Havering Safeguarding Children Board

Annual Report 2016-17

Havering Safeguarding Children Board Chair Forward

The HSCB continues to be well supported by both statutory and non-statutory partners and I would like to thank all members for their continued support and commitment. I would especially like to acknowledge the work of Alice Pleating. She held the role of board manager for 9 years but during 2016 she transferred to work within the MASH. Her support for all board members and myself has ensured that we have maintained a strong board for many years.

The focus of the past year has been on the Ofsted inspection in October 2016. This provided the board with an external review of the effectiveness of Children Social Care and the HSCB. Details of the review will be set out in the annual report. Whilst the Ofsted recommendation was 'requires improvement' for both Children Social Care and the HSCB, their report fully acknowledged that Children Social Care had made and were making exciting changes in approach and structure 'Face to Face' that will help to support children and families in Havering. This approach has been fully supported by the board. They were also very positive about the role of the Board, and were able to evidence the boards influence in challenging and helping to improve outcomes for children.

I would like to thank everyone involved in the inspection for their honesty an openness during the review. Detailed action plans have been produced which will be monitored by the board.

The past year has also seen a very major change in the structure of the Metropolitan Police. This has seen a move to a tri borough structure. Havering has been one of the pathfinder sites and the board has been very involved in consultation around the structure, focusing on the need to ensure safeguarding structures such as the CAIT remain strong.

The coming year will see some continued challenges with the impact of budgetary restraints which continue to be a challenge that must be a focus of the board during this next financial year. The Children Social Care Act which came into force in 2017. As highlighted last year this Act has major implications for agencies and specifically Children's Social Care. A new 'Working Together Guidance' will be introduced to support the new act and will continue to work with the Chief Executives and officers of the three statutory agencies, to ensure that Havering is in the best position to implement the new legislation.

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

Vision Statement

Keeping children and young people safe is the Havering Safeguarding Children's Board overarching priority. All partnership agencies are committed to raising safeguarding standards and improving outcomes for all the children and young people of Havering.

Our Six Strategic Aims

In order to meet our vision, the Havering LSCB has identified 6 strategic Aims

1. Ensure that the partnership provides an effective child protection service to all children and young people ensuring that all statutory functions are completed to the highest standards.
2. Monitor the effectiveness of the multi-agency early offer of help to children and young people in Havering.
3. Ensure that agencies work together to provide the most vulnerable children and young people with the correct help at the right time.
4. Ensuring an integrated multi-agency approach to respond to emerging themes and priorities identified by the Board and through national learning.
5. Assuring the quality of safeguarding and child protection to the wider community.
6. Ensure that partners learn lessons identified through local and national learning, and ensure that learning is acted upon and embedded in practice across all partner organisations.

This report will provide an overview of the following:

1. Ofsted Inspection
2. Overview of the 2016-17 safeguarding strategic aims.
3. Summary of the HSCB board sub group working and governance 2016-17.
4. Appendices: Each agency was asked to supply a summary of their responses to safeguarding in 2016-17. These reports are

attached to the annual report in the appendix.

Ofsted Inspection

2016/17 saw the Havering Children Services and the Havering Safeguarding Children Board being subject to an OFSTED inspection.

This inspection provided an independent overview of children safeguarding in Havering and it is important to highlight the inspection findings in this annual report.

Both Children Services and the Safeguarding Board received a grading of 'Requires improvement'. It was acknowledged by Ofsted that their finding was in light of major structural changes to children services with the introduction of the Face to Face approach.

The below comment sums up Ofsted's findings for Children Services:

- Ofsted recognised that there has been considerable and extensive changes to senior management structure in Havering since August 2015, which has resulted in robust and systematic actions to address operational weaknesses in the quality of service.
- Ofsted recognise that a newly recruited and experienced senior management team has started to make significant and sustainable changes to core social work practice and to key area such as reducing the risks of child sexual exploitation.

They identified the following weaknesses:

- Multi Agency Safeguarding Hub MASH Emergency Duty Team were weak leading to delays in initial responses for some children and families. children received a robust response to their needs once they have an allocated social worker.
- Quality of assessment and planning for children and young people is too variable.
- Services for Care Leavers was found to be inadequate, care leavers were not being well supported.

In respect of the HSCB Ofsted noted the following:

The board has been effective in raising some practice standards by providing challenge to multi –agency partners….. the board has worked effectively to influence increased staff resources to improve looked after children health assessments.

The HSCB provides effective leadership in tackling child sexual exploitation at both strategic and operational level.

Ofsted identified the following weaknesses of the board.

- There still remains a weakness in timely collection of data and effective use of data to ensure effective monitoring and evaluation of key Safeguarding services, including those for disabled children.
- Board must continue to ensure that thresholds are well understood and are operated effectively.
- Still need to increase oversight of private fostering arrangements.

- Ofsted found many good practices in both the Children Social Care and the board.

- Detailed action plans have been agreed and implemented and will be subject to future Ofsted review.

Board Challenge

- To implement the board action plan and monitor impact.
- To monitor the Children Social Care action plan.

Section 1

2016/17 Strategic Aims

The Front Door

The front door to child protection services in Havering is the Havering Multi Agency Safeguarding Hub (MASH). This was designed to facilitate better decision-making and outcomes in respect of vulnerable people. The Havering MASH is a co-located, multi-agency team working in a single, secure hub that receives notifications about potential risk and need. The partners involved in the multi agency team include Police, Public Protection, Health, Housing, Probation, Adult Mental Health, Early Help Advisor, Missing Persons, and Independent Domestic Violence Advocacy.

The aim of a MASH is to improve the quality of information sharing and decision-making at the point of referral. As highlighted in last year's report whilst the MASH has been effective it was identified that it was a victim of its own success as more referrals are received by professionals aware that they are likely to receive an effective response to their concerns. .

In order to address this a review of business processes (LEAN review) was undertaken between January and March 2016. The aim of the review was to:

- Reduce the number of referrals resulting in a statutory assessment.
- Create a joint front door with Early Help and MASH to target the most effective service to children and families at the earliest opportunity.

The impact of the review implementation is reflected in this year's figures.

Contacts are received in two locations the MASH and Early Help. This year's data has highlighted that 71% of all contacts were received by MASH and 29% by Early Help. The total number of recorded contacts has significantly increased but the percentage of contacts progressed to referral to children social care has dropped by 10% to 23%. An indication of increased quality referrals is the % of referrals that are then progressed to full assessment. That has increased from 81% to 89%.

Whilst the board has continued to see improvements concerns were identified by Ofsted. Their inspection highlighted that the MASH process is causing delay in responding to children and families. As has been previously highlighted the board will monitor the resultant Ofsted action plan.

Performance will be reviewed during future audits of MASH which will continue throughout 2017 to 2018. Findings will continue be presented to the HSCB Operational group.

Contact Sources

Whilst the number of contacts has risen during 2016/17 The source of the contacts has changed slightly from previous years. The Police remaining the main referral source at 44 %. Schools have increased to 14% of the number of the contacts from 7%. In numbers the school contacts have increased from 645 to 1472 over double which is a significant improvement.

Secondary Health contacts (inc A&E, Hospital, OT, Ward etc) have also significantly increased from 20 2015/16 to 255 in 2016/17. 49% of that total (125) were recorded in the 4Q.

In order to assist agencies identify and evidence referral the HSCB Threshold guidance document was revised. It is now much shorter and easier to use with regards to multi-agency involvement.

Board Challenge

- The challenge for the board (as identified by OFSTED) is to ensure that the threshold for referral is fully understood and applied appropriately by all agencies.

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 and their family

The progress made in the MASH is further evidenced in Child Protection interventions. The number of section 47 child protection enquires is down 26% from 597 2015/16 to 443 2016/17.

34% (153) of the section 47 enquiries led to an Initial Child Protection Conference this is an increase of 4.5% on the previous year.

This again indicts that the quality of the referral

MASH Referrals and Assessments		
Years	2015-16	2016-17
Total number Contacts received by MASH and Early Help	5859	9293
Contacts received by MASH	5856	6608
Contacts received in Early Help	N/A	2685
Contacts progressed to referral	1937 (33%)	2130 (23%)
Referrals progressed to Assessment.	1842 (81%)	2194 (89%)
MASH contacts progressed to Early Help Service	2156 (37%)	3657 (39%)
Contacts subject to No Further Action	713 (12%)	2268 (24%)
Contacts progressed to Early Help Assessment	391	
Repeat contacts to social care within a year (of total contacts received in Triage/MASH)	2045 (35%)	3866 (42%)

from MASH to social care is improving and is starting to focus on appropriate cases.

The number of children subject to a Child Protection Plan by 31st March 2017 was 296. This was up 4% from the previous year.

Category	2015-16	2016-17
Average Number of children on CP plan at the end of March.	284	296
Average Number of Children on CIN plan		193
Average Number of other LA children on CP plan	17	24
Average Number of new section 47 investigations per month	50	37

Havering continues to have a high percentage of children subject to a Child Protection Plan under the category of Neglect 66.8% compared to English average of 44%. This may be due to Havering not using "Multiple" categories.

Timeliness

The number of case conferences being held within the required fifteen-day timeline has again increased to 65% increase from 58 per cent 2015-16. It is noted in the data that in Q3 the total reached 80 per cent.

Completion of assessments with 45 days is an area where Children Social Care whilst improving is still underperforming. By the end of March 2017, the figure was 63% up from 49% for the previous year. In Q1 Q2 the figure reached 86% and 83 % There are indications that at the latter end of the year the % was increasing, with 83% and 86% of assessments being completed within timescale this dropped back to 43% in Q4.

Once the process has commenced the timeliness of the review conferences continues to be very good remaining steady at 94%.

Board Challenge

- To continue to monitor and challenge timeliness.

86 per cent of active CPPs during 2015 – 16 had been in place for twelve months or less which indicates effective timely protection plans.

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.

Child in Need (CIN)

CIN plans have continued to increase over the year so at March 2017 there were 301 children subject to CIN plans an increase from the 267 as of Mach 2016. The ethnicity of the children has remained reasonable consistent with the pervious, white British children from 60% 10% Black African 5% Black Caribbean 5% Asian.

The percentage of CIN cases that are linked to the "Toxic Trio" (Mental Health, Domestic Violence and substance abuse), has remained static at 33%

10% of children with a CIN plan are disabled.

Children's Social Care

During 2015-16 Havering Children's Social Care under its new director formulated a new way of working.

The new *Face-to-Face* programme was launched in April 2016 and aimed to support practitioners to spend more time working directly to support children and their families in Havering.

To strengthen this programme HSCB supported the Local Authorities bid for government innovation funding. Havering Children's Services were successful in a bid to the Department for Education's Innovation Fund. Havering where awarded £2.4m over two years to fund a ground breaking new approach to working with children and young people. This investment will enable Havering to work closely with young people and co-produce a new delivery model in conjunction with a range of partners from the statutory and voluntary sector.

This investment will be used to develop services for young people Leaving Care and help to bridge the gap between Children's Services and Adult Social Care and ensure they have access to the best opportunities as they move away from the care system.

The programme will also allow us to share our approach to systemic practice with other agencies and foster carers, supporting a common evidence-based approach in our work with young people.
The Innovation and Improvement team (formerly the Transformation Team) will work alongside practitioners to deliver this innovative programme.

With the succession of the Innovation funding Havering now go ahead and define the programme with a plan to launch in September 2017. Havering are aiming to incorporate :-

- Face to Face Systemic training
- Systemic Fostering, working with a small cohort of carers 11-18yrs with complex needs with a supervised social worker.
- Group of foster carers will work together
- Strengthening the Leaving Care Service with an additional 6 practitioners to be recruited.
- Provide a much more effective service offer with regards to teenage pregnancy and mental health issues.
- Leaving Care Service, more support up to the age of 25yrs.
- Support young people with complex needs.
- Partners will be working with us to deliver the Innovation programme.
- See Change Film company on board to film young people about their experience whilst being in care.

As can be seen the funding will help to support the response to Ofsted.

Board Challenge

- To continue to monitor the funding usage and impact.

Staffing

One of the biggest risks identified by the board and which continued to be a challenge during 2016-17 was staffing.

The HSCB has during 2016/17 monitored the work force across the agencies. Agency staffing levels now form part of the HSCB data collection.

Social work staffing continues to be the most challenging with 30 % of the establishment covered by agency staff. However, there has been a significant increase in the number of case holding social workers from 79 at Q1 to 110 by the end of 2016/17. This is being monitored and managed by the Local Authority through its Recruitment and Retention Strategy. In response to increasing demand on the service the Local Authority has employed a further 24 agency staff over the agreed establishment.

