Havering Local Safeguarding Children Board Annual Report 2014-2015

Havering Safeguarding Children Board Chair Forward

This is my second annual report as Chair of Havering's Local Safeguarding Children Board (HSCB).

The HSCB continues to be well supported by both statutory and non-statutory partners and I would like to thank all members for their support and commitment.

The multi-agency partnership in Havering must ensure that partnership working is effective in order to ensure that quality services are delivered in the most cost effective manner.

The introduction of the integrated adult and children Multi Agency Sharing Hub (MASH) has increased agency engagement and improved decision making when determining the level of service required to respond to identified needs.

The Havering MASH is now a leading example of an adult and child integrated service for other London Boroughs.

The introduction of the Early Help and Troubled Families Service, which has integrated all the early help support including the previously names youth offending service now provides a holistic response to early help.

Over the year there has been significant activity in respect of the multi-agency service response to child sexual exploitation (CSE) and missing. This has resulted in a co-ordinated multi-agency response to CSE and missing, which will lead to a consistent understanding of CSE and missing when safeguarding concerns are identified. .

The HSCB has improved the multi-agency understanding of prevalence and identification gang activity and violence against women and girls, which includes female genital mutilation (FGM). This is leading to greater insight into the activity in Havering and better approaches to dealing with victims.

The board continues to work closely with partners. The agency section 11 statutory requirement reviews reflect the work being undertaken and the willingness of agencies to continue to identify and address risks and challenges.

There are many new and varied challenges facing the board. The priorities for the next financial year will be CSE, FGM, gangs and the prevent agenda. This will require the Board to actively seek the voice of Havering's children and listen to their views so that services respond to their needs during this of significant change.

The impact of austerity and budgetary restraints is a challenge that must be a focus of the board during this next financial year.

I am pleased to be in a position to support the development of a strong and effective multi agency safeguarding offer to children and young people during the upcoming year.

Brian Boxall

HSCB Independent Chair

Introduction

The purpose of this report is to fulfil the statutory requirement set out in Working Together to Safeguard Children 2015, which states that all Local Safeguarding Children Boards must publish an annual report on the effectiveness of safeguarding in their local area.

Working Together 2015 asserts that LSCBs do not commission or deliver direct frontline services though they may provide training. While LSCBs do not have the power to direct other organisations they do have a role in making clear where improvement is needed. Each Board partner retains their own existing line of accountability for safeguarding.

Our Vision

The safety of children is Havering Safeguarding Children Board's (HSCB's) overarching priority. All agencies are committed to raising safeguarding standards and improving outcomes for all the children of Havering.

In discharging our duty we will:

- Act to protect children from harm.
- Make Havering a safer place to live.
- Identify and act upon priority areas for improvement so that every child is given the opportunity to achieve potential.
- Involve children and young people in decisions made about them.

This report will provide an overview of a number of areas. These are

1. 2014/15 Board Priorities
2. Learning and Improving Framework
3. Board Sub Groups

Agencies statutory responsibilities

Boards Governance and structure and finance

Board Priorities 2014-2015

In May 2014 the HSCB identified the five key priorities for the Board:

Priority 1: Ensure that the partnership provides an effective child protection service to all children ensuring that all statutory functions are completed to the highest standards.

Priority 2: Monitor the development and implementation of a multi-agency early offer of help to children and families living in Havering.

Priority 3: Monitor the alignment and effectiveness of the partnership when working across the child's journey between universal, targeted and specialist safeguarding.

Priority 4: Coordinate an approach to domestic violence, mental health and drug and alcohol abuse across the children and adults' partnership to ensure that families affected receive the right support at the right time.

Priority 5: Ensure that Havering Safeguarding Children Board communicates effectively with partners, children, young people and their families, communities and residents.

In addition to the above priorities HSCB was to ensure:

- That all statutory requirements set out within Working Together 2013 are fully implemented.
- The HSCB would work with the Adult Safeguarding Board (ASB) to streamline services and processes that were relevant o both boards.

Section 1

2014/15 Board Priorities

Priority 1: Ensure that the partnership provides an effective child protection service to all children ensuring that all statutory functions are completed to the highest standards

The Front Door

The front door to child protection services in Havering is the Havering Multi Agency Safeguarding Hub (MASH). This is an essential multi agency team function that ensures that the information, contacts and referrals received are reviewed and analysed to so that they receive the most appropriate and timely intervention.

Since its inception in September 2012 the Havering MASH has continued to develop and improve. In 2014 the MASH integrated with adult safeguarding. This is the first joint adult and children MASH in London and one of only a few fully integrated MASH's in the country. This change was closely monitored by the HSCB to ensure that the integration was not to the detriment of children's safeguarding.

The integration has strengthened multi agency engagement and also resulted in Mental Health practitioners and housing officer's joining the MASH. This has enabled improved information sharing and has increased the focus on the whole family approach: problems encountered by adults in a family can now been considered within the MASH to include the impact of adult issues on caring capacity, which in turn leads to better outcomes for the child.

Impact

Is the MASH making a difference?

MASH audits undertaken in 2014 to 2015 identified some good practice and found that MASH processes were having an impact on improved outcomes for children.

The audit identified areas for further development and these are being implemented and monitored through the MASH steering group. Audits of MASH will continue throughout 2014 to 2015 and findings will be presented to the HSCB Operational group

MASH processes include a RAG rating system, which is linked to a timescale in which agencies are required to submit information to support decision making. There has been a 75 per cent increase in the proportion of children's cases referred where the RAG rating was increased following completion of the MASH information sharing. This indicates that a higher level of need than initial thought is being identified earlier, leading to the correct level of intervention being provided to the children and their families.

MASH Referrals and Assessments		
Years	2013-14	2014-15
Contacts received.	7410	6984
Contacts progressed to referral	1106 (15%)	1774(25%)
Referral progressed to Assessment.	1066 (91%)	1783 (95%)
Contacts progressed to Early Help.	889 (12%)	964 (13%)
Contacts progressed to Early Help Assessment	126 (2%)	391 (5%)

The improved quality of decision making is also reflected in the proportion of referrals from MASH progressing to a full assessment.

2012/13: 41 per cent

2013/14: 91 per cent

2014/15: 95 per cent

The past year has seen a slight decrease in the number of contacts within the MASH, but the percentage of contacts being progressed to referral has significantly increased. This suggests that the quality of contacts in to MASH is improving. The number of contacts progressed to Early Help has remained steady but the number then progresses to Early Help Assessment has increased significantly.

Contact Sources.

The source of the contacts/referrals has remained consistent to previous years with the Police being the main referral source at 65 per cent. Schools have dropped slightly from 9 per cent to 7 per cent but it is of note that there was a significant increase in school contacts for the last quarter of the year.

Health partners, comprising of acute and community settings, midwives, GPs and the London Ambulance Service, account for 3%. This is a significant drop from the 9% 2013/14. This is an area of concern that needs to be further examined to better understand why this is taking place. A question to consider is whether children are being missed by health professionals or whether the children are being referred by other agencies.

Board Challenge

To be provided with data from multi-agency partners that will assure the Board that those children requiring support are identified at the earliest opportunity to reduce the risk of unnecessary escalation of concerns.

MASH decision making processes are required to be continually tested to ensure that they remain robust and consistent especially during this time of austerity. MASH audits to be undertaken throughout the year and reported to the HSCB quality and effectiveness group for consideration and challenge.

Child Protection

Whilst the MASH acts as the front door and provides the initial direction, it is the effectiveness of the multi-agency response to referrals that impacts on the life of the child.

Does the intervention improve the child's life?

In respect of child protection the increased referrals from the MASH during 2014/15 has directly impacted upon the number of section 47 investigations and the number of children who have subsequently become subject to a Child Protection Plans (CPP)

Category	2013-14	2014-15
Emotional abuse	40%	24%
Neglect	45%	55%
Physical abuse	12%	16%
Sexual abuse	3%	6%

The average number of children being made subject to a new CPPs per month has increased from fourteen last year to twenty-one this year.

In addition Havering has seen an increase in the number of children living within Havering being subject to a CPP from another borough.

One of the HSCB board challenges last year was to improve the identification and response to children that may be suffering from neglect

The breakdown of categories of new child protection plans has changed during 2014/15 with a higher proportion of children being made subject to a plan due to neglect.

This increase may indicate an increased awareness and better identification of neglect.

Fourteen children were made subject to a plan under the category of sexual abuse during 2014 – 2015: this is double that of 2013/14 but is still low. This evidences a low detection rate of sexual abuse, which is reflective of the national picture.

Timeliness.

Category	2013-14	2014-15
Number of children on CP plan at the end of March.	124	214
Number of Children in CIN plan	182	148
Number of other LA children on CP plan	17	41
Number of new section 47 investigations	469	841

The number of Initial Case Conferences increased by 71 per cent in 2014/15. This increased number has impacted on the number of case conferences being held within the required fifteen day timeline set out within Working Together 2015. The number held within timescale dropped from 72 per cent in 2013-14 to 52 per cent during 2014/15.

It is important that the CP plans impact on improving the lives of the children in a reasonable time.

93 per cent of active CPPs during 2014 – 2015 had been in place for twelve months or less. This is an increase from last year of 83 per cent. Only 4 per cent [seven children] had remained on a plan for more than 2 years.

For the year 2013/14 19 per cent [twenty-seven] of CP cases ended within 3 months. The question from the Board was for agencies to consider whether children were being made subject to a plan unnecessarily. An audit was undertaken in March 2015 to review all CPPs that ceased within three months. The audit identified a number of issues, which will be a focus for the Children Services Improvement Board during the next financial year.

One measure of the effectiveness of a CP processes is the number of children who are removed from a CP plan and then placed back on a CP plan within two years. For 2013/14 the number of children placed back on a plan within two years was 5.8 per cent. In the year 2014/15 this percentage reduced to just 1.6 per cent.

The continued use and development of the Family Group Conferences in the more complex and high need cases has proven to be an effective mechanism to facilitate better family engagement. This includes the identification of risks and the actions required to reduce them. This is helping to achieve positive outcomes for children and young people with improved family engagement.

Audit and Review.

Havering Children Services set up a Children Services Improvement Board (CSIB) in April 2014. The CSIB is comprised of representatives from Havering Council and includes Children Services, Learning and Achievement, Business and Performance and Public health. The CSIB was implemented to better understand the effectiveness of the services being provided to children and young people in Havering across the continuum of need. The CSIB process has significantly improved the services approach to auditing, reviewing and monitoring its service offer.

