity to provide any additional feedback and approved a decision that Family Services would provide this where appropriate as part of any assessment carried out.

With an expanding knowledge of child sexual exploitation (CSE), its signs, impact and the need to increase awareness, the sub-group has overseen a multi agency strategic approach to address this safeguarding priority. There have been significant developments in the last year which the LSCB has been instrumental in leading, including the development of the CSE strategy and oversight of the Multi Agency Sexual Exploitation (MASE) panel which considers the cases of significant vulnerability and concern. A CSE Screening Tool has been developed and the six month pilot and results reported back into the sub-group. The outcome of the screening pilot was a confirmation of good levels of local understanding of risks, the levels of vulnerability and the decision making which had taken place.

Missing children and young people continue to be a priority of the LSCB's safeguarding plan. The last year saw an increased multi-agency understanding of the connecting factors of concern for children who go missing from home, missing from education, CSE, gang activity and criminal behaviour. The local authority Missing Coordinator has worked closely with social work practitioners and multi-agency partners to improve practice and safeguarding responses. The sub-group has been instrumental in refocusing the work of partners onto key issues of practice and effective interventions, leading to increased understanding about why children go missing and how they can be supported to not go missing in the future.

**Harmful Practices Steering Group**

The Harmful Practices Steering Group was formed in June 2015 as part of the new governance structure to deliver the 2015-2018 Shared Services Violence Against Women and Girls (VAWG) Strategy and regularly reports to the VAWG Strategic Board and the LSCB. The Steering Group is chaired by the VAWG Strategic Lead and the Deputy Chair is the Joint Head of Safeguarding, Review and Quality Assurance for Children's Services.

The main functions of the Steering Group have been to ensure that the Project for Ending Harmful Practices Pilot (PEHPP) is delivering its objectives and outcomes, and highlight and address any issues arising regarding the delivery of the pilot at the earliest available opportunity. It has also overseen the delivery of the FGM pilot at St Mary's Hospital and Queen Charlotte's Hospital.

**Ending Harmful Practices Training**

The PEHPP has overseen the roll out of a range of training opportunities on topics including FGM, forced marriage, honour based violence and faith based abuse. The training was delivered in stages, with half day multi-agency workshops open to staff from all agencies, followed by a two day specialist workshop open only to social workers, police and health staff. Staff who completed the two day specialist workshops were then invited to attend a series of half day follow up sessions to enable them to tackle the subjects in more depth.

Attendance in the first year of the training programme was good, although there was a high drop-out rate from bookings (overbookings were taken to compensate for this) with a good representation of practitioners from a variety of agencies. Evaluations from the earlier courses were taken into consideration to shape the following workshops and improvements were made in the delivery of subsequent workshops and evaluations continued to show good results as practitioners understanding of the subjects grew. The roll out of the training also coincided with the introduction of the FGM Mandatory Reporting Duty and the LSCB practice note on this topic was widely shared and discussed in training.

**Educator Advocates:**
The PEHP Pilot has also seen Educator Advocates deployed in all three local authorities, initially in Children's Services offices. Their role has been to assist children's social care professionals in effective case management where FGM, Honour Based Violence, Forced Marriage or Faith Based Abuse is a concern. The

advocacy service was also available to support and offer guidance to victims of harmful practices. There were some initial barriers in getting this part of the project to work smoothly (e.g. access to system records, building trust with colleagues in children's social care) but these have gradually been overcome and the result is a steady growth in consultations that the advocates have carried out. The Educator Advocates have been proactive in visiting a range of offices where children's social care staff are based to reach a wide audience and extend the reach of this part of the programme.

**Community Engagement:**
The PEHP Pilot has also delivered a range of community engagement activities across the three local authorities. This includes work done in local schools to engage families during coffee mornings. A local organisation has been set up by men (mostly from Somali and Sudanese communities) and a session was held with them to explore ways we could engage men in the conversations around FGM. Our male FGM worker also co-ordinated the delivery of a training session on FGM to a local school for 120 boys which was very well received.

**Female Genital Mutilation Early Intervention Project:**
A partnership approach to the early identification of girls' at risk of FGM has been running at St Marys and Queen Charlotte's hospitals for a full year. This included a multi-disciplinary team of a specialist mid-wife, a specialist social worker, health advocates from the voluntary sector, a male worker and trauma therapists working together to deliver holistic maternity care to mother's who have suffered FGM, while working with those families to offer early help or safeguarding services to prevent FGM occurring to future generations. In the course of the year 139 families were worked with and 76 received further assessment and support from Children Services. This is compared to the baseline figure which was that no children at risk of FGM had been identified. The project will continue until December 2016.