This increase has been reflected in the average social worker case load which has decreased from 18 to 14 by the end of the year.

In respect of other agencies, the years saw an increase in the number of health visitors from 26 to 29 which is to be welcomed. Whilst the health visitor average case load is still high it has decreased from 821 to 727.

School nurse numbers have decreased by 1 from 16 to 15. Each school nurse has responsibility for 2-3 secondary schools and up to 9 primary schools. The service case load is 4464 which equates to an average case load of 281 for each school nurse. Up from 248 for the end of year 2015-16.

Board Challenge

- For the board to continue to seek information regarding workforce stability and assurance that staffing levels do 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.

Looked After Children		
As of end March	2016	2017
Total	229	248
In Borough	114	109
Out of Borough	110	131

Legal Status

There are a number of orders that can be applied for under the Children Act 1989.

- *Section 31 Full Care Order*
- *Section 38 Interim Care Order*
- *Section 20 Voluntary Agreement.*

Section 20 does not require a court order just agreement of a parent or guardian that the local authority can accommodate their child.

The use of section 20 still remains high. The use of section 20 will be subject of audit to ensure other forms of care order are not more appropriate for the LAC.

	S31 Care Order	S38 Interim Care Order	S20 Voluntary Accommodation	S21 Placement Order	
2014-2015	74 (31%)	26	115	17	
2015-2016	88 (39%)	28	96	18	
2016-2017	96 (39%)	35	101	17	

Placement Stability

Placement Stability meetings bring 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.

In most cases it is better to allow a LAC to remain in the local area. In some cases assessment, would indicate that movement away is the best option. The percentage of children now in a placement out of the borough has increased from 49% 2015-16 to 53% 2016-17. The percentage of those children that are in placement more than 20 miles from where they used to live has also slightly increased by 1% to 17%.

Of concern is the declining of percentage of children under 16 years of age who have been in the same placement for at least 2 years. That has reduced from 70% 2015-16 to 59% 2016-17 .In 2014-15 the percentage was 83% so the decline over a two year period is concerning. And has fallen below the national average of 68%.

Missing

LAC children represent a high number of the missing reports taken and LAC children are more likely to be vulnerable and at risk of CSE. The board required assurance that the response to missing children and LAC in particular was appropriate and effective.

Health

There is a statutory requirement for all children to undergo a health assessment within 20 working days of becoming 'Looked After'. Thereafter children under 5 require review health assessments every six months and over 5 require review health assessments annually. There is a slight reduction in percentage with up to date medicals decreasing from 91% to 88%.

Education

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.

Each LAC should have in place an up to date Personal Education Plan (PEP). This has improved over the year from 64% to 72% by the end of 2016-17. This needs to be maintained and improved.

Board Challenge

- To ensure LAC out of borough placements are appropriate and that the children are receiving good quality support

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

Young Carers

A young Carer is:

A person under 18 who provides or intends to provide care for another person (of any age, except where that care is provided for payment, pursuant to a contract or as voluntary work). This relates to care to any family member who is physically or mentally ill, frail, elderly, disabled or misuses of alcohol, or substances.

Section 96 of the Children and Families Act 2014

Young carers are in many cases a hidden group who are often hard to reach.

Havering during 2016-17 commissioned IMAGO Young Carers Service to support Havering's Young carers.

This service is currently supporting 80 Young Carers in Havering. A number are being supported also by social care:-

- Children Protection 9
- CIN 4
- Early Help *8
- Family Assessment 2

It is of note that 83% are caring for their mother. 30% are caring for an individual with a disability and 45% with a long-term condition. Up to 10 of the Young Carers are spending up to 45 hours a week caring.

There work with these young people are intended outcomes are:

1. Reducing impact of caring
2. Enjoying a life outside caring
3. Aspirations for, and achievement of their educational and employment potential
4. Increased confidence, self esteem
5. Remaining safe, healthy
6. Help young carers to better meet their own need.

The above starts to provide a picture of Young Carers in Havering. But there will also be many Young Carers hidden.

IMAGO have put on Chill Clubs to enable Young Carers to have a rest and provide them with fun and an opportunity to chill. They have also undertaken 9 drop in sessions at local schools.

It is still a new service but there is early signs of success. It has to acknowledge that funding is limited which impacts of the totality of the service that can be provided but it is making a difference, it is raising awareness and helping organisation to identify Young Carers.

Board Challenge

- To continue to monitor the impact of service.
- To listen to young carers.

Independent Reviewing Service (IRO)

Purpose of service and legal context

The Independent Review Officers (IRO) role is set within the framework of the IRO Handbook and the Care Planning Regulations. The responsibility of the IRO is management of the Review process which requires regular

monitoring between Reviews with young people, parents and professionals. The IRO has a key role on the scrutiny of Care Planning for Children Looked After (CLA) and for challenging drift and delay. Within Havering, the IRO function also encompasses children subject to Child protection plans (CPC) as they hold a mixed case load within both areas.

The Independent Reviewing Service falls under the Safeguarding and Service Standards Unit (SSSU) within Havering's Children and Young People Service (CYPS). The unit is based at Mercury House and direct line management for the IROs is undertaken by the SSSU Group manager (IRO manager), who in turn reports to the Principal Social Worker (PSW). The service has responsibility for independently chairing Looked after Children reviews (LAC) and Child Protection Conferences (CPC). All the IROs are experienced senior social workers/ managers and are registered with the Health & Care Professions Council (HCPC), and bring knowledge, expertise and practice awareness to strengthen the effectiveness of care planning.

The service is composed of 1 (FTE) Group Manager and 7 (FTE) IRO posts with an additional interim IRO post to meet service demand. Of the 7 FTE IRO posts, 4 are full time and the remainder work compressed or part time hours thus there are 9 staff undertaking IRO roles. There is also 1 FTE LADO officer 1 FTE IRO resigned from the service in March 2017 and there is a recruitment campaign in place to recruit to this post. The Group manager post was held by an interim consultant, but has now been permanently recruited to: started in post June 2017. Additional posts held under SSSU, and overseen by the PSW are 1.20 outcome and audit officers, 1 (FTE) senior administrator, 3 (FTE) CP and LAC administrators and 1 (FTE) finance and administrative officer. The line management regarding the administration posts will change following the consultation period for the service from June 2017.

In 2016/17, SSSU considered several actions as below. Whilst this was reviewed during 2016/17, it was updated to reflect the aspirations and ambitions we have following Ofsted 2016. The actions were:

IRO's:

- *Continue to implement an effective child protection conference service and delivering key statutory requirements:* IRO's have continued to develop and embed good practice. The use of signs of safety model within child protection meetings has been utilised to reflect not only risks, but also the strengths. Further training took place on the 21st April 2017 on how this model can be consistently used, understood and developed further.
- *Meaningful participation so voices of children and families are heard at the individual and service wide levels and inform service delivery and developments:* there has been stronger and wider discussion across the organisation to embed the use of MOMO within both LAC and CPC meetings. From March 2017, we have utilised a revised and SMART record of minutes and plans which would capture the child's voice, but also the parent's views.
- *Implement effective performance management arrangements to deliver a highly effective service:* there are clear and accountable process in place. Management oversight is more evident and frequent discussion takes place across of services to consider what has gone well, what needs to improve. There is a clear line of direction and practice requirement for practitioners in place

which feeds into better outcomes for children. These are age appropriate, understandable and represent what they want to change.

- *IRO's to ensure that children have emotional physical & legal permanence at first review:* this is discussed at the 2nd review (4 months), managed throughout the duration of their LAC journey. SMART minutes, plans and review of cases is taking place, but this remains an area for further development within 2017/18
- *Continue to monitor the quality of work by effective management oversight:* this is reflected in clear and robust supervision of cases with IRO's. Challenge and discussion is reflected in the child's records, but also relayed to parents and professionals,
- *Principal social worker, Group Manager and IRO's to lead with improved content and format of plans including modification to CCM:* there is ongoing review and discussion taking place about a new IT system. Part of the challenges is how we can adapt the plans, formats held on CCM. Some changes have been made, but there is a level of restriction on what we can achieve at this point pending a new IT system being confirmed.
- *Children in need of protection have clear effective and time-limited child protection plans:* improvements have been observed, but further work is required. Plans have been Quality assured in several cases and a revised template is now in use from March 17. However, plans are not always routinely SMART and can at times lead more towards case management or supervision, rather than be outlined. Additional challenges have been that plans are not always progressed in-between CP conferences or core groups, thus do not always reflect the most recent concerns. IROs will increase and record more frequently midway reviews. This remains an area of further review and investigation for 2017/18
- *Strive to ensure children are not made subject of Child Protection plans unnecessarily:* there is evidence this has taken place and IRO's are robust in terms of decision making and stepping down plans where appropriate. Support services such as early intervention is now in place, records reflect an overview of risk.

Recommendations for future development

During 2017/18, the Independent Reviewing Service will continue to focus upon the development of its quality assurance and practice development functions. This will include Specific, Measurable, Achievable, Realistic and Timely (SMART) outcomes so that we can measure the impact for children and young people. The Independent Reviewing Service will continue to work with young people and parents to seek feedback from them about the service we provided. This could take place after reviews or in the form of 360-degree feedback for PDRs. This feedback will enable us to improve the services we provide both within SSSU, but also to improve our effectiveness. The group manager will continue to regularly quality assure minutes and plans, observe IRO's and ensure the standards are maintained so that best practice is shared. SSSU has an updated service plan and information regarding leaflets on LAC and CPC's. This has been shared within the SSSU, but also the wider organisation. Peer and review evaluations will be explored with a (good) comparator to support further development of SSSU. Peer audits will triangulate with outcomes, performance data and feedback and establish a

stronger presence in planning and communication within the wider service. In 2017/18, there will be further team development days which will focused on developing the team identify and achievements.

Board Challenge

- To continue to monitor the impact of the IRO function.

Private Fostering

Private Fostering is still a major challenge. This was highlighted by Ofsted. The number of registered privately fostered children remains low, and has reduced over the past year 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.

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.

Child Sexual Exploitation and Missing Children

There have been significant developments of CSE during 2016/17, The Ofsted Inspection identified the following findings in relation to CSE:

"Children who are at risk of sexual exploitation, or who go missing from home or care, get the right help and this makes them safer".

Arrangements to tackle child sexual exploitation and cases of children going missing from home and care are prioritised, and most children receive a well-coordinated multi-agency response to their needs. The multi-agency sexual exploitation (MASE) meetings are purposeful and provide an effective framework to reduce risks. However, return home interviews are not always timely and some are not sufficiently thorough or analysed.

Child Sexual Exploitation is a key priority for the local authority and its partners. There is a good awareness of child sexual exploitation among family support workers and social workers, and the quality of practice appropriately safeguards the needs of children and young people. The local authority is refining the risk assessment tool to be more specific and to capture information more robustly. Mapping meetings for individual children ensure that information is shared effectively and there is a well - coordinated response to risk in most cases. In cases seen by inspectors, children at risk of sexual exploitation who are subject to child protection plans receive well-targeted help based on a thorough multi-agency understanding of risk.

A key priority area for the Borough is the improvement of the quality and frequency of the completion of return home interviews.

CSE Co-ordinator role (Strategic and Operational response)

In July 2016, it was recognised that a CSE Co-ordinator role was necessary to develop the Operational and Strategic response to CSE and Missing, this post was filled on the 1 August 2016 with the following priority areas:

- Coordinate the development and completion of a multi-agency Strategy document which

sets out the direction of travel for CSE and the focus areas for periods 2016-2018. In December 2016, the three year Strategy was ratified by the HSCB and can be found on the London Borough of Havering's LSCB website.

- Coordinate the development and completion of the multi-agency Missing protocol which sets out key guidance on how The London Borough of Havering and its partners seeks to operate in relation to children from home, care, education and those children who are placed within the Borough by other Local Authorities. In December 2016, when the missing protocol was ratified by the HSCB and can be found on the London Borough of Havering's LSCB website.
- The Strategic and Operational panels has been streamlined to improve the "joined up working and information sharing" across the forums.
- Training has been offered conducted for Havering staff on CSE, Missing and Return Home Interviews across Havering social care.
- Training has also been provided on CSE, Missing and Return Home Interviews for multi-agency staff during October 2016 safeguarding week.
- Police have offered training on CSE, Missing and Operation Makesafe to all Foster Carers in December 2016, this is due to be repeated and refreshed at the end of September 2017.
- A police and social care data set has been set out in draft format capturing information from January 2017. This data set is based on the recommendations of the University of Bedfordshire. This is a key focus area for the data analyst going forward.