CSIB processes have led to improved data quality and regular auditing of the Children Service functions. The HSCB has worked closely with CSIB and is aware of outcomes in order to be able to act when multi agency responses are identified as a possible area of concern.

The CSIB board has identified some risks and challenges that will be monitored over the next year. One is in relation to timely completion of assessments:

- Delays in completion of assessments – During 2014-15 45 per cent were completed within 45 days
- Improve quality of planning processes.

Staffing

One of the biggest impacts on effective responses to child protection is agency staffing levels and workloads. This was identified as an area of concern in 2013/14 especially in light of significant funding restraints and major organisational changes.

The HSCB has during 2014/15 monitored the work force across the agencies. Agency staffing levels now forms part of the HSCB data collection.

Social work staffing continues to be the most challenging. The introduction of a new workforce strategy and recruitment and retention policy for 2014 to 2015 has started to impact on the situation. The vacancy rate for the end of year 2013/14 was 29 per cent this has now dropped to 23 per cent. The Social worker turnover rate was also dropped from 19 per cent 2013/14 to 12 per cent 2014/15 this has positively impacted on the use of agency staff, which has reduced form 28 per cent 2013/14 to 23 per cent for this year.

Within health, Midwife posts have increased by 8 per cent to 275; however, there is still a vacancy rate of 10 per cent. The number of paediatric nurse posts has also remained steady with a vacancy rate of 10 per cent.

During 2013 to 2014 the board chair challenged the Metropolitan Police Commissioner regarding the staffing levels of the local Child Abuse Investigation Team (CAIT). In their 2015 section 11 response they highlighted the following

'The main issue facing CAIT in the past year has been a lack of trained police staff to cope with the rise in reported incidents. This has impacted on performance and particularly child protection case conference attendance'.

In the short term Havering CAIT has catered for this by utilising police officers who were working on attachment to the team. The long term goal is to increase trained staff and CAIT is in the process of recruiting more police officers to fill vacancies. This will continue to be monitored as crime & staff workloads increase.

The HSCB is working with the CAIT in order to support them during transition and find new way of working e.g. video conferencing.

Board Challenge

- For the board to continue to seek information regarding workforce stability and assurance that staffing levels does not have an impact on the provision of services and to challenge when necessary.

Looked-after-Children (LAC)

Looked after Children are vulnerable and the HSCB needs to be continually satisfied that they are in receipt of timely support in a stable environment. This continues to be a challenge for Havering.

The end of year statistics March 2015 showed that there were 240 LAC, which was an increase of 26 per cent from the previous year. There has also been some changes in the ethnicity of LAC in Havering with an increase of 4 per cent of Black African LAC and a decrease of 7 per cent of White British LAC. There has also been a slight increase in White Eastern European LAC.

The high levels of children starting to be looked after on Police Protection has continued with an end of year figure of 84 compared to 63 the previous year. This is an area that is being reviewed regularly within the Havering Quality and Effectiveness (Q&E) working group.

Placement Stability

Placement Stability meetings, which commenced in February 2014, brings professionals from relevant agencies together to agree the most appropriate support package and placement for each LAC. The meeting predominantly focusses attention on children and people that are in long-term care

All children require stability and continuity if they are to be given every opportunity to reach their potential. LAC have not experienced stability or continuity of care and it is crucial to provide this to them to help them to heal and to provide them with the best opportunity to achieve their potential Significant effort has been put into placement stability and the improvement identified in 2013 -14 has been maintained and slightly improved. Year-end data evidenced that 10 per cent of LAC experienced three or more placement moves within the year. Although this is an improving picture, this remains an area of concern for the HSCB.

LAC generally achieve more poorly within education than their peers. In response to this Havering council has established a LAC Education Panel to oversee the drive to improve educational amongst this group: HSCB will

monitor the stability of education placements for LAC matched to their educational achievements during 2015 -2016. This will support the HSCB to identify whether an increase in educational placements impacts negatively on attainment.

LAC placement lasting two years or more has also increased from 79 per cent in 2013/14 to 83 per cent for 2014/15. This is a good achievement and it will be important to understand why this has improved to allow good practice to be built upon.

The number of LAC who are placed outside the local authority area and more than 20 miles away from where they used to live has increased slightly to 11.6 per cent (25). The local authorities target was 10 per cent. 59 per cent of LAC placed out of borough are placed in neighbouring boroughs.

It is important that LAC, in most cases, remain close to family and support.

Havering children services has worked hard to reduce the use of residential placements for LAC within the last year so that children are placed near to their usual area of residence.

The Board will continue to monitor the LAC Improvement plan, which focuses on placement stability, improving outcomes and increasing the numbers of LAC placed in family placements within the borough.

Health

All LAC should be offered a LAC health assessment. These must occur shortly after placement and then annually. The Havering CCG identified this as an area of risk, which was responded to through the introduction of a LAC administrator in place to work across Children Social Care Services and NELFT to assist with administrative functions.

Board Challenge

- To review the use of Police Protection to ensure that its use is consistently applied and appropriate
- To ensure LAC out of borough placements are appropriate and that the children are receiving good quality support
- To monitor and challenge the difficulties completing LAC health assessments as identified by the CCG.

Private fostering

If a child under the age of sixteen or eighteen if the child has a disability, is being cared for by an adult who is not the parent or 'close relative' for a period of twenty-eight days or more the arrangement is known to be a private fostering arrangement. The child is not looked-after by the local authority. The arrangement is solely between the parent or guardian and the adult caring for the child (known as the private foster carer). Any person caring for a child under these circumstances has a statutory duty to report the arrangement to Children Social Care.

Private Fostering is still a major challenge. The number of registered privately fostered children remains low despite extensive publicity and training. Action is being taken to address this situation and is led by Children Social Care. This remains a priority for the HCSB.

Private Fostering Board Challenge

The board partners will continue to promote and raise awareness of Private Fostering in order to ensure that such arrangements are identified and registered.

Board Challenge

For the board to ensure that partners continue to promote and raise awareness of Private Fostering in order to ensure that such arrangements are identified and registered.

Priority 2: Monitor the development and implementation of a multi-agency early offer of help to children and families living in Havering.

Early Help

Early help is the bedrock to improving outcomes for children and young people. Effective early

help will improve outcomes and help reduce the need for more serious child protection processes.

Early help is crucial in the 'step down' from child protection to child in need and child in need to early assessment processes. Thresholds for services must be fully understood and embedded if step down or step up transitions are to be smooth and supportive to families.

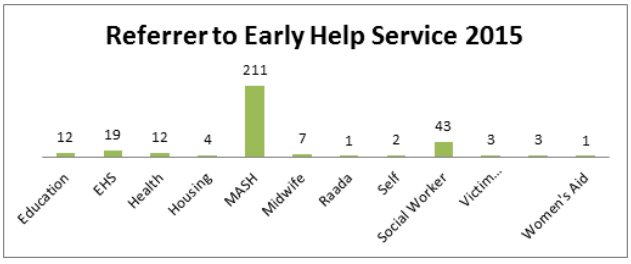
'Early help is better for children: it minimises the period of adverse experience and improves outcomes for children'

Eileen Munro March 2011

It was highlighted in last year's annual report that Havering council had commenced a significant restructuring of the local early help provision. The new structure was fully implemented during 2014 / 15 and included joining Havering Youth Offending services to the early help structure.

The Early Help Service now offers some of Havering's most vulnerable families support in the following areas:

- Family intervention and support – under 12s and over 12s
- Children's centres
- Targeted Youth Support
- Employment Advice
- Adult mental health assessments
- Opportunities to volunteer with the LA
- Housing support and advice
- Support for victims of Domestic Abuse
- Family Group Conferencing
- Parenting Support – surgeries and programmes
- The Youth Engagement Service



There is evidence that MASH and schools are referring cases to early help. This good practice needs to be better embedded across all HSCB partners to ensure children and families are being given the opportunity to access support and help services at the earliest point of need.

The HSCB will require all partnership agencies to provide data evidencing the uptake of early help processes by staff working within their organisation.

The consistent use of early help assessment processes by all partners is crucial to the success of this priority area.

Early Help Board Challenge

The expectation for 2015 – 2016 will be an increased uptake of early assessment processes that will offer consistent response to early need:

The board will to continue to monitor and challenge the speed of implementation and engagement of all agencies.

MASH feedback to provide clear information to partners regarding decisions and identified next steps.

The development of an early help dataset to assist the Board partners to understand the impact of the early help processes on improved outcomes for children and their families.

Priority 3: Monitor the alignment and effectiveness of the partnership when working across the child's journey between universal, targeted and specialist safeguarding

Priority 4: Coordinate an approach to domestic violence, mental health and drug and alcohol abuse across the children and adults' partnership to ensure that families affected receive the right support at the right time.

Havering MASH is in place to ensure children and young people are provided with the correct service response at point of need. MASH considers children across the continuum of need and determines the level off response required. The integration of MASH with safeguarding adults has improved the ability of MASH to think holistically when determining the type of service that is required to address the identified needs.

The newly agreed threshold document will assist agencies to determine the type of service that is being requested when making referrals to MASH. This will assist the MASH to understand the level of concerns when considering the information being referred. As previously stated, MASH is being audited regularly to ensure that processes do provide the correct response consistently to all children.

The HSCB and SAB have a joint independent chair. This structure has enabled better information sharing across both boards. This has increased awareness of priority areas that are important to both boards and includes the impact of parental issues such as mental health, domestic violence and drug and alcohol abuse on parenting / carer capacity.

A critical area for children is when they are experiencing transitions. HSCB and SAB implemented a transition group in 2014 to review transition processes. This has included the transition of children with special needs and autism into adult services.

It is important to continue to develop responses to domestic violence. The majority of this is addressed within the Community Safety Service annual report submission. The HCSB works closely with the service to continually examine all aspects of

- Domestic violence
- Mental Health & Substance abuse
- Violence against Women and Children

Community Safety Service

This team is responsible for the development and implementation of work to reduce crime and disorder, as well as the fear of crime, within the borough. It achieves this through both direct work and by co-ordinating strategic partnership working with the wide range of public, private and voluntary sector partners represented on the Havering Community Safety Partnership (HCSP) and the Safer Neighbourhoods Board.

Domestic Abuse Service Responses

Domestic Abuse multi agency risk assessment conference (MARAC)

The MARAC continues to meet monthly and is chaired by Havering Police. High Risk Cases are presented to the Domestic Violence MARAC with them.