**Safeguarding Children Health Subgroup**

The Subgroup is chaired by the Designated Professionals and meets on a quarterly basis. The purpose of this group is to provide a strategic focus across health agencies to safeguarding children, quality improvement and sharing of learning. During 2015-16, the group met four times although quoracy was not always met owing to competing priorities of health providers.

**Key achievements of the group**

- Implementation of the "Child Protection-Information Sharing" (CP-IS) project has progressed. This will improve the way that health and social care services work together to protect vulnerable children. NHSE have met with the NHS providers who provide unscheduled care and support is to be given regarding implanting CP-IS across different Information Technology systems within health.
- Links have been made between the Homeless Outreach Worker, wider health services and other vulnerable women's groups. Although many of the health providers are aware of risks within this particular group they tend not to be

aware of the services being offered. This has reduced the risk of pregnant homeless women not accessing appropriate healthcare services.

- Work has taken place to identify "bed blocking" in maternity wards by mothers who are subject to delayed discharge for social reasons such as homelessness or awaiting court orders. An audit was undertaken to ascertain the level of bed blocking and the impact on emergency cases. Results of the audit will be presented to the sub-group and appropriate actions agreed.
- An audit has commenced on an apparent trend for increasing numbers of children attending Accident & Emergency units following falls from high rise buildings

The outcomes of these pieces of work will identify service areas that need improving and will strengthen the partnership working between health, social care and housing.

**Priorities of the Safeguarding Children Health Subgroup for 2016/2017**

- To improve the group's quoracy by identifying the key organisational representatives who should attend, rotating meeting days and setting dates for the year ahead to enable the right participants to attend.
- To revise the agenda setting process to ensure meeting outcomes are robust and relevant to members and to allow the group to feedback any issues to the LSCB and wider health partners in a timely manner
- To ensure serious case reviews are a standing agenda item so that recommendations for health agencies and action plans are incorporated into practice at the earliest opportunity so learning can be embedded
- To carry out self-audits and "deep dives" to measure how learning from SCRs impacts upon practice.
- To develop a standardised referral form to children's social care. This aims to alleviate staff anxiety and delays in acceptance of referrals as well as enabling enable professionals to have a common language and to facilitate the challenge and escalation of decisions where required.
- Increase the role of Designated Professionals in providing more scrutiny on health providers' Section 11 audits and where required, working with providers on activity relating to the national inquiry into historical child sexual abuse.

**Learning and Development Subgroup**

The LSCB has continued to provide a wide ranging training offer. This year, a total of 15 Introduction to Safeguarding Children workshops and 34 Multi-agency Safeguarding and Child Protection courses were offered. In response to demand from practitioners we introduced a half day refresher multi-agency safeguarding and child protection workshop.

New specialist workshops added to the programme included a session on the 'toxic trio' (domestic abuse, parental mental health and parental substance misuse) and

also working with difficult and evasive families. In partnership with the Women and Girls Network, we have also offered a series of seven workshops on child sexual exploitation.

The LSCB facilitated the roll out of the Partnership for Ending Harmful Practices Pilot (PEHPP) training. This included twelve half day multi-agency workshops (open to all agencies) covering FGM, forced marriage, honour based violence and faith based abuse. These were followed by two-day specialist workshops for health staff and social workers for more in depth information to be explored. A series of half day follow on sessions were also offered to delegates completing the two day specialist workshops, however, attendance at these was significantly lower as practitioners found it challenging to take so much time away from work.

Working in partnership with the Safer Organisations Manager and Tri-Borough LADO, we hosted accredited Safer Recruitment Workshops and Meet the LADO workshops to raise awareness of this important role.

The LSCB published an e-learning course on private fostering and continued to signpost to free external e-learning on FGM, Forced Marriage and CSE.

Evaluation of the training courses is carried out by a pre and post workshop evaluation form, to show how much learning has taken place on the day. A selection of delegates was then asked to complete a further online evaluation some months later, once they had had a chance to put their learning into practice.