Havering Professionals Forums

The following Havering professional's forum's takes place in Havering:

- **CSE Operational Panel** – This is a monthly meeting which considers all operational matters relating to CSE. This includes new case referrals for the month, a rolling review of opened cases, an analysis of emerging themes and patterns relating to locations of concern, people of concerns and perpetrators and impact on the safeguarding of associated children in Havering. The panel also considers what matters require referral to the MASE panel which is the Strategic mechanism for CSE. This panel also has standing agenda items on county lines, related panels e.g. Missing panels and Ending group violence panel. This is attended by keyworkers who are able to provide case information. This panel also seeks to ensure that key performance mechanism e.g. strategy meetings take pace and that there is good multi-agency attendance. Consultation on CSE cases is also available on a one-one basis across children's social care and related partners, so that there isn't a requirement to wait until the panel for a case discussion.

- **Missing panel** – This is a monthly multi-agency panel which reviews the children generating the highest number of missing episodes, those high risk cases where there are multiplies concerns i.e. Missing, County Lines, CSE, gangs; as well as any themes and patterns emerging from Return home interviews relating to concerning associated persons and locations of concern. The panel also considers any linked information from linked panels and considers whether specific

cases require referrals to strategic panel e.g. EYGV panel/MASE panel for a Borough wide response.

- **MASE Panel** – This is a monthly strategic panel which considers those cases where CSE, Missing and County Lines require a strategic response, where themes, patterns and locations of concern and persons of concern which require a multi-agency intervention and/disruption plans. This panel is attended by decision makers who are able to make onsite decisions on funding, specific multi-agency intervention plans for prevention, disruption and prosecution.

CSE Awareness Raising

- There has been a rolling plan of CSE Awareness across the Borough. The CSE Coordinator (Strategic and Operational) has provided briefings and training sessions for key staff areas e.g. YOT, social workers, family support workers. The Coordinator also acts as a point of contact for partner and external agencies seeking support on cases where CSE and missing are key issues. The below are some areas covered from August 2016 – current.
- Schools awareness raising : The Safer Neighbourhood Board and Community safety team in conjunction with MOPAC (Mayor's Office for Policing and crime) funded an awareness raising project through the Arc Theatre – Broadcast. This was offered to all Secondary schools in Havering to raise awareness on CSE, image sharing and the use of social media. This was done through two delivery streams and also included the delivery of a Junior Broadcast for Year six schools. Please see the attached report detailing the schools awareness raising (Havering Broadcast report Project Report: Winter 16/Spring 17 Tour and Havering Broadcast report spring 2017 tour).

Parents and Carers and Wider Community

- Senior member from Social care/Lead Counsellor and Police to raise awareness on Time FM. This was done by Superintendent John Ross and two Youth parliament representatives.
- Social media Campaign through the promotion of Havering Intranet, Web pages, and social media sites i.e. Twitter, Snapchat, Facebook.
- Local media: Communications department arranged for awareness raising through the Havering Living Magazine, Havering E-newsletter.
- Awareness raising in Key Forums e.g. LGBT Forum, BME Forum, Interfaith Forum, Corporate Parenting Panel.
- Briefing sessions have taken place for Senior leadership and key forums e.g. Corporate parenting panel (September 2016) and Inter-faith Forum (March 2017)
- Police from the Central policing partnership team have arranged to conduct briefings on CSE, Operation Makesafe and Missing for Safer neighbourhood staff in Havering in preparation for the summer holidays, this is due to take place on the 28 July 2017.
- Police from the Central policing partnership team are also due to deliver training to all foster carers at the end of September 2017, this is on CSE, Missing and Operation Makesafe with a particular focus on practical guidance on information gathering, reporting of incidents and information that police would require to locate children quicker.

Missing and Return Home Interviews:

The following mechanisms exist for the oversight and Borough response to Missing and Return Home interviews:

- Weekly missing data is produced (on a Monday and Friday) to identify those children that are missing weekly and over the weekends. This list serves as one of the triggers to identify those cases that require strategy meetings and planned multi-agency actions to find them, conduct return home interviews and plan for reducing missing and harm.
- Case consultations are held one a 1:1 basis for those cases where there is high risk, this would also involve attendance at high risk strategy meetings for individual and groups of children that have been missing or have multiple concerns were missing is a feature.
- Systemic consultation is also sought where there are particular blockages to service delivery and entrenched missing patterns.
- Monthly data is produced to identify high risk and high frequency missing children – these form the basis of discussions at the Missing panel – see point 1b above.
- Patterns and themes are identified i.e. teams where there are high missing episodes and requiring specific support in the completion of good quality Return home interviews.

Return Home interviews (RHI's)

This is an area of particular focus and the Borough recognises the requirement to improve the recording, quality and completion of RHI's across Early Help, Mash and Assessment and Intervention and Support services.

- The completion of RHI's is monitored by the Business Support team , the CSE and Missing Coordinator and Head of Service with a reminder and alert system built in for emails to be sent to staff where RHI's are required reminding them of timescales for completion. An escalation system has been built in for those RHI's that remain incomplete for Deputy Team Manager, Team Manager and Head of Service oversight.
- Team training sessions and briefings are regularly offered to all staff conducting Return home interviews to understand the whole missing episode e.g. How to prepare for a Return home interview from either receiving the police report identifying a child as missing, how to gather information from key people that may have seen the child before they went missing and may have key information on events/triggers that may have contributed to the missing episode, how to identify key patterns relating to County Lines, sexual/gang exploitation, perpetrators and associates.
- The completion of RHI's and analysis of information obtained from RHI's are regularly reviewed and analysed at strategy meetings, missing panels and associated panels where links are established.
- It is acknowledged that this is an area that requires continuing scrutiny and a high degree of focus from the different systems responding to return home interviews. It remains a high priority area and there continues to be robust

explorations of ways to improve the quality of return home interviews.

.Gangs and CSE Analyst

MOPAC funding (Mayor's office for Police and Crime) has been secured through the Community Safety unit for a Gangs and CSE analyst, this role is essential to identify themes, tracking of cases through the multi-agency data set and to contribute to the CSE problem profile. This role has been recently filled and the new post holder is going through a period of induction. This is an essential role and will add value to the delivery of services for CSE, Gangs and Missing children 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

The Early Help Service 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

Past year has seen the further developments of the service:

The Outcomes Star has now been embedded into the Early Help service and is utilised as the assessment and distance travelled tool for all families within the service to support with evidencing the progression and positive changes made by families.

The Outcomes Star is further being developed with partners via the North Locality Pilot, following on from Early Help having trained three train the trainers for the purpose.

The concept that the North Locality Pilot has been born from is based on the principle that services working with families could be more effective if there was a more integrated approach with closer collaboration. The aim is to deliver more effective, whole-family interventions, and try to provide the right support to families at the right time. Feedback from families is that the range of services can be confusing. There are numerous examples of families being referred from one service to another. The North Locality Pilot aims to provide a service to families that do not quite meet the threshold for intervention; we can work preventatively and avoid issues and problems becoming more serious and intractable.

Mentoring Service

A Mentoring Service has been developed within Early Help from March 2017. We have currently recruited and trained 17 Mentors all of which have been successfully matched to young people. There has been a vast demand for this service and as so we continue to recruit Volunteers for the purpose with the aim of reaching 30 mentors by April 2018.

Independent Visitors

In response to Ofsted the Independent Visitors (IV) service has been developed within Early Help. The deadline given for the launch of the IV's was September 2017, we have exceeded this target and currently have 7 young people matched with IVs. These are primarily young people who are UASC, placed out of borough or are not in contact with their parents. This therefore suggests that the service is being targeted appropriately. We currently have recruited and trained 13 IV's and therefore have capacity to continue to match young people.

Board Challenge

- To continue to monitor and be assured that early help is intervening at the earliest opportunity to improve the outcomes for children and their families.

Community Safety Team

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. The following is a summary of the current situation in Havering.

Violence against women and children

VAWG strategy: Significant progress has been made with the delivery of the VAWG Action Plan since the strategy was agreed in 2014, with a number of project actions completed and ongoing actions now implemented into business practice. The strategy is due to be updated for October 2017 and a timeline for this has been agreed.

VAWG support services: Havering Women's Aid is currently commissioned by Community Safety to provide the Domestic Violence Advocacy Project, the Domestic Violence Support Group and MENDAS – a support and advocacy project aimed specifically at male victims with a dedicated helpline. The projects are commissioned to run from April 2017 to March 2018.

Domestic Violence Champions Training: Over 60 practitioners have attended the Domestic Violence Champions Training. The Training aims to create a wider awareness of the referral pathways, an overview of the DASH RIC, and awareness of the different types of abuse. More training dates are being organised for the coming year.

DASH RIC Training: 32 people attended training on the Dash RIC assessment.

Child to Parent Violence Training : 40 people attended a workshop in March which focused on the effects of child to parent violence

Prevent

Through the Havering SCB training portal all Havering staff and agencies in Borough are offered Prevent Awareness Training. There were over 350 participants for this this training and over 95% felt the training met learning outcomes.

Community Safety Team co-ordinate and administer a number of risk panels. These include the Domestic Violence multi agency risk assessment conference (MARAC), the Community MARAC, Anti-Social Behaviour (ASB) panel, Serious Group Violence (SGV) Panel and the drug Intervention Panel (DIP).

A new local prevent group was set up with representation from key departments of the council as external partners such as health and the police

Child Sexual Exploitation

Broadcast is an interactive drama and multi-media programme funded by Havering Safer Neighbourhood Board, which toured five of the Borough's secondary schools from November 2016 to March 2017. The performance is tailored to make year 7 to 9 pupils awareness of sexting, cybercrime and other methods that are used regarding child sexual exploitation.

For 2017, Broadcast has been specially redeveloped in order to further develop the issues with secondary audiences. The programme consisted of an initial scripted scenario and interactive Forum Theatre workshop, combined with a Q&A discussion and PowerPoint Presentation with film clips. In total, 12 Broadcast sessions of up to 60-minutes each took place across five targeted secondary schools in the Borough, performing to approximately 1160 pupils in Years 7 to 9 (mixed gender)

Training

ASB: ASB Training has been provided by the Community Safety Team to Havering Police around the new legislation and in particular the usage of Community Protection Notices. Around 30 officers received training in a classroom setting and 1:1 training is still ongoing as and when officers require it.

Gangs Training: A total of 181 front line workers took part in gangs training in 2016-2017. Following the training 84% felt better equipped to identify individuals at risk or involved in gang activity. Going forward this year we are looking to target Teachers working within PRU's, workers in Children's Homes and Foster carers. This specific cohort has daily contact with individuals who are at greatest risk of being involved in/ at risk of being involved in gangs.

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PREVENT training: Through the Havering SCB training portal all Havering staff and agencies in Borough are offered Prevent Awareness Training. There were over 350 participants for this this training and over 95% felt the training met learning outcomes.

Good Practice

Junior Citizen: Junior Citizen is a personal safety awareness raising programme designed to help young children transitioning from primary to secondary school. This includes road safety, knives, illegal substances, fire safety, Street care and much more. This year 1800 year 6 pupils attended the 2 week long project from 28 schools. The event is sponsored by MOPAC and a receives contribution by MTR Crossrail

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Gangs Conference: Over the last 2 years Havering council has hosted an annual Gangs conference. This has helped to raise awareness of the issue and bring to light the dangers facing our young people in the Borough. This year's event which took place in February 2017 had a total of 150 frontline practitioners from both the public and private sectors attend the conference. The focus of the day was on gangs, knife crime and the overlap between missing persons, child sexual exploitation and county lines. Feedback from the event was extremely positive and very relevant to the local picture.

VAWG Conference: Over 100 people attended the VAWG Conference which took place on the 30 November 2016 at Taunton Hall. A variety of presentations were given ranging from Forced Marriage, The LGBT Domestic Abuse Partnership, and Helping Young People towards Respectful, Non-violent Relationships and the London Fire Brigade: Achieving White Ribbon Status. Plans are already in place for Havering's 2017 conference.

Child to Parent Violence Training : 40 people attended a workshop in March which focused on the effects of child to parent violence

Views of Children &Young People

Over the past year the board has continued to work with Children and Young People.

In May 2016 representatives from the Children in Care Council, the Youth Parliament and Young Carers gave a presentation to board members Panel.