The MARAC's partner agencies include, representatives from the council, police, probation and the voluntary sector. Children's Services, Early Help, Schools and School Nurses are all involved in the MARAC, and this ensures that child protection is a high priority in the cases discussed at MARAC. The support and guidance given by the MARACs partner agencies utilises the knowledge and close working relationship of the service users to ensure the best possible outcome.

During 2014-15 the number of referrals to MARAC has continued to increase, with 241 for the 12-months to February 2015 (compared to 180 for the corresponding period of February 2014). The proportion of repeat cases during the same period increased from 15.6 per cent to 21.6 per cent.

The majority of referrals continue to be made via IDVA's (90 referrals), followed by the Police (includes outside forces, 74 referrals). Referrals made by police (up from 34 to 74) and Children Social Care (up from 20 to 41) have seen the largest numerical increases in the past 12-months. Other MARAC data showed a rise in BME victims being referred (21 up to 31), an increase in male victims (6 up to 13), and an increase in victims with a disability (3 up to 9). There has been 1 referral each for LGBT victim aged 16-17 cases.

Long and short term risks and priorities

The total number of reported and recorded Violence against Women & Girls incidents and offences has increased by 1,008 offences in the current financial year to date (to February 2015), representing a rise of 19.6 per cent. This has been driven by a notable rise in the volume of both Domestic Offences and Domestic Incidents.

The increase in DV Offences is at present currently above the regional average, showing a 25 per cent increase compared to a 20.7 per cent increase across London. Where DV Violence

with Injury is concerned, Havering has the 3rd highest percentage increase.

Havering will receive an additional 3.5 Independent Domestic Violence Advocates (IDVA) provided by the MOPAC Pan London IDVA service. An IDVA will be based in the MASH and Maternity Services/ A&E

Violence Against Women And Girls

The partnership VAWG strategy has recently been signed off by the HCSP a comprehensive action plan focusses on the prevention, protection, safeguarding and provision of services to support victims of domestic violence, FGM , Forced Marriage and Honour based Crimes , CSE and Girls and Gangs.

The VAWG strategic partnership is well established within the borough and continues to meet on a quarterly basis. Representatives from the council, police, probation, Health and the voluntary sector attend this meeting ensuring that on a strategic level the partnership is supporting children and adults in the most effective way.

VAWG Board Challenge

To fully understand the extent in Havering of VAWG especially in respect of children and young people of:

- Female genital Mutilation
- Forced Marriage
- Honour based violence.
- Child Sexual Exploitation and Trafficking.

Parental Substance Misuse.

One of the most common factors that increases risk to children is parental substance misuse. Community Safety has recently recruited a specialist substance misuse worker who works closely with the London Borough of Havering Public Health Team, who are responsible for promoting health and well-being and commissioning drug and alcohol treatment services. At present North East London Foundation Trust (NEFLT) and Crime reduction Initiatives (CRI) deliver drug and alcohol treatment within the borough and our substance misuse officer offers us a unique opportunity to ensure that the procedures around safeguarding are embedded in the delivery of the boroughs drug and alcohol services.

Any safeguarding concerns identified by NEFLT and CRI that are linked to parental substance misuse trigger an enhanced risk assessment. If this reveals a medium to high risk to child/ren, a referral is made to MASH and/or police. This supersedes local service provider interventions and these referrals are tracked and managed using a partnership approach.

There are many changes occurring in the borough of Havering and the first is the re-tendering of drug and alcohol services. This process will aim to have one integrated provider. This new provider will be operational by October 2015.

Serious Group Violence (SGV)

Serious Group Violence is an emerging issue in Havering. The Home Office conducted a five day peer review in November 2014 in the Borough. The Home Office identified a number of areas of good practise which included

- Strong vision and leadership in Havering with a clear focus on preventing problems escalating
- Good understanding of interrelated issues of child sexual exploitation, serious youth violence and missing children through analysis of partnership information via the Multi-Agency Safeguarding Hub (MASH) Missing Person's Protocol and accompanying form.
- Partnership working in Havering is a real strength
- Relationships with local schools and colleges are good: there is a firm foundation for further work to spot risk factors early on and work to build resilience
- The Troubled Families programme in the borough is very strong
- Assessment and referral through the MASH works very well, including sharing individual A&E data
- A number of promising interventions to address youth violence are in place

- The Serious Youth Violence Panel provides opportunities for knowledge transfer and practice development
- Commitment to community/family-based values

Young People, schools and community youth groups were consulted as part of the review.

A Serious Group Violence (SGV) panel meets monthly to discuss work with key gang nominals. Safeguarding is embedded in these meeting and consideration is given to the risks caused by an individual and the risk that is posed to the individual.

The HCSP developed a Serious Group Violence Strategy for the Borough with a comprehensive action plan which is refreshed annually.

Gangs' awareness training has been provided to front line practitioners. Early intervention is key to preventing the escalation of youth violence and the other gang associated issues such as child sexual exploitation.

Havering has commissioned a specialist service (Spark2Life) to provide:

A) One-two-one prevention work with identified gang nominals.

B) Preventative work within schools. Targeting young people at risk through Assemblies, Classwork and one-two-one sessions.

Community Safety is raising parent awareness of SGV through working with schools through a programme of targeted parent awareness evenings.

The SGV panel works closely with the gangs researcher within the MASH.

Increasing numbers of complex and vulnerable families moving into the Borough from Inner London Boroughs has increased the risk of gangs associated violence in Havering.

Board Challenge

To fully understand the extent in Havering of VAWG especially in respect of children and young people of:

- Female genital Mutilation
- Forced Marriage
- Honour based violence.
- Child Sexual Exploitation and Trafficking.

To continue to increase awareness and understanding of the level of make-up of the gang structure in Havering.

Priority 5: Ensure that Havering Safeguarding Children Board communicates effectively with partners, children, young people and their families, communities and residents.

HSCB has developed a communication strategy, which was presented and ratified by HSCB partnership agencies during 2013 -2014.

Communication Board Challenge

To ensure that each partner agency fully embeds the communication strategy and reports back information making the HSCB leads conduits for information in and out of the HSCB.

HSCB has produced termly newsletters, which have been distributed to in excess of one thousand HSCB contacts.

Views of Children &Young People

There are number of process across agencies that captures the views of the children, young people and families.

LAC are accessed via view point the views of children subject to CP plan are also captured via view point.

The Viewpoint findings 2014/15 were reported to the HSCB. The challenge is to ensure that each agency utilises the feedback so that services are improved to better meet the needs and requirements of children and young people.

The annual Children and Young peoples survey is carried out with aged 10 to 17 years olds in the Borough of Havering.

There were 1440 respondents

- 14% eligible for free school meals
- 25% carer for relative
- 80% feel happy
- Large number stated they felt unsafe on public transport
- 28% stated they had been bullied over past 12 months

- 61% two stated they had been bullied admitted to bullying others
-

The feedback from the children has helped to inform the Children Service section 11 action plan.

These responses are fed back to the HSCB: the HSCB needs to be more proactive in involving children and young people.

The proposed action to progress this during 2015/16 includes the following:

In March 2015 the London Assembly Police and Crime Committee published a report entitled "Confronting Child Sexual Exploitation in London". The report contained a number of recommendations including recommendation 5 which states *"Every LSCB in London should have a forum in place to engage with children and young people affected by CSE, including those that have in the past gone missing and looked after children, to increase understanding, provide appropriate care and support to young victims and those at risk of CSE, and encourage confidence in reporting"*

The HSCB has worked with the Children's Society, which has agreed to pilot the establishment of such a forum in Havering.

The re-launch of the Children in Care Council provides an opportunity during 2015/16 to engage LAC young people in the work of the board. The HSCB chair will meet with this group to explore how they can help the board.

The Havering Youth Parliament will also be consulted and asked to present finding from their activity to the board.

The Children Society CSE forum pilot, commissioned by the HSCB, will help provided good feedback from CSE victims.

Board Challenge

To improve the use of feedback to better inform board future board strategy.

Section 2

Learning and Improving Framework

Case Reviews

Local Safeguarding Children Boards (LSCBs) should maintain a local learning and improvement framework which is shared across local organisations that work with children and families. This framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result

Summary of Work Group Purpose

The purpose of the HSCB Case Review Working Group is to ensure that the statutory requirements contained in Chapters 3 and 4 of Working Together to Safeguard Children 2015 are embraced and delivered. The main statutory requirement is for the group to implement a learning and improvement framework where partner agencies are clear about:

- Their responsibility for contributing to the learning and improvement processes.
- Effective dissemination of learning.
- Making sustainable changes to services.

The local framework should cover the full range of reviews and audits including:

- Serious Case Reviews.
- Child Death Reviews.
- Management review of a child protection incident which falls below the threshold of a SCR to provide useful insights about the way organisations work together to safeguard and promote the welfare of children.
- Review or audit of practice in one or more agencies.
- Identify and drive improvements to safeguard and promote the welfare of children.
- Translate the findings from reviews into programmes of action to bring about sustainable improvement and prevention of future deaths/harm.

Activity 2014/2015

Serious Case Reviews.

One serious case review has been undertaken during 2014/15 it involved a review of a child

protection case where a decision was made to prematurely cease as a child protection case. This over a period of a number of years led to children failing to thrive and suffering long-term effects. Whilst Havering commissioned and led the serious case review the history of the case involved 2 other London Boroughs. All agreed to support the serious case review and learn from the case findings. The case is near to it conclusion and will be publish in early 2015/16.

A second serious case review has recently been commissioned and will commence in 2015/2016. It concerns the response to allegations of physical abuse and the subsequent information sharing process.

Learning Reviews

2014/15 saw the completion of three learning reviews. All three cases are subject to a multi-agency action plan which has pulled the learning together from the three reviews. It will be monitored during 2015/16 to ensure learning has been embedded in practice.

The following is a summary of the recommendations for the HSCB to ensure learning.

Case one

A young person involved with CAMHS services and being at risk of committing serious sexual offences.

Case Two

Case concerns where a young person committed a serious crime and caused serious harm to a member of the community.

Case Three

The use of Section 20 (CA1989) to place a child with an extended family when mother went missing. This raised the issue of who had parental responsibility for a vulnerable child.

The three learning reviews were considered by the case review working group and an amalgamated action plan developed. The action will be reviewed and implementation monitored through the case review working group. The action plan forms **appendix 1**

Conclusion

The working group continues to monitor cases and make recommendation is respect of learning /serious case reviews. The board will monitor the agreed action plan to ensure that learning from these case are embed in the organisation culture.