Our priorities for 2016-17 include improving the way we evaluate training workshops, by holding focus groups to further measure the impact of training. The specialist course offer will be reviewed and additional workshops on the toxic trio and parental mental health and e-safety will be explored. A learning event for schools on the Southbank International School serious case review is also being developed.

## SHORT LIFE WORKING GROUPS

### Parental Mental Health Short Life Working Group

Central North West London Mental Health Trust and West London Mental Health Trust have been meeting regularly with representatives from children's social care regularly and more recently have engaged primary care in this short life working group. Participation of other agencies has been more sporadic. The working group has reviewed the challenges that issues of parental mental health and safeguarding pose for the multi-agency network and have identified key themes for the LSCB to consider at its Board meeting when the working group's final report will be presented. Themes focus on:

- Challenges for primary care
- The role of specialist adult mental health services
- The development of perinatal mental health services
- Information sharing
- Training

The group has also contributed to the development and completion of two multi-agency audits which have provided assurance on joint working and compliance with safeguarding policies. Findings from the audits will also be addressed in the final report.

**Neglect Short Life Working Group**

Neglect continues to be a key priority for the Board and in late 2014, a decision was taken to commence a short life working group (SLWG), tasked to consider:

- the needs of frontline professionals in the recognition of the signs of neglect
- how to increase understanding of the impact of neglect
- the identification of tools or guidance that might best increase professional capacity to work with families to address neglect and the harm to children.

The group has considered and reflected on a wide range of issues, including the needs of a wide range of stakeholders and the different nature of their relationships with families which impact upon their understanding of neglect.

First actions of the SLWG included:

- a review of a range of tools already used by other agencies nationally;
- development of the neglect pages on the LSCB website
- consideration of the National Society for the Prevention of Cruelty to Children (NSPCC) core programme on neglect, and development of in-house resources to aid the understanding of how a child or young people lives day to day when neglect may be an issue.

It was recognised that the family practitioners' access to the Focus on Practice programme within Children's Services has done much to assist frontline social workers to work more effectively with families, and that new sets of formal procedures or assessment models were not what was required.

The SLWG also concluded that schools and early years provisions are key to understanding the lived experience of children and their families' experience. Therefore more valid recognition needs to be placed on the information and understanding which such agencies bring to the wider professional understanding of this. These agencies are most likely to have a long term connection with a family and may also have a sibling group in attendance for many years. Some of these agencies have expressed difficulties at times in communicating their concerns when referring to statutory social work services. Locality social work teams acknowledge this, particularly in relation to the application of thresholds for interventions.

Recently published SCRs on the children Sofia and Leon recognised that such thresholds can be too high, and do not always evaluate the impact of chronic neglect, its "drip-drip" effect and its emotional impact which is difficult to measure. All agencies and practitioners recognised that this needs to be reviewed and improved where required.

Additional developments instigated by the SLWG include the development and piloting of two set of tools which have been developed and trialled across the three

Family Service Directorates and in a number of schools. The purpose of these tools is to improve understanding of neglect, communication of concerns, focusing more on the 'lived experience' of children.

In collaboration with the NSPCC the Board agreed to the initiation of a Neglect Campaign into 2016-2017, with the launch being delivered through a multi-agency conference in May 2016. The aim of the conference was to increase awareness and recognition of neglect, with presentations from a number of prominent researchers and highly qualified professionals.

The work of the SLWG has increased professional awareness of neglect, improved the environment for professional discussion and debate and ensured that all practitioners working with families have access to a variety of tools to inform their work, supported by enhanced information on the LSCB website.

**ASSURANCE STATEMENT**

This year LSCB can take some assurance from the review by Ofsted that it is 'Good', as well as from the two 'Outstanding' and one 'Good' judgements from the inspections of the local authority children's services. Areas where the LSCB has to be assured of the range of services and their effectiveness - adoption, fostering, care leavers, early help, social work services - were inspected, as were areas where we share key responsibilities e.g. CSE, missing children. Some areas of joint work, FGM, were highlighted as particularly notable. Reviews of local health services' safeguarding arrangements, described in this report, also give a high level of assurance that services are good. In addition the strong relationships in the LSCB and across local partnerships enable challenge and problem-resolution and there is good 'working together'.