This was followed up with a video made by the young people.

Their major involvement was in the work around transition and the Adult Safeguarding Adult Review. They provided feedback for the review and have presented their lived experiences at a number of events.

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

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

Case Review Working Group

The purpose of HSCB Case Review Working Group (CRWG), 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 local Learning and Improvement Framework supports the work of HSCB and its partners so that:

- reviews are conducted regularly, not only on cases which meet statutory criteria, but also on other cases which can provide useful insights into the way organisations are working together to safeguard and protect the welfare of children and this learning is actively shared with relevant agencies;
- reviews look at what happened in a case, and why, and what action will be taken to learn from the review findings;
- action results in lasting improvements to services which safeguard and promote the welfare of children and help protect them from harm; and
- there is transparency about the issues arising from individual cases and the actions which organisations are taking in response to them

The Local Framework covers the full range of reviews and audits including:

- Serious Case Reviews
- Safeguarding Adult 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.
- Management review of a Safeguarding adult incident which falls below the threshold of a SAR to provide useful insights about the way organisations work together to safeguard and promote the welfare of children.
- Oversight of the delivery of multi-agency dissemination of learning events to ensure that staff are made aware of key priorities identified within learning review processes

Key Areas of progress and achievement matched to business plan priorities to include Current activities and on-going work

Activity April 2016 to April 2017

- The group has met on three occasions throughout the reporting period when there has been a case referred for consideration for SCR or SAR. The group has considered four cases in total – two pertaining to a child / children and two pertaining to the care received by an adult.

Re Serious Case Reviews

- Of the two children's cases considered neither met the criteria for review. Of note, the non-statutory SAR considered the transition between children and adults services.

Long and short term risks and priorities

- The CRWG reported concerns to the Operational Board in relation to drift in the implementation of action plans developed following serious case reviews and learning reviews. This was addressed through the establishment of bi-annual Learning & Improvement Executive board which commenced September 2016.
- The purpose of these meetings is to ensure that each organisation is held to account for the way in which actions are implemented and how this has impacted on improved outcomes for service users.
- This transfer of responsibility has ensured appropriate senior organisational oversight of action plans and has enabled the CRWG to focus on it prime function of establishing whether a case has met the criteria for Review

How the work group utilised the views of children, young people, parents and carers

- Children, young people, parents, carers and adults with care and support needs are not actively involved in the CRWG processes. As part of consideration of whether a case has met the criteria for review, there will be consideration as to whether the voice of the child or adult is evident in the delivery of services.

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

- See section above regarding long and short term risks and priorities

Evidence that learning is being embedded

- The challenge for the Case Review Group and all partner agencies is to evidence the embedding of learning in practice. This is a priority for action in the coming year.

Serious Case Reviews.

Two serious case reviews have been progressed during 2016-17.

The overview report written in response to each review will be published once all processes have completed.

has impacted on improved outcomes for service users.

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"

Summary of 16/17 Child Death Overview Panel Report

Number of deaths recorded in 2016/17.
The Havering CDOP is aware of the deaths of twelve children and young people aged less than 18 years normally resident in the borough during 2016/17.

This included one death which occurred out of borough that was not reported to the Havering CDOP and was only identified by the end of year 'cross-check' against the ONS Primary Care Mortality Database. Further information is being sought to enable this death to be reviewed and understand why we were not advised of this death when it happened.

Twelve is more deaths than identified in 2015/16 (9) but well below the peak seen in the three years 2010 – 2013 when an average of 24 deaths were reported each year. There is currently no evidence to suggest that this is a significant adverse trend. Nonetheless surveillance will continue.

Number of deaths reviewed.
Eleven reviews were completed in 2016/17; 9 reviews were still outstanding, the oldest from 2015/16.

Description of cases

Age at death

Nearly 60% of all deaths occur in the first year of life; more than 40% within 4 weeks of birth.

Gender and Ethnicity

Interpretation of data regarding ethnicity and childhood deaths is problematic given the very small numbers involved. This said, a quarter of all deaths reviewed by CDOP were Black African children. Nationally Pakistani, Black Caribbean and Black African babies have the highest infant mortality rates which may be due to the fact that these ethnicities are more likely to live in a deprived area and more likely to have parents in a less advantaged socio-economic position.[1]

Category and prior expectation of death

About 60% of deaths were expected – i.e. death was deemed likely in the next 24 hour period. Expected deaths often resulted where a baby was born prematurely, with significant congenital anomalies or suffered from malignancy or a known life limiting condition.

Nonetheless about 40% of deaths were unexpected. Perinatal events and sudden unexpected death of older babies were the most common category of unexpected death.

Cause of death

Neonatal death or a known life limiting condition was recorded as cause of death in 2/3rds of cases.

The next most frequent cause of death was 'other' including 3 cases of infection / sepsis and Sudden Unexpected Death of an Infant (SUDI).

Deaths with modifiable factors

Modifiable factors i.e. factors that might be addressed to reduce the risk of recurrence were identified in 5 of the 24 cases reviewed over the 3 years. These cases involved lifestyle related risk factors and or improvements in clinical care.

Safeguarding issues

None of children considered by CDOP over the period 2014/15 to 2016/17 was the subject of a serious case review.

No deaths were categorised as deliberately inflicted injury, abuse or neglect.

The CDOP didn't identify safeguarding issues as a modifiable factor in any case.

Parental engagement

Parents continue to be sent a letter explaining the CDOP process and suggesting that they can contribute their views should they wish. For the first time in several years, parents have responded both to contribute to the process (x1) and to ask for assistance (x2) in securing more information about the circumstances of their child's death. In the former case, the CDOP chair and administrator met with a parent to understand their views so that they could be presented clearly to the Panel.

Progress with priorities from 15/16

- SUDI – Health Visiting and midwifery confirmed that advice given to parents complied with best practice.
- Sepsis – Both CCG and BHRUHT shared progress made with roll out of training and systems designed to monitor delivery of best practice.
- Smoking in pregnancy – LBH has commissioned stop smoking service for pregnant women and other residents in the same household.
- Coordination across wider foot print and better integration with CCG's clinical quality processes – in principle agreement from BHRCCGs and LSCB and CDOP chairs in all 3 boroughs. Meetings to discuss implementation have still to begin.

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

Whilst the CDOP aims to complete its work as quickly as possible there are often delays due to factors such as securing post-mortem reports. This leads to some death reviews not being completed in the year (financial) that they occur.

Nine new cases were reported in 2015/16. This is consistent with the previous year. Four cases were closed in 2015/16 only 2 of these deaths occurred in year. The remaining 7 deaths reported to CDOP in 2015/16 remain open.

Concerns have previously been raised that some deaths may not have been reported to the CDOP. However, an audit has shown that the CDOP process in Havering identified all deaths known to the ONS (Primary Care Mortality Database).

Due to the small numbers a view of deaths occurring over a 3 year period provides a better picture.

When considering deaths 2013 to 2016 a third of deaths occurred within a month of birth; a half within the first year of life.

70% concerned White British Children which is a similar proportion of White British children in Havering school.

For the purposes of CDOP, an unexpected death is defined as-

'the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death'.

The final decision lies with the Designated Paediatrician. Just under half of child deaths where unexpected during this period.

Number of expected and unexpected deaths by category of death

Neonatal death or a known life limiting condition was recorded as cause of death in 2/3rds of cases. The next most frequent cause was 'other' including 3 case of infection/sepsis and Sudden Unexpected Death of an Infant (SUDI). There was also 1 case of drowning and two deaths as a result of a traffic accident.

Safeguarding issues

None of children considered by CDOP over the period 2013/14 to 2015/16 was the subject of a serious case review.

No deaths were categorised as deliberately inflicted injury, abuse or neglect.

The CDOP didn't identify safeguarding issues as a modifiable factor in any case.

One child had been the subject of child protection arrangements at some point, but not at the time of their death.

Board Challenge

- To review the future arrangements of the CDOP in light of the recommendations in the Wood Review.
- To work with neighbouring boroughs and in order to provide a greater picture over and increased population size.

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"

This year has seen the appointment of a permanent Local Authority Designated Officer and a 28 hour Business Support post. The Group Manager for the Safeguarding & Service Standards unit has line management responsibility for the LADO.

The aim of the Local Authority Designated Officer service is to provide a knowledgeable and robust team that oversees allegations against people who work with children and therefore in a position of trust.

Over the past year the demands on the LADO role has continued to increase, this is a trend that has been seen nationally and also in line with the experience of Havering's neighbouring authorities.

Referrals to the LADO service have continued an upward trend, and in the 2016 - 2017 reporting year there were a total of 395 contacts to the LADO. There were a total of 226 contacts which met the threshold for a LADO enquiry and were converted into referrals. This is an increase of 23% on new referrals in the year 2015 – 2016 and 111% in contacts. Contacts continue to rise each quarter. Of the referrals received there was a total of 143 strategy meetings chaired by the LADO in this period.

The increase is believed in part to be a result of improved awareness of the LADO process, national awareness has increased due to Public Inquiries such as the Jimmy Saville inquiry as well as Operation Fremont which are large scale police investigations into non recent abuse allegations. The increase in organisations' and professionals' awareness of the LADO process has also brought an additional demand from agencies across the borough for training.

During 2016 - 17 the multi-agency training has been delivered via the LSCB training programme in addition to single-agency presentations. In this period the LADO identified a clear need to promote the LADO role borough-wide and support awareness particularly amongst smaller organisations.

The new training programme has specifically targeted dance and drama groups, faith groups and after school clubs to ensure that awareness of the process reaches as many of the smaller organisations as possible. Demand for the training to date has been so high that four extra training days have been put on to meet demand. The training and awareness raising during 2016 - 17 is likely to result in an ongoing increase in consultations and referrals to the LADO but will consequently improve practice in organisations and therefore provided greater safeguarding for children.

There has been a focus this year on joint working with stakeholders in the Local Authority. Regular tri borough meetings now take place between the L.B. Havering, L.B Barking and Dagenham, L.B. Redbridge LADOs and the BHRUT safeguarding leads at Queen's hospital, to explore any concerns or patterns in respect of local safeguarding issues.

Regular meetings also take place between the LADO and Education Safeguarding Lead to discuss any identified safeguarding issues within specific schools, or areas, themes which may have emerged or concerns shared. This enables targeted training to be put in place in order to address this or support specific schools.

A review was undertaken of the LADO forms. Following feedback by partner agencies an investigation guidance template has been designed following a request from education safeguarding leads. This is now sent out to all agencies that are required to undertake their own internal investigation.

The Havering LADO has been an active member of the London LADO group and has been involved in discussions regarding the Chapter 7 – Managing Allegations Procedures within the London Child Protection Procedures.

The data in the following report provides clear evidence of the increased change in demand on the LADO in this period, in relation to previous reporting years in Havering.

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.

During this 2016/17 there were a total of 59 courses scheduled with a total of 1326 places available. Of these places available, 905 participants attended courses equating to 69.4% of capacity reached. The non-attendance fee that was implemented during the year generated £560. This is £1200 less than last year, due to no doubt to delegates being more aware of the charging process.

Training Courses

During this period 21 separate courses were scheduled. Below is a breakdown of course attendance:

The most attended course was Introduction to Safeguarding with 80 delegates attending. This remains the only level one course offered by HSCB and is accessible to a much larger delegate base who maybe non-specialist frontline staff for example, GP receptionists to SENCOs who are in need of a refresher course. This course has become very popular with the Chaperone Service who are required to attend training before they can be employed.

Last year Effective Supervision was added to the training programme as one of the Board priorities but only achieved a 20% attendance rate. It is therefore heartening to see that this year 73 delegates attended as opposed to only 9 last year, particularly as this remains the only two day course run by HSCB and delegate availability is sometimes difficult.

Attendance by Organisation

Delegates from Education and Children Services attended the most courses with 14% and 31% of attendees respectively. This isn't to say that this is a proportionate representation; we could be seeing the same repeat candidates attending the courses. BHRUT, Housing, CCG and Probation had the least representation with less than 1%. Professionals from these agencies also attending safeguarding training internally, BHRUT provide extensive in-house training for all their staff that is scrutinised by the CCG to ensure it is compliant with intercollegiate guidance. In terms of the CCG, very few staff are patient facing and that is why they are under-represented in the training figures. For Health staff the designated professionals are required to be trained at level 5 which is higher than what is offered by HSCB. We recognise that they may feel the training is not suited to them.

Post Course Evaluations

Each candidate is required to complete the post-course evaluation 4-8 weeks post training to evaluate how the training has impacted the way in which they work with children and families. 35% of delegates completed evaluations for this period, compared to 22% of last year.