The risk is the on-going costs of reviews and the ability of agencies to be able to allow staff time to support the review process. This will lead to delay. The board will continue to consider the best alternatives in order to obtain the best learning process in a cost effective way and reasonable time scales.

Board Challenge.

- To incorporate national and local learning into briefings and to ensure that this is disseminated widely and understood by practitioners.
- To continue to ensure multi agency learning impacts on service delivery through focused audit and feedback

Child Deaths: The Child Death Overview Panel (CDOP) and Serious Case Reviews

Working Together 2015 states:

The LSCB is responsible for ensuring that a review of each death of a child normally resident in the HSCB's area is undertaken by a CDOP The CDOP will have a fixed core membership drawn from organisations represented on the LSCB with flexibility

The Havering CDOP is responsible for reviewing the circumstances of all child deaths within the borough.

Gender & Expectation			
	Female	Male	Total
Expected	4	2	6
Unexpected	1	2	3
Total	5	4	9

During 2014-15, CDOP were notified of nine deaths in total. Six were categorised as

'expected'. The three remaining cases were classified as having modifiable factors relating to co-sleeping, poor lifestyle choices from mum and poor obstetric care resulting in an internal investigation at the hospital.

Havering has seen a decline in the rate of child deaths since 2012-13 across all ages and categories. Neonatal deaths remains the most common cause of expected death for infants within Havering, this is reflective of the national picture. There have been no identified trends this year which indicates that previous common causes such as co-sleeping and blind cord safety deaths are currently reducing within Havering.

There continues to be two Designated Doctors sharing the role, both of which have been very responsive to supporting the service. In addition to this all statutory and voluntary agencies have continued to be supportive in attending the Rapid Response meetings. There is also a good working relationship with the London Ambulance Service and Police who continue to attend or provide information to the Rapid Response meetings when necessary. This means that Havering's CDOP has been compliant with the requirements set out in Working Together as well as working jointly on the key issues arising from childhood deaths to learn lessons and minimise deaths arising from specific areas.

Safeguarding in Employment

Working Together 2015 Chapter 2

Local authorities should put in place arrangements to provide advice and guidance on how to deal with allegations against people who work with children to employers and voluntary organisations. Local authorities should also ensure that there are appropriate arrangements in place to effectively liaise with the police and other agencies to monitor the progress of cases and ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process.

Local Authority Designated Officer (LADO) Role

The role of LADO was under the management of the Havering Council Children Services

Year	Number of cases	Percentage increase/decrease year on year
2005/06	12	
2006/07 -	6	(50%)
2007/08	23	283%
2008/09	47	104%
2009/10	44	(6%)
2010/11	51	16%
2011/12	62	22%
2012/13	106	71%
2013/14	160	51%
2014/15	121	**(24%)**

Safeguarding Service Standards Unit. LADO activity until November 2014 was shared across the team with appropriate professionals undertaking the functions. This included duty team managers, the group manager and independent reviewing officers. There is no statutory training for the post.

In early 2014 it was identified that a number of issues had arisen due to an increase in the volume of LADO referrals and because there was no one person responsible for the post. These included:

- Lack of continuity and ownership
- No single point of contact for both in-house and external partners
- The volume of LADO work increased but those carrying out the role had their own 'full-time' role to address
- No specific administrative support
- Occasional oversights in record-keeping.

The role is now carried out by dedicated one member of staff supported by a business support colleague. This has improved communication between key partner agencies including Ofsted, Youth Groups and nursery settings for example.

As a result of this new dedicated position it was felt that the HSCB safeguarding in Employment Group could be disbanded. The new LADO is a member of the Operational board and will report regularly to the board on the progression of the LADO action plan.

Activity

When looking at the data recorded and taking no account of the first two quarters of 2014 -2015, the expectation is a continued rise in referrals. This is reflected in the last two quarters of last year and the first quarter of this counting period.

The reason for this is:

- Improved awareness of process;
- Single point of contact for LADO within the Local Authority;
- Internal and external training sessions.

Furthermore when attending the National LADO meeting in March 2015, it was a point of discussion that nationally there has been an increase in referrals.

Working with Partners

Since November 2014 new relationships have been developed with various groups in Havering by the LADO officer.

Board Challenge

- To monitor the LADO action plan and ensure that it receives multi agency support.
- To continue to highlight and challenge areas of concern.

Training & Development

HSCB has offered a range of training courses for the borough's multi-agency partners. This training is available to all agencies and individuals in the borough who work to protect children and young people.

Training and Events 2014-15

- 49 scheduled courses delivered
- 4 cancelled
- 5 additional training events delivered
- Havering LSCB Annual Conference

HSCB training was delivered to nine hundred and ninety-eight delegates during 2014-15

HSCB implemented an on-line training application system during 2015-15. Whilst overall the on line system worked well, complications were experienced because ICT systems were not always compatible. This is being addressed by Havering Council during 2015/16. .

Introduction of Impact Analysis Process

During this year we introduced the process to evaluate the impact of training. Delegates were asked to complete post course evaluations 4 – 6 weeks after attending training. A full analysis and review has been carried out and the report is attached as an appendix to this training report.

The impact of training is expected to lead to increased knowledge and skills thereby improving performance. We encountered difficulties when assessing the feedback as delegates attended training for a variety of reasons:

- New to position so part of their general development
- As a refresher
- Safeguarding leads need to have knowledge of a variety of areas so attend a number of courses
- Staff attend training but may never experience related issues so may never put learning into practice
- Delegates found it difficult to articulate how the training could be applied to their day to day role, often siting confidence as the key
- Delegates found it difficult to articulate how the training could be applied to their team with the most common response being 'sharing information'
- Delegates found it very difficult, almost impossible to articulate how the training impacted on children and families.

LSCB Newsletter

The LSCB newsletter is expected to be produced and distributed termly. The newsletter is developed through board partner input and during the year only one has been produced. This will be improved during 2015/16

SECTION 3

Board Sub groups Groups

Child Sexual Exploitation and Missing (CSE) Working Group

Child Sexual Exploitation continues be a priority for the board. The main objective and activity for the year 2013/14 was to raise the awareness of CSE for all professionals. This was achieved and the introduction of the assessment tool and a significant level of training helped to support understanding.

2014/15 has seen a greater focus on the identification and responding to young people who have been or may be vulnerable to CSE, which includes those children that go missing. This section will consider both CSE and missing.

CSE Prevalence

During 2014/15 there was an increase in recording of CSE incidents within Havering. There were 55 recorded crimes (Havering borough ranked 18th out of the 32 boroughs) and a further 25 CSE incidents recorded as non-crime.

There were 133 additional cases brought to the attention of the Local Authority for CSE/exploitation who were not victims recorded within the police system.

There is a question over some of the recording processes and much is at the discretion of the individual reporting understanding that they may be dealing with a victim or potential victim of CSE.

This would indicate that there is still a level of under reporting/recording of CSE incident.

Challenge

There is a need to improve consistency of recording.

What this improved level of data has enabled the first attempts to profile what CSE looks like in Havering.

- The victims are predominantly female 96 per cent of recorded CSE
- The most common age of victims was 13 to 16 90 per cent of recorded victims.
- The ethnic profile found that 72 per cent of clients were White British, 12 per cent white other, 75 mixed , 5 per cent Asian and 4 per cent black
- Just 7 per cent were children with child protection plans.
- 33 per cent were Looked after Children
- Categories most frequently recorded alongside CSE clients were ‘family dysfunctional, ‘missing from home’, abuse of neglect’, sexual abuse and ‘domestic violence.
- 16 to 18 may be identified as victims of domestic violence rather than CSE

Contact points.

The CSE Exploitation and Missing group review identified a number of issues that will hamper the process.

There is need for more sophisticated training in order to ensure that all professional are fully conversant. Training has been undertaken but is patchy

The CSE risk assessment Tool Kit is in place but following the Rotherham report by Professor Alexis Jay in November 2014 there is a need to review the tool.

There is a need for a highly developed local profile. This has commenced but need to be supported by consistent data set and accurate recording.

The LA and the board have also started to work with the Children Society in respect of working with children and young persons identified as being at risk of CSE and also to undertake missing person interviews.

The Children Society was commission by LBH to provide an independent advocacy service for Havering Children and young people under the age of eighteen living in care or leaving care or a child in need.

Below is an example of the work and outcomes for the young person.

Case Study

B= Young person engaging in the Missing out Service

PW= Missing out Service Project Worker.

B is a White British young person from Havering, who is 14 and looked after by Havering Children services. B is assessed as a high risk young person who frequently goes missing and is a risk of child sexual exploitation.

PW attended strategy meeting with other professionals involved to discuss the level of risk B was facing, her needs and what services need to be put in place to best support B.

Her needs included:

-Practical support attending meetings and appointments with regards to specific issues.- Practical support to advise keyworkers on addressing sensitive issues with B.

-Emotional support to address missing episodes, physical health, mental and emotional health and drug misuse

B has had three formal sessions with three more remaining.

Missing episodes have decreased with no further missing episodes since B has been accessing support and settled into new placement

B has had sessions on the following topics

- Risks when going missing: Push & pull factors, safe choices when going out

- Physical health (attending a GUM clinic)

- Understanding emotions and feelings in friendships & relationships.

B has reported that being in a new placement has enabled her to concentrate on herself and to not worry about what people are saying about her. She has reported to be missing her friends and having access to her mobile phone however, she understands that this is something that will help to reduce taking risks.

B has engaged well with the Missing Out service and has reported that she is enjoying the sessions because PW listens and encourages better communication between B and other professionals.

B is starting to have a better understanding of what it means to go missing and why it is important for responsible adults to report her as missing if they do not know where she is. B still needs support with emotional and mental health issues as well as physical health which is on-going between B and her keyworker.

B will need further support when she is placed back with her parents to apply these life tools to real life situations if/when they occur.

The Board is now working to support the Children Society to undertake work obtaining feedback from the young people they support.

In March 2015 the London Assembly Police and Crime Committee published a report entitled "Confronting Child Sexual Exploitation in London". The report contained a number of recommendations including recommendation 5 which states *"Every LSCB in London should have a forum in place to engage with children and young people affected by CSE, including those that have in the past gone missing and looked after children, to increase understanding, provide appropriate care and support to young victims and those at risk of CSE, and encourage confidence in reporting."*

The Children's Society has agreed to pilot the establishment of such a forum in Havering

In December 2014 Havering took part in a peer review with LB Hillingdon. This identified a number weakness in front line practice and in particular processes around the MASH. These findings were supported by a further case audit undertaken by children social care.