Children's services commit more resources and time to the LSCB than any other partner and in 2015/16 chaired all three partnership groups and all sub-groups with the exception of the Health sub-group. Whilst partners are committed to participation in sub-groups, it is notable that no sub-group or short life working group has been chaired by the Police. During 2016/17 the Police have agreed upon a SLWG that they wish to chair. This is welcomed as is the stronger leadership by the police at a local borough level and across the three boroughs. In relation to funding, the local authority input – both financial and 'in kind' for the LSCB – is way beyond what any other partner commits. All London LSCB Chairs have noted that the Metropolitan Police continues to choose to fund partnership safeguarding in London 45% less than all the other large urban Metropolitan Police Forces in England. Safeguarding is a complicated and demanding partnership arrangement that needs appropriate resourcing if it is to be effective.

However, the organisational arrangements for the LSCB, commented upon by Ofsted, have continued to be under pressure with the new Business Manager recently covering her previous role of training manager as well as her own work. A 'move' of the managerial arrangements of the small safeguarding 'team' to Children's Commissioning coincided with increasing demands on the remaining staff – and it has been through strong competence and willingness of staff that the arrangements have 'held' sufficiently for the Board's work to continue. The support for multi-agency work across the LSCB relies on the small business support team and the

LSCB will not be able to maintain its momentum without this. The LSCB has met its statutory responsibilities in 2015/16.

The LSCB comprises all the required statutory partners and has strong and effective relationships with other partnership bodies across the three boroughs. Lay persons are engaged with the Board's work. The Board works closely with the Adult Safeguarding Executive Board for the three boroughs. All leaders and professionals, as well as voluntary organisations, prioritise safeguarding children. There could be a stronger link with front-line staff so that information from them directly informs the Board's work: the current emphasis upon relationships between and developments led by senior, strategic managers could be improved by a more genuine engagement of frontline workers, children and their families and the wider community. A multi-agency focus on and improvement of multi-agency practice should be the key means through which better outcomes can be realised and impact measured.

The national review by Alan Wood of the role and functions of LSCBs published with a response from government at the end of May 2016 will lead to national changes (currently being debated in parliament) for LSCBs in future years. I will complete my term as Independent Chair in 2016/17. National changes, which will place safeguarding responsibilities (yet to be defined) on local authorities, health and the police – as the three 'local leaders' – will pave the way for the current roles and functions operating at a local level to be re-defined and the structures to be reshaped. Early work by the LSCB to anticipate these changes is underway. New legislation and statutory guidance will be published during 2017. In the meantime, holding onto key staff and partnership working is imperative.

**LSCB PRIORITIES FOR 2016-17**

Following a review of progress with previous priorities by the Board and consideration of developing needs across the three areas, the following four priorities with associated outcomes and actions have been agreed through the LSCB's Safeguarding Plan for 2016/17:

1. **Build on partnerships to improve safeguarding practice with a particular focus on increasing the capacity of vulnerable parents to safeguard their children effectively**

   **Outcome: More children are effectively safeguarded in families where parents have complex problems.**

   The actions to achieve this priority and outcome are as follows:

- Maximise partnership arrangements to evaluate and increase their impact upon safeguarding children where parents are affected by domestic violence and abuse, mental health problems and substance misuse.

- Improve links and, where appropriate, hold to account key partnerships[8] to demonstrate that strategic work has a positive impact upon frontline practice and outcomes for children.

**2. Improving communication and engagement**

**Outcome: those who should benefit from the work of the LSCB are aware of and have an influence on what the Board is seeking to improve**

The actions to achieve this priority and outcome are as follows:

- Develop a comprehensive communications strategy for all Board activity.
- Listen to and review issues raised by multi-agency staff about safeguarding and confirm action taken by the LSCB in response.
- Listen to feedback from vulnerable children, young people and parents about the impact of safeguarding issues upon their lives (including issues such as radicalisation, CSE, missing children and FGM) and ensure the Board responds to this where required.
- Build upon progress and further develop an interactive LSCB website.

**3. Demonstrating our impact and knowing where more effective practice is required**

**Outcome: The Board is clear where improvements are required and can demonstrate actions which have made a positive difference to practice and children's lives.**

The actions to achieve this priority and outcome are as follows:

- Streamline and improve the use of multi-agency data to better measure our impact and progress as well as identifying where we need to improve.
- Ensure the work of sub-groups and short life working groups informs and delivers the LSCB's Safeguarding Plan
- Maximise impact and of learning from serious case reviews across the three boroughs by coordinating subsequent action plans.
- Review how the impact of the Focus on Practice programme is experienced by agencies responsible for safeguarding children and the opportunities for multi-agency learning from the programme.
- Promote the best outcomes for children who have experienced neglect.