The completion of post course evaluations therefore remains a challenge and it might be worth considering carrying out ad hoc telephone evaluations. The evaluations that were

completed were positive with 40% of delegates stating that their knowledge had improved from some knowledge to a good level and 20% stating that their knowledge had progressed from good to high. 27% of delegates said that their knowledge remained the same.

Safeguarding Week

The first Annual Safeguarding Week took place in October 2016. The week consisted of 36 briefings ranging from 45 minutes to two hours and two annual all day conferences. The events, 17 for children and 14 for adults, provided safeguarding advice and awareness to professionals and those in the voluntary and faith sectors, working with both adults and children. Seven events were both children and adults focussed. The majority of events reached 80% capacity with five events being oversubscribed and overall feedback was good. Over 700 delegates attended throughout the week.

SECTION 3

Board Sub Groups

Quality and Effectiveness Working Group

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

CYP Quality & Effectiveness working group

The working group provides overview and scrutiny to the work undertaken by the HSCB partners to safeguard children within Havering. The objectives of the group as set out within the HSCB Business Plan 2015-2018 are:

- Monitor and analyse performance against defined HSCB targets and objectives utilising learning from key strategic drives including MASH, Early Help processes, Alcohol reduction strategy, HWBB, JSNA, CSP, VAWG strategy, Serious Youth Violence strategy, CSE strategy.
- Collate data to inform HSCB priorities.
- Monitor safeguarding practices and systems through an annual self-assessment audit of s11 (CA2004) compliance.
- Identify and provide robust evidence for performance improvement.
- Develop a multi-agency audit programme and undertake multi-agency audits and report findings to Havering LSCB.

- To receive reports on single agency audit activity and scrutinise findings.
- Report on the effectiveness of inter-agency working re safeguarding.

The Quality & Effectiveness working group has been extremely active in promoting the objectives identified above. A highlight of the group's activity is set out below:

Audits completed by multi-agency partners:

- CSE audit following the peer review: the findings from this supported the direction of CSE activity within Havering
- LAC missing audit as previously discussed.
- MASH multi-agency audit

Some observations / questions from the audit activity were:

- Is feedback sent to the referrer and is this recorded? CSC noted that feedback had been given however for the two cases where the GP had completed the MARF, CCG noted that feedback had not been received.
- There was no evidence of the outcome of the referral being fed back to the referrer or Partners.
- There wasn't clear evidence of the threshold document being applied to evidence decision making / feedback to partners.
- SW making the MASH decision and Group Manager reviewing Discussions between the Managers and Social Workers are not always clearly recorded even though they are taking place.

The audit of MASH was undertaken prior to changes that were made to MASH processes following the lean review and the subsequent MASH review. The audit was a helpful benchmark to assist the partnership to better understand the impact of changes made within MASH on improved processes when delivering services and working effectively with partners. A further audit of MASH to include the uptake and application of threshold when referring cases to MASH will be undertaken in September 2016

Group activity

A dataset workshop was held in December 2015 and a HSCB dataset was agreed by the partnership: this will be implemented in April 2016 and reported biannually. All partners have agreed to contribute to the agreed performance pack. The Q&E group will oversee implementation of this and ensure all agencies provide data as required.

The group has focussed on Child Protection processes and how best to ensure the correct practitioners attend conferences and core groups to ensure that all information known about the child is discussed, and that professionals do not attend with little knowledge of the family. This continues to be a focus for the group and updates are provided by NELFT and the Principal Social Worker regarding the impact on improved outcomes in relation to changes made.

Self-Harm has been an area of scrutiny for the group: The group requested BHRUT provide information regarding children and young people that present to A&E with symptoms of self-harm. This is on-going and is being progressed by BHRUT and CCG.

LAC children medicals has identified as a risk and action to address this is being led by CCG with support from C&YP services

Priority areas for the group over the next six months

Develop and agree an audit programme for 2016-17 that is achievable and is focused on the key priorities of the HSCB in order to support the Board to understand the effectiveness of the partnership in safeguarding children and young people.

To continue to oversee the effectiveness of CP processes, identifying areas of strength and areas that require change / further scrutiny to improve the process so that it is meaningful and effective.

To receive and analyse data in relation to safeguarding and report to the Board regarding the effectiveness of the partnership in safeguarding children and young people in Havering

To progress the actions identified within the HSCB action plan 2016-17 on behalf of the HSCB Executive.

Three positive achievements since last report.

- New HSCB dataset agreed
- Health participation within CP processes streamlined
- Performance reports and data used to challenge and support partners in improving safeguarding processes. This has included A&E activity and LAC health assessments.

Long and short term risks and priorities

The group is extremely busy with all delegates balancing competing work pressures and demands. In order for the group to be effective, the work plan must be achievable and focused on themes that will provide meaningful and relevant information to partners in order to assist to understand the impact of services on outcomes. Once agreed, partners must commit time and resources to progressing the audit programme

- The revised HSCB dataset will require information from all partners to ensure that the data agreed as relevant and necessary by partners is submitted in a format that can be understood with clear narrative to assist the group to understand and analyse the information.
- Balancing national and local priorities in an environment that can at times be politically driven, so that any change in direction is not reactive but considered and thought through.

Future actions to address these

- The work plan will contain four multi-agency audits plus one audit that is longitudinal to follow families through child protection processes. This will be embedded within usual business processes of organisations to limit the impact of additional workloads.
- Open and transparent discussion will assist to identify gaps or pressures that may impact on the timely submission of data so that action can be taken to address this in a timely way.

- The group must be led by the Operational and Executive Boards whilst reporting information to assist the board to agree the direction of travel. Emerging themes and priorities must be considered by the Executive and Operational to reduce the likelihood of the group reviewing vast amounts, which may reduce the level of positive impact on the outputs from the group.

Transitions sub group

The Transitions sub group supports both the HSAB and HSCB. The role and purpose of the group is to review current children to adult services transitions policies and procedures in health and local authority services and to audit compliance with existing policies and procedures, highlighting and sharing good practice initiatives and to disseminate learning from policy and practice reviews. The group is chaired by a member of NELFT's SMT and the vice chair is from the London Borough of Havering (Community Safety Team Leader).

In February 2017, the group organised a major Child to Adult Transition conference. Young people from the Sycamore Trust (a charity that aims to educate the community and empower individuals affected by Autistic Spectrum Disorders and/or Learning Difficulties) gave first-hand experience of the strengths and weaknesses of the support they received at various points of transition including primary education, secondary education, further education, employment and independent living. In addition, presentations by practitioners covered current legislation, policies and guidance that related to transition and workshops explored improvements that could be made around: how partners and agencies work together to improve transition, transition and safeguarding and involving service users effectively in making meaningful transitions. This event will be built on by the HSAB in 2017-18, with a major event on a similar theme planned for May 2017.

Board Governance and structure and finance

Governance

The HSCB is chaired by an Independent Chair; the appointment was made by a panel of HSCB members, which was chaired by the Chief Executive. The Independent Chair holds regular meetings with the Lead Member for Children Safeguarding, the Chief Executive and the Director of Children, Adults and Housing. The purpose of each meeting is to hold the Independent Chair to account for the effectiveness of the HSCB and to provide space to ensure open and honest discourse between the Director of Children Services and the Independent Chair regarding the service activity as it relates to children's safeguarding within Havering.

The Nurse Director, Barking & Dagenham, Havering & Redbridge CCG is Vice Chair to Havering SCB; regular discussion is held between the Independent Chair and the Vice Chair.

All statutory partners are represented at the HSCB at an appropriate level and actively participate within the business of the Board.. There has been difficulty in securing / maintaining regular attendance from NHS England and CAFCAS. The impact of this has

meant strategic insight in to NHS England priorities and direction of travel specifically in relation to GPs is missing from Board discussion. CAFCAS is significant because of its work with the most vulnerable children within Havering and the knowledge it holds from both local and national perspective.

The structure of Havering's SCB was reviewed during 2015 in order to strengthen governance processes to support the Board to manage business priorities more effectively as the Board's responsibilities increased.

Structure

Executive Board

The Executive Board is chaired by the Independent chair; it has a small membership consisting of the strategic leads from all statutory partners and holds ultimate responsibility for the effectiveness of the multi-agency safeguarding offer to children and young people in Havering.

The Executive Board formally agrees

- Business priorities of the board and the business plan
- The annual report
- Final overview reports and recommendations from SCRs
- Action plans to respond to SCR / LR recommendations
- Actions to respond to Board risks and the responsible working group / partner organisation to progress the actions.

Operational Board

The Operational Board is chaired by the Independent Chair and has senior staff with links to practice within the membership. All members actively participate within the discussions and this is evidenced within minutes of meetings. The Operational Board's agenda includes both children and adult priorities to ensure that cross cutting priorities are considered by both strategic boards.

The Operational Board is in place to provide overview and scrutiny of the progress of HSCB / SAB Business plan priorities and to provide assurance to the SA / SC Executive Boards in relation to the progress of business plan objectives. Concerns that are identified by the Operational board and HSCB working groups in relation to the effectiveness of the safeguarding offer are added to the HSCB /SAB risk register, monitored by the Operational and reported to the Executive Boards.

Progress of the HSCB action plan is monitored by the Operational Board. The Operational Board drafts the Executive Board agenda to ensure that it is appropriately focused on relevant areas of business.

Operational Board minutes are circulated to Executive Board to allow for scrutiny and challenge of business activities.

Working group activity is overseen by the Operational group

Quality & Effectiveness working group

The Q&E group is chaired by a member of NELFT's SMT and all organisations except CAIT are represented. All members participate fully within meetings, identifying areas of risk and areas that require further scrutiny. These are progressed by the group and also raised at the Operational / Executive level

Case Review working group

The Case Review Working group is chaired by a member of NELFT's SMT and all partner organisations are represented at the meetings.

The group has considered and progressed SCRs and LR and overseen the implementation of action plans. Drift in progress of actions has been escalated to the Executive and a decision made for the Executive leads to hold responsibility for the progression and implementation of action plans.

Child Sexual Exploitation working group

This group is chaired by the Director of Children and Young People Services and has representation from all key partners who actively participate within discussion and decision making.

HSCB Risk Register

The HSCB risk register holds the areas identified by the Board as requiring oversight in order to progress actions quickly to reduce risks. The risk register is owned by the Executive and activity progressed through the working groups and operational board. The risk register is rag rated to include impact of activities agreed to mitigate risk and is a standing agenda item at every HSCB group meeting and is used by the Independent chair to inform discussions held with the lead member and meetings with senior strategic leads from the partnership.

Annual report

The HSCB publishes an annual report. The report is presented to the Havering Health & Well Being Board and Overview and Scrutiny by the Independent Chair. The report is sent electronically to MOPAC, Chief Executive and London Councils and held on the HSCB website.

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 deterring 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 2015/16 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 15/16
Havering Council	£121,640.00
Police	£5,000.00
London Fire Brigade	£500
CCG	£28,706.49
BHRUT	£4,778.33
NELFT	£4,778.33
National Probation Service	£800
The London Rehabilitation Company	£1000.00
CAFCASS	£567.13
Total	**£167, 465.30**

The projected contributions from partner agencies total £167,465.30. This budget excludes the additional contribution required to

finance The Child Death Overview Panel (CDOP) statutory requirements. The CDOP was 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 £10,000.

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.

APPENDIX

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 2016 to 2017

Havering Clinical Commissioning Group (CCG)

Brief summary of service as it relates to safeguarding children: Havering Clinical Commissioning Group (CCG) is part of Barking & Dagenham, Havering and Redbridge Clinical Commissioning Group Conglomerate – BHR CCGs
Havering CCG commissions services for children within Havering through children health services providers namely BHRUT and NELFT. Havering CCG places safeguarding children high on the board agenda and this is reflected within the structures and roles and responsibility of senior staff. The CCG safeguarding structure is established across Barking, Havering and Redbridge BHR CCGs where the CCG Accountable Officer has overall responsibility for safeguarding within BHR CCGs Governing Body

The safeguarding accountabilities are discharged through the delegation of responsibilities to the Board Nurse Director and is supported by the Deputy Nurse Director. The Chief Operating Officer (COO) within each CCG is the operational lead for ensuring implementation of safeguarding functions supported by the CCG designated professionals for safeguarding. For Havering CCG a Designated Nurse and a Designated Doctor for safeguarding children have been appointed to provide a strategic and professional lead on all aspects of the health service contributing to safeguarding children across the health economy in Havering.