Further audit and review of CSE referrals through the MASH continue to indicate cases at level 1 & 2 are not always receiving a timely responses.

As a result of these identified concerns a 'Virtual Assessment and Intervention Team' is being piloted. This is being managed within the 12 Plus Service.

The aims and objectives of the team will be to ensure that all CSE referrals are responded to effectively and appropriately.

The HSCB will receive regular updates and is overseeing the pilot through a CSE steering group.

Quality and Effectiveness Working Group

1. Summary of Work Group Purpose

Working Together (2015) sets out the requirement for each LSCB to have in place processes to monitor and challenge the effectiveness of the safeguarding offer to children across the spectrum of need:

In order to fulfil its statutory function under regulation 5 a LSCB should use data and, as a minimum, should:

- assess the effectiveness of the help being provided to children and families, including early help;
- assess whether LSCB partners are fulfilling their statutory obligations set out in chapter 2 of this guidance;
- quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned; and
- monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

Working Together 2015

The Quality and Effectiveness group is in place to oversee the effectiveness of the multi-agency safeguarding and child protection service offer to children, young people and their families in Havering. The group receives and reviews performance data from the partnership, challenges information and identifies actions required to improve the service offer when required.

Audits are undertaken to assure the group of the effectiveness of the partnership when working throughout the child's journey across the continuum of need.

2. *Key Areas of Progress and Achievement*

The multi-agency performance dataset has been embedded during this financial year and reported on biannually to the Quality and Effectiveness group and to the HSCB. The performance framework has been amended as required to ensure that the board receives the best possible data to assist it to understand the effectiveness of the partnership when responding to safeguarding needs.

The group undertook a number of multi-agency and single agency audits over the year in order to understand the effectiveness of multi-agency response to children identified to require services. This process provided assurances to the Board regarding the service offer and also identified areas that required further scrutiny. Areas requiring additional scrutiny have been included within the Quality and Effectiveness audit plan for the forthcoming year.

The HSCB requested partnership agencies to undertake an self-assessment audit of S11 compliance in November 2014 with a request for submissions by March 2015.

The S11 audit findings will be used to inform future s 11 audits with a focus on the effectiveness of agencies response to Child Sexual Exploitation (CSE).

There has been a significant amount of progress to understand the partnerships response to adolescents and vulnerability, which includes CSE, LAC, Missing, Gangs and youth offending. The partnership is developing processes to strengthen and support a co-ordinated response to all of these important areas so that there is collaboration and meaningful communication pathways across all areas of work to reduce duplication and streamline work streams.

3. *Current Activities*

The Group will continue to monitor the impact of the multi-agency service offer on improved outcomes for children and will further develop the performance framework to understand the effectiveness of services across the spectrum of need.

An audit programme will be developed to assist the Group to better understand the story beneath the data and to identify where services can be improved for children.

Multi-agency partnership working has been identified nationally and locally to present challenges to practitioners. The Q&E group has identified the need to better support staff in their understanding of each agencies role and function to better support them when working across organisations.

This will be addressed through the provision of multi-agency briefing offered to front line practitioners to focus on

- Threshold for services
- Agency professional's roles and responsibilities
- Lessons learned from learning reviews, case reviews, audit activity and national learning

The briefings will be facilitated by Q&E group members and will provide time for reflection and learning in a safe place. The briefings will allow for networking opportunities to develop and strengthen working relationships further.

4. *Long and short term risks and priorities*

The current dataset does not report on the effectiveness of early help services. There has been significant work undertaken to strengthen the early help response within Havering. Understanding the impact of the changes will be a priority for 2015 – 2016. The Group will develop an audit programme to assist in its understanding:

- Effectiveness of MASH and how this relates to practice across the partnership
- How systems support staff to work effectively
- Effectiveness of the Child Protection Response
- Effectiveness of Early Help
- Effectiveness of multi-agency response to adolescent vulnerability.

The LSCB priorities for 2015-16 will be child protection, early help, child sexual exploitation and neglect: The Group will embed a process to understand the effectiveness of the partnership in relation to the LSCB priorities.

Transition Sub Group

The Transitions Group is a sub group of both the Local Safeguarding Children's Board (LSCB) and the Local Safeguarding Adult Board (LSAB). It was set up in 2014 and held the first meeting on the 8th May 2014. The aims of the group are as follows:

- To review current children to adults services transitions policies and procedures in health and local authority services in Havering.
- To audit compliance with existing policies and procedures.
- To highlight and share good practice initiatives
- To disseminate learning from policy and practice reviews.
- To provide assurance to the LSAB and LSCB of policy compliance with regard to transitions.
- Liaising, coordinating and responding appropriately to actions agreed by Local Safeguarding Children's Board (LSCB) Local Safeguarding Adults Board (LSAB)

Membership includes representatives from health and social care, including children and adult services across a range of functions such as physical disability, learning disability and mental health, community safety, police, youth offending, education and commissioning. Attendance and engagement at each meeting has been good.

The work plan for the group identified a range of service pathways with a review programme in line with the aims as above.

The first identified area for the group to look at was child to adult transitions across mental health services. A sub group was formed which fed back to the main group. The findings were as follows and recommendations were agreed by the group

1. NELFT does not have an up to date Transitions policy at the moment although this is currently being developed and this group will liaise with the author to ensure learning is shared.

   Recommendation: The NELFT draft policy will be agreed by all partner agencies in Havering and will be informed by the learning from the sub group.

2. Havering Transition Protocol is currently under review and the group will link in with the author to ensure learning is shared.

   Recommendation: The Havering Transition

Protocol will reference and be referenced by the NELFT Transitions Policy and will be informed by the learning from the sub group.

3. Where children and young people have a clear diagnosis or treatment plan transitions into adult mental health services are robust.

   Recommendation: That this continues and the good practice identified in these processes are shared to inform practice in other pathways.

4. Autism services for children are identified, however, provision for adults is not consistent across the borough

   Recommendation: Transition arrangements must take account of differences in service provision and criteria between children and adults services.

5. Where children and young people do not have identified diagnosis, but on going social and emotional problems, once they leave the structure of education, and are not in receipt of adult health services, there is little in place from statutory services. The group identified that hand over back to GPs in these cases is not always robust.

   Recommendation: That discharge planning take account of loss of structured services and that information handed back to GPs is more robust. That an assessment take place at point of discharge outlining ongoing issues and vulnerabilities to GP.

6. There are concerns that young people are being discharged from CAMHS then coming back into mental health services through Improving Access to Psychological Therapies (IAPT) teams, where they don't engage despite having identified needs.

   Recommendation: scoping to identify the scale of this, whether it is clinically indicated or as a result of poor transition practice. Once identified, actions to be agreed as necessary.

7. There is recognition that transition may be a time of stress for a young person. Where they are not moving onto identified statutory services and they have a history of mental health and/or emotional problems then the stress may be greater. National guidance identifies suicide as a risk during transition.

   Recommendation: That a Suicide Prevention Strategy for Havering is developed with all statutory and third sector providers, led by Public Health.

We propose that examining the experience of people who have gone through transition will be helpful in informing future work and discussions are underway as to how this could happen.

The group has identified that there are a number of groups in Havering also looking at transition pathways: we are currently scoping these in order to link up and ensure that work is not replicated and that information is shared to enable learning to inform future practice.

Section 4

Agencies statutory responsibilities

Section 11 statutory requirements

Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

Working Together 2015

Havering Safeguarding Children Board (HSCB) during 2014/15 undertook an audit of section 11 compliance.

Each agency completed a section compliance report covering each statutory requirement. These were supported by comprehensive single agency action plans that will be subject to regular monitoring by the board.

The following are the overarching conclusions and actions.

Standard 1: Senior Management have commitment to the importance of safeguarding and promoting children's welfare

This standard was fully understood by all partners with each response evidencing that there was a clear line of accountability within the organisation that was held within job descriptions and understood throughout the organisations.

As within the previous S11 self-assessment audit, agencies referenced internal audit processes as evidence of compliance with S11

standards. This audit activity has not been consistently submitted to the HSCB Quality and Effectiveness working group for challenge and scrutiny.

Action from Standard 1: all SCB partners to submit reports and actions regarding single agency activity to the HSCB quality and effectiveness group once the reports have been formally signed of by agency quality assurance business processes. Each agency to submit their safeguarding audit programme to the quality and effectiveness group annually so that there is a thorough understanding of each agency's quality assurance processes.

Standard 2: There is a clear statement of the agency's responsibility towards children and this is available to all staff

Each submission evidenced that processes were in place to ensure that all staff at all levels of each organisation were aware of their safeguarding responsibilities.

The returns provided evidence of the growing importance of working together to strengthen the multi-agency response to safeguarding. This included MASH processes, multi-agency audit processes and multi-agency meetings. The submission from Havering Council noted that better processes had allowed agencies to identify more accurately the families in need of services, which has allowed a better targeting of services. This was identified to have led to a reduced in the number of families being subjected to agency scrutiny unnecessarily.

All s11 returns noted that S11 requirements were embedded within contracts if commissioning was undertaken by the agency.

The 2013 S11 returns identified a need to continue to strengthen the work being progressed in relation to capturing and responding to the views of services. This area continues to be a focus of organisation business so that the views of services users are utilised to support the development of services.

Standard 3: There is a clear line of accountability within the organisation for work on safeguarding and promoting welfare

All s11 returns identified that this standard was met despite an increase in the workload of all agencies in relation to safeguarding. Each agency has clear lines of accountability within their organisational structures and these are freely available to staff.

As previously stated, agencies provided assurance that staff were aware of their responsibility to act if a safeguarding concern was identified regardless of their role or core responsibility.

Supervision processes have been embedded across all organisations and additional supervision capacity is being added to meet the increasing demands of staff.

Standard 4: Service development takes into account the need to safeguard and promote welfare and is informed, where appropriate, by the views of children and families

There was evidence of considerable activity across partnerships in improving the multi-agency service response to this standard. All s11 returns provided assurance that the views of service users were sought and taken in to account when developing and delivering services.

The change to probation service process has allowed more autonomy when developing a service response: this has led to a more 'think family' approach to service delivery.

The returns from both NELFT and Havering Council discussed a number of new and emerging activities that had been developed to provide processes to assist in capturing the views and opinions of children, young people and their families.