[8] To include Health and Wellbeing Boards, VAWG, Safeguarding Adults Board, Children's Trust Board, Crime and Disorder Partnerships, MARAC and MAPPA.

- Assess the effectiveness of multi-agency early help partnership work at a borough level in improving outcomes for children, ensuring the LSCB is sighted on service changes that may impact on safeguarding.

- Review multi-agency action and planning to improve outcomes for children and young people whose needs are difficult to meet, and who may pose risks to other children.

- Develop links with commissioners in all relevant agencies to be able to identify where improvements in safeguarding are needed.

**4. Improving the effectiveness of the Board**

**Outcome: All partners are consistently aware of and engage with the priorities of the Board**

The actions to achieve this priority and outcome are as follows:

- Continue to monitor attendance of partners at Board meetings taking effective action when attendance is infrequent or turnover of key members is anticipated.

- Develop a Forward Plan to include key Board activities and scheduling in other required reports.

- Develop a work plan for the LSCB business support team that coordinates activities arising from the Board and partnership groups and drives through the priorities for children.

- Ensure there is an analysis of the impact of multi-agency safeguarding training at a tri-borough level.

## LSCB BUDGET

| | LBHF | RBKC | WCC | FORECAST |
|---|---|---|---|---|
| **Contributions received in 201516** | | | | |
| Sovereign Borough general fund (BUDGET at Period 13) | -87,369 | -67,612 | -69,926 | **-224,907** |
| **Partner Contributions in 2015/16** | | | | |
| 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) | -40,000 | -40,000 | -40,000 | **-120,000** |
| **Total Funding excluding reserves 2015/16** | **-134,919** | **-115,162** | **-117,476** | **-367,557** |
| **Forecast Expenditure in 2015/16** | **LBHF** | **RBKC** | **WCC** | **FORECAST** |
| Salary expenditure | 83,200 | 83,145 | 82,527 | **248,872** |
| Independent Chair | 5,153 | 5,153 | 5,153 | **15,459** |
| Training | 3,016 | 3,016 | 3,016 | **9,048** |
| Peer review/consultancy | 1,625 | 1,625 | 1,625 | **4,875** |
| Multi-agency Auditing | 3,333 | 3,333 | 3,333 | **10,000** |
| Other LSCB costs | 409 | 109 | 109 | **627** |
| **Total expenditure** | **96,736** | **96,381** | **95,763** | **288,881** |
| Serious Case Review related expenditure in-year | 1,750 | 2,224 | 4,354 | |
| **Forecast variance 2015/16 excluding Serious Case Review expenditure** | **-36,433** | **-16,557** | **-17,358** | **-78,676** |
| **Moved to B/S for partner income** | **36,433** | **16,557** | **17,358** | |
| **Final outturn** | **0** | **0** | **0** | |
| **LSCB Reserves as at Period 1 2015/16** | | | | |
| | **LBHF** | **RBKC** | **WCC** | **FORECAST** |
| Reserves Brought Forward into 15/16 | -5,500 | -72,835 | -90,579 | **-168,914** |
| **Adjustment in year 2015/16** | 5,500 | -16,557 | -17,358 | **-28,415** |
| Contribution to LSCB balance sheet accounts | -36,433 | 0 | 0 | **-36,433** |
| **Reserves to take forward into 2016/17** | **-36,433** | **-89,392** | **-107,937** | **-233,762** |

**GLOSSARY OF TERMS**

| | |
|---|---|
| BAME | Black, Asian and Minority Ethnic |
| CAFCASS | Children and Family Court Advisory and Support Service |
| CAMHS | Child and Adolescent Mental Health Services |
| CDOP | Child Death Overview Panel |
| CRC | Community Rehabilitation Company |
| CCG | Clinical Commissioning Group |
| CQUIN | Commissioning for Quality and Innovation (payments framework) |
| CP-IS | Child Protection-Information Sharing project |
| CSE | Child Sexual Exploitation |
| FGM | Female Genital Mutilation |
| HCPC | Health and Care Professions Council |
| HMRC | Her Majesty's Revenue and Customs |
| IGU | Integrated Gangs Unit |
| MAPPA | Multi-Agency Public Protection Arrangements |
| MARAC | Multi-Agency Risk Assessment Conference |
| MASE | Multi-Agency Sexual Exploitation meeting |
| MASH | Multi-Agency Safeguarding Hub |
| NHSE | National Health Service England |
| NPS | National Probation Service |
| NSPCC | National Society for Prevention of Cruelty to Children |
| PHSE | Personal, Health and Social Education |
| Ofsted | Office for Standards in Education |
| SCR | Serious Case Review |
| SLWG | Short Life Working Group |
| VAWG | Violence Against Women and Girls (partnership) |