Review of Safeguarding Activity 2016-17

- Recruitment to the vacant post of Designated Nurse for Safeguarding Children and Looked After Children (previously separate roles for safeguarding and LAC)
- Development and implementation of a safeguarding children supervision policy

- Development of a domestic abuse policy
- Refresh of the safeguarding children and adults strategy 2017-2020
- Working closely with to local authority to improve the timescales and quality of initial health assessments for looked after children
- Implementation of a safeguarding children allegations against staff policy
- Development of a PREVENT policy

Individual agency responses to key risks and priorities

Please identify the specific contributions that your agency has made to the priorities below and explain how you know that the work that your agency is doing is effective.

Workforce and staff sufficiency	There was a service review of the safeguarding team within the CCG which resulted in combining the safeguarding and LAC functions into one role. The post was recruited to in January 2017 and the post holder commenced in May 2017. The post is a statutory function as outlined in the intercollegiate guidance 2014.
Inter-agency thresholds and escalation of decision making	The LSCB has an escalation policy in place which requires the multiagency to escalate to the CCG cases of concern. Work has been undertaken in partnership with providers to enable data collection around case escalation.
Private Fostering	Plans are underway to address the issue of private fostering at the Havering safeguarding GP forum in July 2017.
Child Sexual Exploitation	The Designated Nurse for safeguarding children attends the CSE and Missing panels to influence the delivery on the CSE agenda from a strategic and operational point of view. BHR CCGs has an identified CSE champion.
Violence against women and girls	The CCG has developed a domestic abuse policy for their workforce and is actively engaging with the VAWG work-stream.
Child and adolescent mental health.	The CCG is currently undertaking a CAMHS transformation program of work to ensure that mental health services for children and young people is fit for purpose, safe and effective.
Learning from SCRS	The CCG has engaged with partners to ensure that there has been the necessary participation in serious case reviews and their learning events. Updates on outstanding action plans are monitored via the CQRM platform to ensure scrutiny. The CCG has also engaged with primary care to share the learning from serious case reviews.

Identify the expected impact on outcomes of the agency responses to the key risks and priorities.

Impact outcomes Within your agency	The safeguarding team is currently in the process of refreshing the safeguarding strategy to strengthen the embedding of safeguarding into the commissioning cycle. It is anticipated that this will lead to increased assurance that commissioned services are safe and effective.
Contribution to multi-agency working	A number of HSCB work-streams have not had representation by the CCG due to vacant posts and capacity issues. However, since the recruitment of a substantive designated nurse, these work-streams are now covered to further build upon multiagency working.

Example of Effective/Emerging Practice

The implementation of the CP-YP system within the local authority and provider organisations.

Metropolitan Police

Brief summary of service as it relates to safeguarding children

The Metropolitan Police Service (MPS) has a dedicated Sexual Offences, Exploitation, Child Abuse Command (SOECAC). The local CAIT team (covering Barking & Dagenham and Havering) is managed by Detective Inspector Kevin Jeffery. The Borough Commander for the local police is T/Chief Superintendent Sean Wilson.

Operationally each part of SOECAC still functions within their area of expertise but they are merged within supporting units (partnership, intelligence, continuous improvement teams (CIT) & proactivity).

Within the broad functions of crime prevention, crime detection and assistance provided for risk assessments, Child Abuse Investigation Teams have several distinct functions. Whatever the function, the basic principle: **'THE WELFARE OF THE CHILD IS PARAMOUNT'** is always the primary consideration in any decision made or action undertaken.

All allegations of crime within the scope of 'child abuse' (victims under 18) are recorded & investigated in co-operation with Local Authorities and other appropriate agencies: **Intra-familial abuse**, **Professional abuse, Other carers**, **Non recent allegations, Parental Abduction and SUDI investigations.**

Children at risk of significant harm are identified by police officers through robust risk assessments and reports from Children's Social Care. Risks for children living within domestic violence households are reduced and minimised as Police have a good awareness of the impact this has on the emotional well- being of children.

Joint investigations undertaken by the CAIT and Children's Social Care are underpinned by strong working relationships between both agencies. Strategy discussions are timely and actions match the risk accordingly.

CAIT attendance and contribution to Initial Child Protection Conferences (ICPC) and Review Case Conferences (RCC) ensures risks are identified and responded to immediately.

All CAIT staff are required to complete the Specialist Child Abuse Investigators Development Programme (SCAIDP) and Achieving Best Evidence (ABE) training.

The local borough police for Barking and Dagenham have the responsibility for identifying and reporting Child Sexual Exploitation (CSE).

Review of Safeguarding Activity

The MPS has standing operating procedures that dictate how officers and police staff should deal with safeguarding concerns.

Barking & Dagenham CAIT and borough police have 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.

Borough police have a Multi- Agency Sexual Exploitation (MASE) meeting every month to discuss all new cases on a monthly basis with all agencies represented. Borough police are also part of the Multi Agency Safeguarding Hub (MASH), which is the front door for all children safeguarding issues for the borough.

How has the organisation contributed to the Havering SCB vision statement and strategic aims

The MPS work in close partnership with social services, exchanging information to improve and protect children within the borough. CAIT officers are trained to a high standard with personalised training packages. Police proactively act on referrals to police to intervene at the earliest opportunity and attend all meetings in line with safeguarding policies and working together agreement 2015.

Long and short term risks and priorities

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 Barking & Dagenham and Havering CAIT has catered for this by utilising police officers & civil investigators working on attachment. 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 and staff workloads increase.

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

The key area for CAIT is to develop case conferencing by video / telephone link 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.

Under the One Met Model (OMM) from 27th March 2017 police units are being brought under one unit called, Safeguarding, East Area, Basic Command Unit. This will consist of three boroughs, Barking & Dagenham, Havering and Redbridge. CAIT, Sapphire (adult rapes), Domestic Abuse teams, CAIT referrals, MASH and Mispers will sit in one team. There will be a total of four Investigation teams, each team responsibility sitting with a Detective Inspector and consisting of three Domestic Abuse Teams, one Sapphire Team and one CAIT. This is in its infancy stage and will evolve to provide a new service having a front door for all crimes.

Effective/Emerging Practice

The new Pathfinder site of the OMM has been in operation since 27th March 2017 and still in its infancy stage. This is going to be reviewed in September 2017.

Barking Havering and Redbridge University Hospital Trust (BHRUT)

Brief summary of service as it relates to safeguarding children:

Barking, Havering & Redbridge University Hospitals NHS Trust (BHRUT) is an acute hospital Trust situated in the North East of London. The Trust serves the London Boroughs of Barking and Dagenham, Havering and Redbridge and the county of Essex. The Trust serves a demographically diverse population of around 750,000 in outer North East London of people from a wide range of social and ethnic groups. This consists of Barking and Dagenham 202,000, Havering 249,100 and Redbridge 296,800.

The Trust meets all 8 standards of Section 11 Children's Act (2004). In this reporting period the Trust completed a Self-Assessment Audit Tool to for a neighbouring Local Safeguarding Children's Board to demonstrate its commitment in meeting statutory requirements. The item rag rated as amber below, Standard Three relates to a protocol which is awaiting publication by Havering LSCB. The Trust awaits receipt of this protocol. The Trust last completed and submitted a Section 11 Self-Assessment to Havering Local Safeguarding Children's Board in August 2016.

Standard	Description	RAG
1	Senior Management commitment to the importance of safeguarding and promoting children's welfare	Green – Actions Completed
2	Clear statement of the agency responsibility towards children and this is available to all staff	Green –Actions Completed
3	A clear line of accountability within the organisation for work on safeguarding and promoting welfare and is informed, where appropriate, by the views of children and families	Amber – Action in progress. A protocol is awaiting publication by Havering LSCB relating to a SCR
4	Service development takes into account the views of children and families	Green –Actions Completed

5	Effectiveness of Training	**Green –Actions Completed**
6	Safer Recruitment	**Green –Actions Completed**
7	Multi –Agency Working	**Green –Actions Completed**
8	Effective Information Sharing	**Green –Actions Completed**

Review of Safeguarding Activity 2016-2017

Safeguarding Children priorities are highlighted in the BHRUT Safeguarding Children Annual Report 2016/17. BHRUT has an overarching Safeguarding Children Strategy 2016-2018. Progress on the strategy is discussed quarterly at the Trust's Safeguarding Strategic and Assurance Group. In 2016/17, the key priorities were as identified below. The Safeguarding Children team achieved all key priorities identified within the 2017 strategy objectives.

- Continue to provide safeguarding training through all levels (1, 2 & 3) of safeguarding children's training
- Safeguarding children supervision training will be provided to identified staff and supervision will be cascaded across the Trust by Named Safeguarding Professionals and supported by trained Safeguarding Children Supervisors who have undertaken a formal supervision programme
- Safeguarding children and maternity audits will continue quarterly to include audits within Maternity, Emergency Department, Human Resources, Sexual Health and Paediatrics. Learning will be disseminated as a result of the audits and practice change will be embedded
- Obtaining the 'Voice of the child' in addition to the Trust Family and Friends questionnaire
- Implement a daily planner for children with autism and learning disabilities to provide a structure of what to expect while in hospital
- Increase awareness of autism across the organisation
- The Trust will continue to work with all partner agencies to ensure the needs and welfare of children and young people are met
- The Trust will continue to fulfil its duties under Section 11 of the children Act 2004 and demonstrate it by reviewing the Section 11 audit tool across all three boroughs
- Ensure that the recommendations arising from the Lampard review are fully implemented and embedded locally
- Maintain a focus on Child Sexual Exploitation, Female Genital Mutilation, Modern Day Slavery, Human Trafficking, Forced Marriage and PREVENT
- Ensure the Trust is compliant with safer recruitment processes, particularly around external contractors
- Implement the Child Protection Information Sharing system (CP-IS)
- Continue to fulfil statutory requirements to participate in multi-agency case reviews, serious case reviews, as identified by the respective safeguarding boards and also to Domestic

Homicide Reviews (DHR) as Identified by the Home Office and Community Safety Partnership Trusts

- Continue to raise awareness of and ensure robust arrangements are developed and in place, to address the risk of harm associated with both national and local issues such as human trafficking, child sexual exploitation, missing children, radicalisation of vulnerable individuals, female genital mutilation and domestic abuse

How has your agency utilised the views of children, young people, parents and carers to improve services?

At the point of discharge, children/young people/parents are given a questionnaire to complete which includes the Friends & Family Test question. The Paediatric Department has established two meetings every month at which children, young people and parents/carers are invited to review/develop information leaflets. Concerns, areas for development and issues are also raised by children/parents at this meeting.

The Trust obtains the views of children, young people, parents and carers via the 'Voice of the Child' surveys which are undertaken as per the Trust's Safeguarding audit schedule. Children, young people, parents and carers are encouraged to raise any unmet needs with their named nurse, ward manager, matron or medical staff, or the PALS and/or Complaints teams if local resolution fails. Every opportunity is taken to resolve immediately anything that is raised. All meetings are documented in the child's health care records with the resolution plan. All patient feedback is acted upon and staff are briefed weekly through the ward safety brief of any concerns or changes in practice to improve patient outcomes. In 2017/18 the Child Health Division is establishing a Children and Young Peoples Trust Operational Group and a Strategy Group, to shape the future of the children's services within the Trust.

How has the organisation contributed to the Havering SCB vision statement and strategic aims?

Vision Statement

- Keeping children and young people safe is the Havering Safeguarding Children's Board overarching priority. All partnership agencies are committed to raising safeguarding standards and improving outcomes for all the children and young people of Havering.
- The Chief Nurse is a member of tri-borough LSCB's. Divisional representatives are members of all Trust safeguarding groups.
- The Named Nurse, Safeguarding Children is an active member of the Havering Quality and Effectiveness meeting and Case Review Working Group, and attends/supports Multi Agency Sexual Exploitation meetings, Local Authority Designated Officer (LADO) meetings. The Safeguarding Advisor for Learning Disabilities and Autism is a representative of Havering Positive Parents Group. The Named Doctor for Child Protection, Paediatric Liaison Nurse, and Deputy Named Midwife attend Child Death Overview Panel Meetings.