The CCG noted that both NELFT and BHRUT provided the CCG with evidence that this standards was understood and implemented.

Standard 5: There is effective training on safeguarding & promoting the welfare of children for all staff working with or, depending on the agency's primary functions, in contact with children & families

All agencies reported that an induction programme was in place for staff joining the organisation. Each s11 response referenced a single agency training programme that was in place to ensure that staff were provided with the correct level of training to support them in their role within the organisation.

All audit returns provided assurance that each organisation understood the importance of training to equip staff to identify and respond to possible signs and symptoms of harm.

Evidence of the impact of training on improved

outcomes was the identified increase in reporting of concerns notably in relation to CSE, FGM and domestic violence.

Standard 6: Safer recruitment procedures include vetting procedures and those for managing allegations are in place.

a. Organisation has safer recruitment & selection procedures in place in line with statutory guidance.

All agency returns provided assurance of compliance with this element of the standard.

b. Organisation can demonstrate that agencies commissioned to provide services have safer recruitment in place

Havering Council provided assurances that commissioning processes included a requirement for service to provide evidence of compliance with all s11 standards. Compliance with contract requirements is monitoring by Havering Council within usual business processes.

The CCG response provided a level of assurance that services commissioned directly by the CCG were required to comply with the standard and to provide evidence of this. The CCG does not have oversight of management use of recruitment agencies: there is an expectation that the recruitment agencies used by BHRUT and NELFT are part of the NHS Buying Solutions Framework with an expectation that they comply with s11 standards. Although not explicitly noted within S11 returns, both NELFT and BHRUT confirmed that they comply with CCG expectations when using recruitment agencies.

c. Safer recruitment training is in place for managers involved in recruitment

All returns provided assurance that training was available to all relevant staff to ensure compliance with this element of the standard.

d. Organisation has managing allegations procedures in place

All returns provided assurance that processes were in place to respond correctly when a safeguarding allegation was made against a professional.

e. A senior manager has been identified for the managing allegations process & knows who the LADO is and when to contact them

All s11 submissions provided assurance that a designated professional was in place to manage allegations and to support staff through this process: This was not explicitly stated within the LCRC return; however written confirmation of compliance with this standard was submitted separately.

f. Support is available for staff who are subject to allegation

All s11 submissions confirmed that there were appropriate services in place within the organisation to support staff when an allegation is made against them.

g. Audit processes are in place to monitor safer recruitment & managing allegations

All returns provided assurance that processes are in place to monitor processes at an organisational revel.

Standard 7 the response to this standard evidenced a commitment to ensure effective multi agency working across the continuum of need. The evidence supports a commitment to multi agency safeguarding hub processes, information sharing and embedding early assessment processes.

The number of early help assessments completed in year 2014-15 was 396, which is an increase on previous years but still suggests a low take up when considering the high level of tier 4 CSC assessments completed that result in no further action.
Uptake and completion of early help assessment processes will be required to be reported quarterly to the HSCB Quality and Effectiveness working group for scrutiny and challenge. The newly implemented early help service will help to improve take up of early help assessments and will provide support to those initiating early help processes.

Standard 8 returns from all agencies and service areas evidenced a good understanding of information sharing processes and protocols. Single and multi agency training was identified as a key to embedding good practice.

Conclusion

There is evidence of a strong commitment across HSCB partners to ensure section 11 standards are complied with. The s11 has provided assurance to the HSCB that all agencies required to comply with S11 understand their duty and are committed to ensuring compliance with processes.

The returns indicated that there was a comprehensive audit programme embedded

across all services reporting with the exception of the Metropolitan Police: Metropolitan Police quality assurance processes are progressed through daily 'Grip and Pace' where senior managers review cases and determine timelines as appropriate. KPIs are scrutinised during regular performance meetings. Risks are escalated through agreed internal escalation pathways and, when necessary, escalated to the HSCB.

The quality assurance work undertaken at single agency level is not routinely reported into HSCB quality and effectiveness group. Audit reports including actions to address emerging issues should be reported quarterly to the HSCB Quality and Effectiveness working group for challenge and scrutiny.

The impact of training on improved outcomes has not always been easy to determine. The impact of learning on improving knowledge and understanding is evidenced within post course analysis: an increase in referrals regarding CSE and FGM may also be indicative of improved understanding of this area of work.

The s11 self-assessment audit provided the HSCB with assurance that S11 requirements have been priorities across statutory partners during structural and transformational organisational changes. Partners have identified gaps within standards and identified action to ensure that each element within the standards are embedded.

The section 11 audit tool requires agencies to report on compliance biennially. The HSCB will need to determine whether an annual self-assessment audit of compliance should be completed to allow the HSCB to fully understand agency commitment to these standards during this time of austerity and shrinking resources.

Recommendations:

1. Each agency to implement their agreed action plan and report to the quality and effectiveness group quarterly and by exception.

2. Single agency audit activity to be reported to the HSCB Quality and Effectiveness group at quarterly intervals.

HSCB to consider whether to initiate a further section 11 audit in 2016

Single agency successes and areas for further improvement

In preparation of this annual report each agency represented on the board except Havering Council Children and Young People Services, which is intrinsically incorporated throughout the body of this report, were requested to submit a report setting out their individual successes and areas for future improvement.
This section will set out the agencies identified risks and challenges and their actions and priorities for the year 2014 to 2015

Havering Public Health Service

Background

The Public Health Service helps the London Borough of Havering (LBH) protect and promote the health of the population by providing expert health related advice to elected members, the Health and Wellbeing Board, council services, partner agencies and the public. The service has a range of mandated and non-mandated functions.

As well as providing system leadership, multi-disciplinary perspectives and a commitment to evidence based practice the Public Health Service is responsible for commissioning a number of services. The most pertinent to children and young people's safeguarding include:

- School Nursing
- Substance Mis-use
- Sexual Health
- Health Visiting (to be transferred in October 2015)

Safeguarding remains an important aspect of Public Health work.

Review of Safeguarding Activity 2014 – 2015

School Nursing

The Public Health team has been working with health and social care partners to understand the role of health professionals in safeguarding of children and young people. A pilot audit was undertaken with partners from children services and school nurses, to review school nurse involvement in safeguarding. The preliminary findings suggest that in some instances other health professionals may have had more to contribute to safeguarding efforts than school nurses, who are often seen as the default health representative. This work is on-going and reports will be submitted to the LSCB Quality and Effectiveness group in the upcoming weeks.

Looked After Children (LAC)

The Public Health team has worked with partners in the CCG and Community Trust (NELFT) in order to understand how initial health reviews and subsequent health reviews are undertaken for LAC. Clarity over commissioning arrangements are currently being explored to ensure this group receive a high quality and responsive health care service that's has the capacity and skills set to meet the needs of LAC in Havering.

Sexual Health & Substance Misuse Services

Through contract monitoring, on-going safeguarding issues are raised and discussed with the provider to ensure any action necessary to safeguard service users is taken. Ensuring that providers actively contribute to local efforts to tackle FGM, CSE and gangs has been a priority in 2014/15.

Housing

The last year has seen a number of major changes in the Council's Housing service:

- The new Housing Service structure designed to improve service quality and control risks to residents came into effect.
- An audit of the Housing Service by the Chartered Institute of Housing (CIH) resulted in the service developing a comprehensive action plan including elements relating to safeguarding
- Housing policies designed to support and protect service users were revised and updated.
- A review of the Council's Supported Housing was undertaken as a result of the changes to the changes to the Supporting People funding.

Priorities of the service

Housing Services manages and maintains the Council's stock of some 9,900 tenanted and 2,200 leasehold homes. It also provides services for people in housing need and co-ordinates housing strategy across the Borough.

The priorities of the service for the forthcoming year include:

- Delivering on all aspects of the CIH action plan in relation to the safeguarding agenda – in particular training and awareness building
- Continuing with our programme of home improvement and modernisation to bring all our homes up to an agreed decency standard
- Building new social housing homes in Havering and adapting existing homes to new uses where possible.
- Working with our partners to tackle anti-social behaviour across the Council's social and commercially managed housing stock.
- Responding to the changes in the welfare system to give advice to residents and to minimise the impact on them, and to reduce poverty and Financial Exclusion
- Reviewing and updating the way we deliver our services to make it easier and more convenient for residents to use them.

Working in partnership with Children's Services

The Housing Service recruited a Housing professional to a new post, Housing Link Officer, in the Multi Agency Safeguarding Hub (MASH) to act as the link between MASH and housing.

The Housing Service funded a Housing professional to a housing advisory post in the Early Help team to act as the link between the teams.

Welfare reforms

This has been a key issue for Housing Services and for residents on low incomes. Many local families have seen Housing Benefit reduced or are subject to a cap in the total amount they can receive in benefits. Through a team of officers the Housing Service advises residents on how to mitigate the impact and to sustain their tenancies in both the social and private housing sectors.

Anti-Social Behaviour

The Anti-social Behaviour, Crime and Policing Act 2014 comes into effect on April 2015. Housing has made preparations for the new legislation by:

- Reorganising services internally so that tackling anti-social behaviour is carried out in the same team as tenancy management
- Retaining our Neighbourhood wardens and CCTV services
- Revising our anti-social behaviour policy and procedures to reflect the emphasis on supporting residents responsible for anti-social behaviour who are often themselves victims in need of support.

Schools

School safeguarding and whistleblowing policies have been revised, and as of July 2015 every school in Havering – maintained, academy and independent – has implemented policies which clearly reference 'Working Together' and 'Keeping Children safe in Education'.

Required 3 year training for all school staff is also up to date, with every school having run this essential training, or have it booked to deliver between September and December 2015. Many schools run this training twice and attendees are from across the whole school workforce, including teachers, teaching assistants, support staff, midday assistants, cleaners and bus escort staff.

Schools use a section 175 audit document; this covers the statutory elements of Section 175 Education Act 2002, Section 11 Children Acts 2004 and Keeping Children Safe in Education, March 2015. 27 schools have completed a detailed, supported audit, all schools audited are compliant, many have very well developed in school processes which support high quality recording of child protection issues, enabling timely and detailed referrals and on-going support for the child. A further 36 schools have completed the S175 self-review as part of a self-evaluation of safeguarding processes.

A range of additional training has been run specifically for schools, in addition to the training run by the LSCB. This additional training has included training for designated leads and also specific topics such as FGM, Radicalisation and Extremism.