**CONTACT DETAILS**

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## APPENDIX A: LEGISLATIVE AND STATUTORY CONTEXT FOR LSCBS

Section 14 of the Children Act 2004 and Working Together to Safeguard Children 2015 outlines the statutory obligations and functions of the LSCB as below:

(a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
(b) to ensure the effectiveness of what is done by each such person or body for those purposes.

**Regulation 5 of the Local Safeguarding Children Boards Regulations 2006** sets out that the functions of the LSCB, in relation to the above objectives under section 14 of the Children Act 2004, are as follows:

1(a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:
(i) the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;
(ii) training of persons who work with children or in services affecting the safety and welfare of children;
(iii) recruitment and supervision of persons who work with children;
(iv) investigation of allegations concerning persons who work with children;
(v) safety and welfare of children who are privately fostered;
(vi) cooperation with neighbouring children's services authorities and their Board partners;
(b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;
(c) monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;
(d) participating in the planning of services for children in the area of the authority; and
(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

**APPENDIX B: LSCB BOARD ATTENDANCE 2015-2016**

## LSCB Main Board Attendance 2015-16

| Role | 21st April 2015 | 14th July 2015 | 13th October 2015 | 24th November 2015 | 19th January 2015 |
|---|---|---|---|---|---|
| LSCB Chair | y | y | y | y | y |
| Executive Director of Children's Services (Tri-borough) | y | y | y | y | y |
| Director of Family Services (H&F) | y | y | y | y | y |
| Director of Family Services (RBKC) | y | x | y | y | y |
| Director of Children's Services (WCC) | y | y | y | y | x |
| Director of Schools | y | y | y | x | y |
| Head of Combined Safeguarding & Quality Assurance | y | y | y | y | y |
| LSCB Business Manager | y | y | x | y | y |
| Director of Adults Safeguarding | y | y | y | x | y |
| Housing | y | y | y | y | x |
| Borough Command | y | y | y | y | y |
| CAIT | y | y | y | y | x |
| Probation | y | x | y | x | y |
| Community Rehabilitation Company | y | y | o | o | o |
| CAFCASS | x | x | x | y | y |
| Prisons | y | x | y | x | y |
| Ambulance Service | y | y | y | x | x |
| Voluntary Sector | y | y | y | y | y |
| Lay member | y | y | y | y | y |

| | | | | | |
|---|---|---|---|---|---|
| NHS England | x | x | x | x | x |
| Health CCGs | y | y | y | y | y |
| Designated Doctor | x | y | y | y | y |
| Designated Nurse | y | y | y | y | y |
| Head of Safeguarding, CLCH | y | y | y | y | o |
| CLCH Director of Nursing | x | y | y | x | y |
| Imperial Director of Nursing | y | x | x | x | x |
| Chelwest Director of Nursing | x | y | y | x | y |
| WLMHT | y | y | y | x | x |
| CNWL | y | y | y | y | y |
| Public Health | x | y | y | x | x |
| Community Safety Team (Commissioning) | y | y | y | x | y |
| Policy Team (Commissioning) | y | y | y | y | y |
| Head Teachers | x | x | x | y | y |
| Cabinet Member for Children's services, H&F | x | x | y | x | x |
| Cabinet Member for Family and Children's Services, RBKC | y | y | x | y | y |
| Cabinet Member for Children's Services, WCC | x | x | x | y | y |

Please note for the purpose of this table 'y' means attendance of the LSCB Member of a representative, 'o' means a representative was not expected and 'x' that no representative attended. Please see the minutes of individual meetings for more in depth information.

This report was prepared by the LSCB Independent Chair, Jean Daintith, with support from Emma Biskupski (Interim LSCB Business Development Manager) and Steve Bywater (Service Manager, Strategy, Partnerships and Organisational Development).

We would like to thank the many members of the LSCB who also made contributions to the report.

**Draft Reviewed by LSCB:** 11 October 2016

**Published on** (tbc) 2016