- The Trust participated in Havering LSCB Audit programme in the reporting period of 2016-2017. The Trust also undertook all audits as identified within the Trusts Audit schedule in 2016-2017 and findings were reported to Havering LSCB via the Havering Multi Agency Audit Tracker.
- The Trust has actively participated in 1 Practitioner Learning Event relating to a Havering Serious Case Review (publication outstanding), and an additional Serious Case Review (Embargoed during this reporting period).
- Learning from Incidents/Practice/Serious Case Reviews/Domestic Homicide Reviews are shared with staff at the Trust's Safeguarding Children Operational Group and Strategic and Assurance Group meetings, Patient Safety Summits, Supervision and Bulletins.

Six Strategic Aims

Ensure that the partnership provides an effective child protection service to all children and young people ensuring that all statutory functions are completed to the highest standards.

Section 11 audits serve as a benchmark to ensure the highest standards are met in providing an effective safeguarding services. The Trust has completed in this reporting period a Self-Assessment Tool to demonstrate its commitment in meeting statutory requirements as set out within Children's Act (2004). The Trust has an action plan in place to progress an item relating to imbedding a protocol when published by Havering LSCB.

Monitor the effectiveness of the multi-agency early offer to help to children and young people in Havering.

The Trust actively monitors the number of pre-CAF requests made to the London Borough of Havering, and this is included within the Trust's monthly dashboard. Performance data is discussed at the Trust's Safeguarding Children Operational Group and risks reported to the quarterly Safeguarding Strategic and Assurance Group. The Safeguarding team regularly promote the HSCB Threshold and Assessment Protocol with staff during contact and supervision. This protocol is accessible on the Trust's intranet for all staff to access.

Ensure that agencies work together to provide the most vulnerable children and young people with the correct help at the right time.

The Trust actively supports the LSCB Sub-groups to ensure all children are effectively safeguarded. The Trust supports the following HSCB Sub-Groups meetings:

- Safeguarding Children Operational Board
- Multi Agency Sexual Exploitation Group
- Child Death Overview Panel
- Violence against Women and Girls
- Quality and Effectiveness Working Group
- Case Review Working Groups

- Positive Parents
- Team Around the Family Meetings
- Serious Case Review/ Domestic Homicide Review Panel meetings
- Local Authority Designated Officer (LADO) Strategy meetings

Ensuring an integrated multi-agency approach to respond to emerging themes and priorities. Identified by the Board and through national learning.

The Trust has a Safeguarding Children and Adults Amalgamated Serious Case Review/ Safeguarding Adult Review/Case Learning Review Action Plan. Reports are provided to the Safeguarding Children Operational Group, Safeguarding Strategic and Assurance Group and Part 2 of the Trust Board (Confidential).

Assuring the quality of safeguarding and child protection to the wider community.

The Trust utilises the Section 11 Audit Tool as a framework for quality assurance. The tool is shared with the CCG at CQRM meetings, and all action plans pertaining to the tool are discussed with relevant LSCB. The Trust last submitted a Section 11 Tool to Havering LSCB in August 2016.

Ensure that learning is acted upon and embedded in practice across all partner organisations.

The Named Nurse, Safeguarding Children is a member of the Havering Case Review Working Group and attends quarterly meetings in conjunction with Serious Case Review Panel meetings. The Deputy Chief Nurse, Safeguarding and Harm Free Care also supports attendance at Serious Case Review (SCR) Panel meetings.

Regular reports relating to Serious Case Reviews, Domestic Homicide Review (DHR) /Case Learning Reviews (CLR) are presented and discussed at the Safeguarding Children Operational Group, Safeguarding Strategic and Assurance Group and Trust Board (Part 2).

In addition to this, since August 2016 Safeguarding Children cases are presented for discussion at the Trust's monthly Safeguarding Children's Operational Group meeting. This is followed by the Trust wide circulation of a Safeguarding Bulletin which shares the lessons learnt and good practice of safeguarding cases/incidents.

Individual agency responses to key risks and priorities.

Please identify the specific contributions that your agency has made to the priorities below and explain how you know that the work that your agency is doing is effective.

Workforce and staff sufficiency	**The Safeguarding Children's Team was fully established during the reporting period, and comprises of:**

	• Named Doctor for Safeguarding Children (3 PAs) • Named Nurse for Safeguarding Children (1.0 WTE) • Deputy Named Midwife, Safeguarding (1.0 WTE) • Two Paediatric Liaison Nurses, Safeguarding Children (2.0 WTE) • Safeguarding Children's Advisor, Learning Disability and Autism (1.0 WTE) • Safeguarding Children's Secretary (1.0 WTE) **In July 2016, following the completion and approval of a Safeguarding Business Case, the Deputy Chief Nurse, Safeguarding and Harm Free Care, has progressed the appointment of a number of new posts:** • Emergency Department Safeguarding Advisors (2.0 WTE) Queen's and King George Hospitals • Safeguarding Advisor for Harmful Practices (FGM, CSE, Domestic Abuse) (1.0 WTE) **As of 31 March 2017 recruitment into the following posts remains in progress:** • Named Midwife, Safeguarding (1.0 WTE) • Safeguarding Office Manager (1.0 WTE) **The Deputy Chief Nurse line manages the Named Nurse for Safeguarding Children, on behalf of the Chief Nurse who has executive responsibility for safeguarding.**
Inter-agency thresholds and escalation of decision making	The Safeguarding Team regularly cascaded information relating to Havering Safeguarding Children Board Threshold and Assessment Protocol. This document is accessible to all staff via the Trust Intranet. This material is also promoted with staff at supervision.
Private Fostering	The Safeguarding Team regularly cascaded information relating to Private Fostering and all Havering Safeguarding Children's Board 9HSCB) promotional material i.e. 60 Second Guide etc is available on the Trust Intranet Web-site and is accessible to all staff. This material is also promoted with staff at supervision and is included within safeguarding training.

Child Sexual Exploitation	The Trust's Named Nurse, Safeguarding Children is the Trust Champion for Child Sexual Exploitation. The Trust continues to have quarterly CSE/FGM Lead meetings to advance this agenda. In this reporting period partnership working was strengthened by including the Havering Domestic Violence /VAWG Officer and the Havering Strategic Lead for CSE and Missing at meetings. Child Sexual Exploitation awareness is incorporated within the level 1, 2 and 3 Safeguarding Children training programmes. All staff have access to the Trust's Intranet Child Sexual Exploitation webpage, which contains key information relating to this subject. The Trust's Named Nurse, Safeguarding Children supports information sharing/attendance at tri-borough Multi Agency Sexual Exploitation (MASE) meetings for children identified at risk of CSE. The Trust has endorsed the Pan London Child Sexual Exploitation Operating Protocol (March 2015 2nd Edition) during this reporting period and has a Child Sexual Exploitation Policy in place since October 2016. CSE referrals are discussed at the Trust's Safeguarding Children's Operational and Safeguarding Strategic and Assurance Groups. The Safeguarding Team have appointed a Harmful Practices Advised following a successful business case in June 2016. This post holder will advance this agenda in 2017/18.
Violence against women and girls	The Trust continues to have the support of the Independent Domestic Violence Advisor (IDVA) who works across sites at King George and Queen's Hospitals to provide domestic violence and abuse (DV) support and advice to patients and staff affected by DV. The post is funded by the Mayor's Office Policy and Crime (MOPAC) and the Trust is in its second year of the agreed contract. The Trust representative at Violence against Women and Children Strategic Group is the Deputy Named Midwife. The IDVA has regular input at DV training, which aims to raise awareness of the impact of DV not just on the person directly affected but also on the children and young people in the family; and of the

	services that are in place to support families. The IDVA takes direct referrals from staff by email or phone and makes initial contact with a client within 24 hours but can attend a clinical area in case of immediate need. Community Midwives continue to represent the Trust at the monthly Tri-Borough Multi-Agency Risk Assessment Conferences (MARAC), to ensure that information about cases of high risk domestic violence are safely and effectively shared to ensure services users are protected and measures put in place to safeguard. All women who book for antenatal care are offered 'time to talk' alone to discuss confidential matters which provides an opportunity for Midwives to ask about domestic violence and abuse. An audit undertaken on DV presented at the Safeguarding Children Operational Group in this reporting period identified that the compliance with DV enquiry at booking, had increased from 94% in March 2016 to 98% in 2017.
Child and adolescent mental health.	In this reporting period the trust undertook two audits relating to Self-Harm. Audit findings were shared with Havering Quality and Effectiveness Group. i. **Audit to assess compliance with the Clinical Care Pathway for Management for Children presenting to the Emergency Department.** This audit demonstrated that improvement and excellent progress was achieved in managing children presenting in the emergency departments following the introduction of the new clinical care pathway in 2014. The audit showed that there was collaborative working of various teams involved in care provision as well as excellent compliance with the new clinical care pathway for managing children with mental health illness in the emergency departments at Queens's hospital. i. **Audit to assess compliance with the Clinical Care Pathway for Children who Self-Harm and live in the London Borough of Havering**

	This audit identified that in the reporting period 2015-2016 30% children who attended the Emergency Departments at BHRUT with self-harm presentations resided in Havering. The audit demonstrated that the Voice of the Child was captured in all cases and the age varied from 12-17 years. The most common age ground was 15 years. All children were referred as per the Clinical Care Pathway to Mental Health Services, followed by a referral to Children's Social Care. The Trust supports sharing information with Havering Quality and Effectiveness Group relating to the number of Children presenting to Emergency Departments to support Havering's dataset
Learning from SCRS	Learning lessons from Serious Case Reviews and safeguarding children cases is undertaken in a number of forums which include the Trust Safeguarding Children Operational Group and Safeguarding Strategic and Assurance Groups. Shared learning also takes place at the Trust's, multi-professional Patient Safety Summits.

Identify the expected impact on outcomes of the agency responses to the key risks and priorities.

Impact outcomes Within your agency	**The key Risks identified in this reporting period included** **Risk Number 746 –** Availability and Access to Child Safeguarding Information. The Trust implemented the Child Protection Information Sharing System (CP-IS) in October 2016. This now enables staff in unscheduled care settings to be able to identify those children identified as vulnerable by Social Services, if they attend unscheduled care settings. The impact of this is increased awareness of children subject to Child Protection Plans. **Risk Number 543** – Safeguarding Training Compliance. This was an identified risk during this reporting period to ensure that the Trust was meeting the key performance Indicator of 85%. This risk was removed as the workforce achieved the key performance indicator in September 2016. **Risk Number 859 –** Named Professionals, i.e. Named Nurse

	Safeguarding Children, Named Midwife and Paediatric Liaison Nurse, not showing visible presence in clinical areas supporting staff. This remains an identified risk as of 31st March 2017 In July 2016 , following the completion and approval of a Safeguarding Business Case, the Deputy Chief Nurse, Safeguarding and Harm Free Care, has progressed the appointment of a number of new posts: • Emergency Department Safeguarding Advisors (2.0 WTE) , Queen's and King George Hospitals • Safeguarding Advisor for Harmful Practices (FGM, CSE, Domestic Abuse) (1.0 WTE) As of 31 March 2017 recruitment into the following posts remains in progress: • Named Midwife, Safeguarding (1.0 WTE) • Safeguarding Office Manager (1.0 WTE) It is anticipated that when the team is fully established the workforce will become more visible internally and externally and proactively drive the agenda forward.
	Risk 944 – Safeguarding Children Supervision. This risk was identified in this reporting period that the trust was not meeting its key performance indicator of 85% In response to this, the Trust established a Task and Finish Group and revised its Safeguarding Supervision Policy to incorporate a training needs analysis to identify and clarify the requirement of key staff. The Trust has developed a detailed action plan outlining the actions to strengthen supervision in 2017/18.
Contribution to multi-agency working	In 2017-2018 some of the Key Priorities to multi-agency working include • Continue to review Section 11 (Children's Act 1989/2004) requirements to ensure the Trust fulfils its responsibilities for Safeguarding Children • Share learning from Serious Case Reviews/Case Learning Reviews/Domestic Homicide Reviews, and evaluate the learning from monthly Safeguarding Bulletins • Embed Safeguarding Children Supervision across the organisation • Improve the Protection and Support of Children who are at risk of, or who have been, sexually exploited, and strengthen our work

	promoting a "Think Family" approach in identifying Child Sexual Exploitation (CSE) and Deliberate Self-Harm (DSH) • Improve the protection and support of children at risk of Harmful Practices, e.g. Female Genital Mutilation (FGM) and those living with Domestic Violence (DV) • Strengthen the Safeguarding of Children with Disabilities • Improve Operational Governance of Child Safeguarding Practice in Maternity and Sexual Health Services (CASH) to improve the quality of referrals made to Children's Social Care and other Safeguarding Documentation • Promote awareness of Neglect and its relationship to other forms of harm to ensure better outcomes for children • Promote awareness of Private Fostering • Promote awareness of the Paediatric Liaison Nurse roles and develop an internal and external resource for staff/public • Review the scope of the project for the CP-IS system within the Maternity department.