Early Years Settings

Since May 2015 five training sessions have been facilitated for Early Years staff in PVI (private, voluntary and independent) settings or schools across Havering. To date 90 practitioners have participated in either an Introduction to Child Protection course or Safeguarding for the Designated person training. A further 50 practitioners will be trained in autumn 2015.

Early Years Quality Assurance support to PVI settings has been revised and as of May 2015 all settings visited have participated in a Safeguarding Audit. The audit, written by the Quality Assurance Team, requires settings to audit their own policies and procedures and draw up an action plan. The trialling of this has been successful and it is envisaged that the audit will be made available to all settings to consider prior to their Safeguarding Audit.

Police: Local Havering Command

Havering police have responsibility for the initial response to calls from the public and then the ongoing investigation thereafter. This relates to Emergency response team as initial responders and initial investigators. In addition CID units based at Romford Police station then support further with secondary investigations and links into partner agencies while giving ongoing support to victims and their families. CID units most likely to be involved in safeguarding matters will be Community Safety Unit led by a Detective Inspector and supported by 3 Detective sergeants and 15 Constables.

3. How has the organisation contributed to the Havering LSCB strategic priorities?

a) Havering Police attend LSCB and sub groups. Data is reviewed and fed back to the senior leadership team to ensure we are providing an effective response to child issues in collaboration with our partner agencies.

b) Havering Police are an integral part of the safe guarding partnership, through the Multi Agency Safeguarding Hub (MASH) having been one of the first Borough in London to launch the MASH unit . We have 1 Detective sergeant and 3 constables and 3 analysts embedded within the hub. We continue to evolved and develop the MASH responding to local needs.

c) Havering Community Safety Unit is very much part of the Safeguarding Portfolio which consists of management of Sexual offenders (Jigsaw), Multi Agency Public Protection Arrangements (MAPPA) , Multi Agency Risk Assessment Conference (MARAC) Youth offending services (YOS) . Child Sexual Exploitation (CSE). Through these portfolios Havering Police seek to best co-ordinate the right support for families

4. Long and short term risk and priorities

Havering Police have formed a Child Sexual Exploitation unit, this links in very much with central Sexual offences abuse command. Cases are identified and graded according to risk. Short term we are seeking to increase staffing levels by 50% over the summer 2015. Longer term aims are to increase staff knowledge of CSE issues as they change and develop.

5. Actions to be taken to address the risk and expect impact on the outcomes

Staff have been identified to increase staff numbers within the CSE unit.

As intelligence comes to light the CSE will circulate and cascaded MPS wide and Havering CSE officers will act as subject experts to offer advice and support for first responders and secondary investigators

6. Example of Effective/Emerging Practice

Child Sexual Exploitation is a relatively new and emerging way of Policing, learning on local and national best practises.
CSE is very much imbedded in local safeguarding Havering Police seek to build on this success with a view of securing an intelligence picture of exploitation within our Borough and beyond. With this intelligence in place then putting plans in place to disrupt and bring offenders before the courts

Police: Child Abuse Investigation Team (CAIT)

Long and short term risk and priorities

In support of Havering CID the Metropolitan police have a unit of specialised investigators dedicated to child abuse - CAIT, this team has responsibility for Barking & Dagenham and Havering Boroughs and are based at barking side Police station. Their remit covers;

- Intra- familial abuse.
- Professional abuse.
- Other carers such as carers, babysitters, voluntary groups.
- Allegations outlined in the Child Abduction Act 1984 Section.

- Intelligence led investigations in relation internet crimes
- To investigate sudden and unexpected death in infancy of children under 2 years with the family.

Havering CAIT has a strong working relationship with other safeguarding partnership agencies (Child Social Care, Education, Health etc). They also have a dedicated team of police staff deployed to represent the MPS at case conferences and to produce reports for them.

There has been improved input and understanding of the Child Risk Assessment Matrix (CRAM). This is the research conducted into every CAIT allegation to ensure any direct or potential risk to children can be managed and strategies implemented.

CAIT's are subjected to inspection by the Continuance Improvement Team (CIT) on an annual basis.

CAIT's are further held to account by the Metropolitan Police Authority.

- Initial Case conferences 44% attended / target 100%
- Review Case conferences 6% attended / target 50%
- Strategy discussions 654 - 545 with 24 hrs (83.3%)
- There has been a 21% annual increase in reported offences.

a. What the agency has learnt from its performance information

CAIT has struggled to attend conferences through the financial year due to staff vacancies. However as staffing levels have increased so has performance (ie:- initial case conference attendance in February was 89% compliant).

b. How this learning has informed decision making

The senior leadership team within SOECAC continue to review processes to establish if video / phone conferencing can be implemented to increase conference compliance.

2. Main achievements and areas of strength

The MPS constantly reviews its commitment and development of policies to safeguard children. Since the 'Baby P' inquiry, the MPS has implemented a detailed risk assessment matrix (CRAM) to ensure that all factors are considered when decisions are made with regards to child protection investigations.

The MPS have developed new requirements on the Crime Reporting Investigation System (CRIS) to ask questions of reporting and investigating officers relating to risk factors to consider when making safeguarding decisions. It also ensures managers can make informed and focused decisions whether to commence single or joint agency investigations.

It has been a longstanding practise that children's evidence is obtained via video recorded interviews (ABE's) and that if a child is under 5 or has special needs then consideration should be made to use intermediaries. This enables the most vulnerable children to be heard and improve their outcomes in the criminal justice system.

The partnership team actively seek the views of partner agencies regarding local CAIT teams and reviews the effectiveness of partnership working as stipulated in "Working Together to Safeguard Children 2015".

3. Main areas of concern and issues for development in relation to safeguarding

The main issue facing CAIT in the past year has been a lack of trained police staff to cope with the rise in reported incidents. This has impacted on performance and particularly child protection case conference attendance.

In the short term Havering CAIT has catered for this by utilising police officers who were working on attachment to the team. The long term goal is to increase trained staff and CAIT is in the process of recruiting more police officers to fill vacancies. This will continue to be monitored as crime & staff workloads increase.

6. Key areas for development and action plan

A key area for CAIT is to develop case conferencing by video / phone links to improve CAIT input within conferences. CAIT and partnership agencies have seen a marked increase in demand of their services. CAIT continue to try and meet the challenge of case conference attendance by finding an effective way to improve CAIT input and engagement.

7. Key messages / recommendations for LSCB Priorities

CAIT reported incidents have continued to rise over the last 3 years. CAIT senior managers continue to address staff vacancies to meet that demand.

CAIT's recommendation to the board is to review working practices regarding case conferences to consider video / phone conferencing.

Health: Clinical Commissioning Group

Long and short term risks

Clinical Commissioning Groups (CCGs) are statutory NHS bodies with a range of statutory duties, including, safeguarding children and young people. Havering CCG is a major commissioner of local health services for residents living in Havering and need to assure itself that all the CCG commissioned services for children and young people across the health economy in Havering have effective safeguarding arrangements in place and is in accordance with their statutory duty under section 11 of the Children Act 2004.

The CCG safeguarding structure is established for Havering CCG where the Nurse Director has executive responsibility for safeguarding within the Governing Body. The safeguarding accountabilities are discharged through the delegation of responsibilities through the Nurse Director and is supported by the Deputy Nurse Director and the designated professionals. The Chief Operating Officer (COO) within the CCG is the operational lead for ensuring implementation of safeguarding functions supported by the CCG designated professionals for safeguarding.

Havering CCG has developed a Safeguarding Children & Adults Framework which detailed how the CCG will discharge and fulfil all the statutory safeguarding children and adult functions both strategically and operationally.

The CCG has appointed the following professionals in 2014/15

Named GP for Havering

Designated Doctor for Looked After Children across BHR CCGs (interim)

Designated Doctor for Safeguarding Children

Designated Nurse for Safeguarding Children

Risks and Challenges

There is an ongoing risk with the initial and review health assessments for looked after children which are not completed within the statutory requirement and there is concern raised regarding the quality of the assessments. It is a priority for the CCG to ensure there is a robust system in place to improve the timeliness and quality of health assessments for looked after children

It is also a priority for the CCG to ensure there are robust contractual service specifications for safeguarding and reviewing processes for services commissioned for children and young people

Actions to be taken to address the risks and the expected impact on outcomes

To address the risk for looked after children, the appointed Designated Doctor and Designated Nurse for looked after children have been charged with the strategic task of reviewing the health assessment service and identify gaps in service. Following this review, they will make recommendations to the CCG for an improved and sustainable service.

Example of Effective/Emerging Practice

The Designated Nurse lead for child protection information sharing project is in a unique position of being a CP-IS board member and had personally championed the implementation of the first LIVE integrated CP-IS project at Homerton Hospital. The designated nurse is the CCG CP-IS lead and will use her knowledge and experience to help support and drive implementation of CP-IS

North East London Foundation Trust (NELFT)

Long and short term risks

North East London NHS Foundation Trust (NELFT) provides mental health and community services for people living in the London Boroughs of Waltham Forest, Redbridge, Barking & Dagenham and Havering and also manages community health services in south west Essex. NELFT is committed to ensuring that all patients receive care in a safe, secure and caring environment supported by a number of Safeguarding Children arrangements. There is senior management commitment to the importance of safeguarding within the Trust; the Chief Nurse undertakes this Executive lead role.

NELFT has Named Doctors and Named Nurses who provide advice, guidance and support to staff across the Trust on safeguarding children issues. Roles and responsibilities for these roles are clearly outlined in the job descriptions.

Integral to NELFTs Governance arrangements, the Strategic Safeguarding Group for NELFT meets on a quarterly basis .Its function is to ensure that the Trust executes its statutory safeguarding responsibilities and to ensure that national policy and guidance are interpreted and applied at a local level.

A safeguarding report is presented to both the Trust Board of Directors annually and to the Quality & Safety Committee (QSC) on a bi-annual basis; this report covers all areas of safeguarding children including changes in national and local policy, audit results, key developments and staff training.

Long and short term risks and priorities

With the changing demographics and increase in safeguarding activity in Havering, NELFT needs to ensure that staff have the appropriate skills and competencies and are appropriately supported in their safeguarding role.

Collaborative working with the Strategic Lead for Domestic Abuse and Harmful practices will continue to progress the actions identified in the Rotherham enquiry around Child Sexual Exploitation.

Integrated working across the adult and children safeguarding teams to be further embedded to support an increase in the numbers of referrals to MARAC.

Improvement in access to and quality of advice and support in relation to safeguarding adults and children for NELFT staff and multi-agency colleagues

Actions to be taken to address the risks and the expected impact on outcomes

- NELFT to continue to review and challenge its arrangements to support safe and consistent practice to ensure that children and young people are appropriately safeguarded.
- For there to be an improvement in access to and quality of advice and support in relation to safeguarding adults and children for NELFT staff via the provision of a single point of contact for advice and support.
- Completion of the development of Safeguarding Operating Procedures to support the Safeguarding Children Policy

Example of Effective/Emerging Practice

- NELFT recognises the importance of high quality safeguarding children supervision to support staff in practice to improve outcomes for children. To strengthen the delivery of safeguarding children supervision NELFT has developed a formal induction programme for safeguarding children supervisors to support practitioners in this key role.

Barking, Havering & Redbridge University Hospitals NHS Trust

Barking Havering & Redbridge University Hospitals NHS Trust (BHRUT) continues to ensure that it is doing everything it can to ensure that as an Local Safeguarding Children's Board (LSCB) partner agency member it is fulfilling its commitment as required under Section 11 Working Together 2015.

BHRUT has established robust systems and processes to ensure there is a timely and proportional response when safeguarding concerns are raised when a child/children are considered to be at risk or likely to be at risk of "Significant Harm".

This has been achieved as follows:

Safeguarding Team

The Safeguarding Children's Team is fully established and comprises of:

- Full time Named Nurse
- Full time Named Midwife
- Full time Named Doctor for Safeguarding Children
- Full time Paediatric Liaison Nurse/Child Death Co-ordinator
- Full time Team Secretary

The Deputy Chief Nurse line manages the Named Nurse Safeguarding Children and Named Midwife on behalf of the Chief Nurse, who has Executive responsibility for safeguarding.

Long & Short Term Risks, PRIORITIES & Actions Taken

- To develop practice in responding to Domestic Violence/Sexual Violence and Abuse in line with the Publication of the NICE Guidelines March 2014

Actions:

The Trust's Named Midwife has been nominated as the Trust's Domestic Abuse Champion and is a member of the B&D Domestic Violence/Sexual Violence Group.
The Trust is reviewing its approach to managing Domestic Abuse, which includes developing a Trust wide Domestic Abuse Policy.

- At least 85% of eligible staff to attend Level 3 safeguarding children's training.

Actions:

Regular monitoring by the Deputy Chief Nurse/Head of Safeguarding and compliance reported at the Trust's Safeguarding Children's Operational and Safeguarding Strategic & Assurance Group meetings.
Compliance monitored at the Trust's monthly Divisional Performance meetings.

- To develop staff awareness of harmful practice i.e. Child Sexual Exploitation (CSE) Trafficking and Female Genital Mutilation (FGM)

Actions:

To establish FGM/CSE leads in all relevant clinical areas.

Quarterly FGM/CSE meetings to be established and chaired by the Trust's Deputy Chief Nurse/Head of Safeguarding.

Effective /Emerging Practice

In April 2014 the Trust introduced mandatory safeguarding screening tool within the Emergency Care Department to encourage a "think family approach" and recognition to the "invisible child/ren.

Since implementation, Emergency Care staff (Adults and Paediatrics) recognition of vulnerabilities and risk to children has increased.

An audit of the effectiveness of this tool is due for completion in early Q 1 2015.

Conclusion The Safeguarding Team continue to make significant progress in ensuring that the Trust executes its duties and safeguarding responsibilities and maintains focus on the welfare of children. This is evidence based by interagency working and improved inter-hospital and external working relationships with Havering LSCB Board members and related subgroup members

Children and Families Court Advisory and Support Services (Cafcass)

Cafcass (the Children and Family Court Advisory and Support Service) is a non-departmental public body sponsored by the Ministry of Justice. The role of Cafcass within the family courts is: to safeguard and promote the welfare of children;

provide advice to the court; make provision for children to be represented; and provide information and support to children and their families.

Cafcass' statutory function, as set out in the Criminal Justice and Court Services Act 2000, is to "safeguard and promote the welfare of children". Safeguarding is therefore a priority in all of the work we undertake within the family courts and the training and guidance we provide to staff reflects this.

Review of Safeguarding Activity 2013-2014

A key focus during 2014/15 was continued improvement following our "good" Ofsted judgement in April 2014. Ofsted summarised that Cafcass consistently worked well with families to ensure children are safe and that the court makes decisions that are in the children's best interests. The report also highlighted areas where Cafcass should make improvements, and these areas formed a dedicated action plan which we implemented throughout the remainder of the year. An audit in November 2014 assessed that all of the following actions had been met:

- To improve the minority of safeguarding letters which are not yet fit for purpose: this has been met;
- Improve effectiveness of efforts to contact parties. Where sufficient efforts have been made these should be better recorded: this has been met;
- Ensure that in all private law work casework begins as early as possible once a Family Court Adviser (FCA) has been allocated: this has been met;
- Improve the percentage of "good" work in private law work after first hearing (WAFH) in London: this has been met;
- Improve further the analysis in the report to the court and ensure that all relevant information is pulled through in to the report based on research: this has been met.

-

A national audit of practice was undertaken in November 2014 with the objective of providing a snapshot assessment of the standard of casework. The audit measured the progress of work since the audit in September 2013 and the Ofsted inspection of April 2014. The conclusions were positive, reporting the percentage of work graded as "good" at 65%. This represents a significant improvement of 16% from the previous year's audit.

We will undertake three thematic audits in 2015/16, focusing on further improvements required. These will look at the extent of the improvement in the joint working between the Independent Reviewing Officer (IRO) and the Guardian; the Guardian's involvement and agreement to any position statement filed in proceedings; and evidence in WAFH of the improvement in analysis of assessment and increased use of research and tools.
Further scrutiny is given to our safeguarding practice and processes by the Family Justice Young People's Board (FJYPB) comprising young people with direct experience of the family court. The FJYPB contribute to our publications, review our resources for direct work with children, and are involved in the recruitment of frontline staff. Board members also review the complaints we receive from children and young people.

Long and short term risks and priorities

We continue to respond to, and facilitate, developments within the family justice system and in particular the move, in private law towards supporting parents, where possible, to make safe decisions outside court proceedings. We are currently piloting a programme announced by the MoJ, to provide advice and to encourage out of court pathways for separating parents, where it is safe to do so. The supporting separating parents in dispute (SSPID) helpline was launched in November 2014. Callers are put through to a Cafcass practitioner who can talk through the difficulties of separation, offering support, guidance, and information. We also ran a six month pilot of a safeguarding advisory support service for mediators, aimed at providing support in cases featuring child protection concerns.

Cafcass is also working on the Parents in Dispute pilot, in partnership with the Tavistock Centre for Couple Counselling. The chief aim of the project is to support separating parents involved in high conflict disputes in the family courts. FCAs in London have been able to recommend that separating parents attend the course in order to help parents to reconsider their

behaviour in order to better focus on their children and create positive outcomes for them.

A significant emerging issue in recent years has been child sexual exploitation (CSE), We are implementing a CSE strategy which involves consolidating systems to capture data on CSE in cases known to us; providing mandatory training on CSE to our staff, running workshops to increase awareness; reviewing policy guidance to staff; creating dedicated management time to support the delivery of the strategy at a national level; and creating CSE ambassadors within each service area.

Section 5

Board Governance and structure and finance

LSCB Financial Contributions

HSCB is funded under arrangements arising from Section 15 of Children Act 2004. The contribution made by each member organisation is agreed locally. The member organisations' shared responsibilities for the discharge of the HSCB's functions include determining how the resources are provided to support it.

During the financial year 2014-2015 the largest proportion of the budget was spent on:

Staffing £108,519

Havering's independent chair £17,835.

Multi-agency training programme £25,000, which included classroom based learning and a conference.

The budget agreed for 2014/15 was comprised of contributions from the key partner agencies represented on the Board and in all cases except Havering Council, which increased its contribution, is the same as the previous three years.

Name of Agency	Contribution 14/15
Havering Council	£121,640.00
Police	£5,000.00
CCG	£28,706.49
BHRUT	£4,778.33
NELFT	£4,778.33
National Probation Service	£1,000.00
The London Community Rehabilitation Company LTD	£1000.00
CAFCASS	£562.15
Totals	**£167,465.30**

The projected contributions from partner agencies total £167,465.30. This budget excludes the additional contribution required to finance CDOP statutory requirements: CDOP was jointly funded by Children's Social Care and Havering Health services as previously agreed by Havering LSCB.

The Child Death Overview Panel is funded by contributions from Health and Children Social Care and covers all CDOP processes. CDOP costs for the year were £44,465

The HSCB had a carry forward from the previous year of £17,000

Governance

Due to changes in agency structures and funding the HSCB chair agreed to review the current board structure including membership, board meetings and sub group structures. During 2015/16, the board will introduce an executive group, which has a smaller membership consisting of agency, leads. This will be the strategic board., which will be supported by an operational group, that has a bigger membership reviewing operational issues including the work of the sub groups. This operational group will work closely with the SAB operational group including having a shared meeting.

During 2014/15 the board recruited a Lay member, unfortunately a second was recruited but was unable to take up the post.

Board Challenge.

- To keep the structure under review to ensure that it enables the board to operate at the level required.
- To recruit a second lay member
- To have open and honest communication to understand the impact of austerity and budget cuts on services and how this will impact on safeguarding.
- To continue to challenge all partnership agencies to ensure that safeguarding remains a core priority during times of budget cuts.

Staffing and support

Board staffing has remained stable over the year. A business manager, training and development officer and an administrator are in place to assist the board in achieving agreed priorities. The Board is chaired by an independent person.

Moving forward: Priorities

2015 – 2016

In the forthcoming year, the Board's focus will be:

- child protection,
- early help,
- child sexual exploitation and missing
- neglect:

The Board Priorities will remain the same

Priority 1: Ensure that the partnership provides an effective child protection service to all children ensuring that all statutory functions are completed to the highest standards.

Priority 2: Monitor the development and implementation of a multi-agency early offer of help to children and families living in Havering.

Priority 3: Monitor the alignment and effectiveness of the partnership when working across the child's journey between universal, targeted and specialist safeguarding

Priority 4: Coordinate an approach to domestic violence, mental health and drug and alcohol abuse across the children and adults' partnership to ensure that families affected receive the right support at the right time.

Priority 5: Ensure that Havering Safeguarding Children Board communicates effectively with partners, children, young people and their families, communities and residents