Example of Effective/Emerging Practice

In this reporting period the Trust implemented the Child Protection Information System (CP-IS) in unscheduled care settings. This has enabled all staff in unscheduled care settings to see whether :

- An unborn is the subject of a Child Protection Plan (CPP)
- A child requiring treatment has a Child Protection Plan (CPP)
- A child is a Looked After Child (LAC), regardless of where they live in England

On 24 February 2017, the Trust underwent a review of the effectiveness of CP-IS by the CP-IS Benefits Realisation Team NHS England. The purpose of this review was to understand the impact CP-IS was having on frontline staff and whether CP-IS benefits have been realised for the organisation. The findings identified that the business change process for implementing CP-IS was making good progress in becoming embedded within the existing safeguarding process and was working well in Emergency Departments and Paediatric areas. There were four recommendations arising from the review which the Corporate Safeguarding Team have actioned.

Children & Family Court Advisory & Support Service (CAFCASS)

CAFCASS (the Children and Family Court Advisory and Support Service) is a non-departmental public body sponsored by the Ministry of Justice. CAFCASS represents children in family court cases, ensuring that children's voices are heard and decisions are taken in their best interests.

The demand on CAFCASS services grew once again in 2016/17, by around 13% in public law (involving the local authority) and 9% in private law (involving arrangements for children following parental separation). Demand is now approximately 30% higher in public law, and 20% higher in private law, than it was three years ago, putting the family justice system under considerable pressure. Nonetheless, each of CAFCASS Key Performance Indicators has been met.

CAFCASS main priorities in 2016/17 were to continue to improve the quality of our work, and to support family justice reform. These are a few examples of how we have done this:

Production of the **Domestic Abuse Practice Pathway** which provides a structured framework for assessing cases where domestic abuse is a feature, and ten new evidence-based assessment tools.

A revised **Quality Assurance and Impact Framework**, together with mechanisms to establish, and raise, the quality of our work including thematic audits, Area Quality Reviews, and the work of the National Improvement Service.

Provision of continuous **Learning and Development** opportunities for staff including: e-learning; Research in Practice resources, the CAFCASS library and the dissemination of internal research.

Contributions to **innovations** and **family justice reform**, designed to improve children's outcomes and make family justice more efficient. These are formed in private law by projects trialling pre-court or out-of-court ways of resolving disputes; and in public law projects aimed at helping local authorities and parents to 'find common ground', thus diverting cases from or expediting cases within, care proceedings.

Support to our **child exploitation** and **diversity** ambassadors/champions who collate learning from inside and outside the organisation on these subjects and promote it to colleagues.

The CAFCASS **research programme** which supports the work of external researchers, such as the ground-breaking work of Professor Karen Broadhurst and her team into repeat removals from mothers in care proceedings; and undertakes four small-scale internal research projects each year. This year we have undertaken, for example, studies into: domestic abuse in spend-time-

with (contact) applications (this has been in collaboration with Women's Aid); trafficking and radicalisation cases known to us; and high conflict (rule 16.4) cases.

Havering Young Offender Service (YOS)

The Youth Offending Service (YOS) is a key partner in ensuring the safety of children and young people in Havering; specifically those children who find themselves involved in the Criminal Justice System. Havering YOS supports young people to desist from offending as its primary function, and we assess and monitor any young person's risk and vulnerability when they become known to us. Within this process, we ensure their safeguarding both in terms of understanding what is going on within their family dynamic, and also what their movements are when they are at school, in the community and with friends.

The Youth Offending sits in Early Help within the wider Children and Young People's Services. The YOS is also overseen directly by central government in the wake of the Crime and Disorder Act 1998. The overseeing body are the YJB, and our inspecting body is Her Majesty's Inspectorate of Probation. The focus of all YOS' has been designed by the YJB to support an offender-focussed desistance programme. However, after the Charlie Taylor review of 2016, Havering YOS is beginning to review how its focus on offender-led assessments and interventions can also include whole-family-led assessments and interventions. We hope that this will significantly improve the way we safeguard and interact with young people as our work will include looking at young people's family history and any familial factors which contribute to their offending behaviour.

The YOS joint works with children open to children's services and the bridges being built between services is encouraging. Under LASPO 2012 every young person who is remanded automatically becomes looked after, and we have worked closely on many occasions with our partners in social care to deliver joint-working to aid the effective use of time in prison, and also re-settlement as well. This arrangement promotes the safeguarding of children and young people who commit the most serious crimes.

Havering YOS practitioners complete a holistic assessment of the young person, including their state of mind, learning needs, drug and alcohol use, family background living arrangements, the risk they pose in the community, and how vulnerable they are. We establish this assessment of need using the multi-agency team that has been developed since the Crime and Disorder Act 1998 made the YOS a legal entity. Havering YOS ask our expert seconded staff to complete the relevant parts of the Asset Plus assessment overseen centrally by the YJB. As such every young person who becomes known to our service will receive an assessment from our CAMHS nurse, Speech and Language Therapist and Drug and Alcohol worker. This ensures we allow experts in

their field support us to complete a correct assessment and safeguard appropriately as a result; tailoring interventions around each individual young person.

After assessing a young person and understanding the factors which impact their safety, we look to intervene swiftly and with purpose to ensure the continued safety of young people with often complex needs. For those who pose the highest risk in the community or are highly vulnerable we hold risk/vulnerability management panels. These are multi-agency panels where all agencies involved in the young person and family's life are invited to contribute to a holistic, whole family, multi-agency plan going forward. This is to ensure that we minimise duplication and have clear roles and responsibilities for all agencies involved. This significantly informs our plan of action to safeguard that young person and how to support their family.

Recognise achievements and the progress that has been made in the local authority area as well as providing a realistic assessment of the challenges that still remain.

YOS practitioners are highly trained individuals in supporting young people to desist from offending, and due to the multi-agency nature of our service; we prioritise what will be best for the young person in desisting from offending going forward. If we are concerned regarding their safety, our first port of call would be to ensure, if there isn't already, social care are involved where appropriate. If we are concerned about a facet of their personhood that requires a referral, the YOS practitioners would refer as needed to joint work with another professional. This is a key way that the YOS safeguards young people – we ensure the right professionals are involved at the right time, to ensure the right intervention when it is needed most.

Havering YOS has a complex cohort of young people who can need intensive intervention. Because of gang affiliation, county lines drug running, and Child Sexual Exploitation concerns Havering YOS has trained its entire staff in CSE and also in how to deliver work with young people who display sexually harmful behaviour (AIM2 training). YOS is represented at the CSE and missing panel, as well as on the oversight body for that panel, the MASE. Havering YOS has looked to ensure both front-line and strategic aspects of its vision has incorporated the focus on CSE. We often see CSE as a symptom of something else – trafficking, gang affiliation or drug-running. As such the YOS is a key partner in understanding the wider implications of CSE, and the associations it has with other risk-taking behaviour.

Havering YOS has also taken into account the need to further understand neglect in light of the JTAI announced by Ofsted. We have incorporated practice development in team meetings to ensure our staff understand the effects of neglect, but also the cumulative factors that can build to causing a child significant harm without the intervention of the appropriate professionals. We have completed a review of assessments and added questions into supervision to ensure neglect is being accurately identified and understood as a key safeguarding concern, but also a cause of offending behaviour.

Havering YOS has also identified and prioritised parenting support as a key way of ensuring adequate safeguarding of children in our service. We have, as part of our Youth Justice Plan, a focus on ensuring Parenting Orders are sought in Court to ensure parents/carers are held to account for their children's behaviour where they are seeking to minimise their involvement as parents/carers. YOS parenting is linked closely with parenting in Early Help to support a preventative agenda in how we deliver parenting as well – working well with parents/carers on a voluntary basis to ensure the co-production of a safeguarding plan with the family.

As part of Havering YOS' assessment, we require the young person and the parents/carers to complete a self-assessment that is integrated into the assessment completed by our multi-agency staff, thus gathering their views and perspectives with regard to how they perceive themselves, their/their child's offending behaviour, and also what the positive aspects are in the family's life that it is important to build on. This impacts the way in which we will assess and intervene in a young person/family's life, and we value the voices of the family, who we consider to be an expert in their own life.

Havering YOS also asks for feedback from young people and their parent/carer during their Order and after their Order is finished. Traditionally this is done using Viewpoint. We also ask parents/carers and young people to complete updates on their self-assessments going forward through their Order so we have an accurate portrayal of how they feel they are progressing. We need to get better at using this information to inform how we deliver services and intervene going forward, and this is something Havering YOS is aware of and needs to be kept accountable for by the relevant governance.

It's important to note here, as well, that due to the above working patterns we are seeing a reduction in First Time Entrants (FTEs) and also re-offending.

We still have several areas of challenge. The first is continue to invest in our relationships between services to ensure good outcomes for our young people. In feedback from the YOS staff, we are still experiencing a need to improve co-ordination when several agencies have assessments open at the same time. We regularly experience young people who are in the midst of crisis and have two, sometimes three assessments open to different agencies including the YOS, and this needs to be addressed going forward. This will also feed into the evidence to support a locality model of delivery, and also supporting the YOS into more holistic and family-led work.

Demonstrate the extent to which the functions of the LSCB as set out in Working Together are being effectively discharged. This should include assessments of policies and procedures to keep children safe, including:

Havering YOS complies with the policies and procedures for the safer recruitment of all members of staff, including appropriate vetting of all staff including staff from other agencies. DBS checks are completed by HR, but we request to see DBS checks and have end dates of DBS checks as a standard template question in our supervision notes. For all our seconded staff from

other agencies we request to see DBS checks as part of the vetting process and are involved in interviewing our seconded staff with their home agency. For our commissioned contractors for the Junior Attendance Centre and our gangs mentoring project, we vet all staff that have direct contact with children and insist on seeing DBS checks for any other sub-contracted professional or mentor.

All staff have had the appropriate level of safeguarding training, and those who need a re-fresher course are all booked on for October's LSCB training. All YOS staff have also completed the following training. Restorative Justice, AIM2 assessment training, Good Lives training and desistance training. In addition, all YOS staff have had at least level 1 gangs training (delivered in house) and four of the six front line staff have had level 2 training. All YOS staff have received the in-house CSE training as well, and two members of staff have had externally delivered training in supporting children who are domestically violent towards their parents.

The YOS has a very clear process for stepping up cases to MASH if we feel a child is suffering significant harm and at risk of/suffering abuse. Havering YOS regularly steps up cases to MASH and the need for a clear, concise and swift response to our step-ups is fed-back to social workers dealing with our concerns. The relationship between YOS and MASH/assessment is improving, although we will need to continue building relationships and communication lines between agencies to ensure we implement fully learning from previous child deaths.

Havering YOS is fully aware of the priority issues within Havering Local Authority and by the Youth Justice Board. We are in attendance at the CSE and Missing panel, as well as at the steering group for that panel, and have a say in the strategic development of tacking CSE in the borough. All our staff present cases where needed to the CSE panel and are all aware of the need to include risk of CSE in assessments – particularly with regard to the welfare of the young person – but also the impact on their likelihood of re-offending. Havering YOS also delivers group work for female offenders which covers topics such as self-esteem, putting yourself at risk and healthy boundaries in relationships.

Include a clear account of progress that has been made in implementing actions from individual Serious Case Reviews / Learning Reviews (SCRs/ LRs) completed during the year in question, plans to evaluate the impact of these actions and to monitor how these improvements are being sustained over time. This also applies to SCRs commissioned in previous years where any actions remained outstanding at the start of the reporting year.

This was the addressed learning for the YOS from the learning review for Child LS.

Theme from Learning reviews for child **LS** Evidence required from **CSC, Police, YOS** **RISK ASSESSMENTS IN RELATION TO BAIL ADDRESSES**			
Havering YOS ensure that whenever a bail address is proposed and they are in	Tim Churchward		Currently the process regarding the servicing of Youth Courts still falls short of this type of hearing. If a young offender

Court a thorough address check is undertaken. The issue of young people appearing in out of borough Courts and on non-youth Court days is still an issue.	Tim Churchward		appears on a non-youth court date currently there is the potential for bail addresses to be proposed at Court without contact with the home YOS. The current guidance to magistrates and legal advisors is that they should ask the PLO at Court to check the suitability of the address. This would however only check the address for known perpetrators and would not involve a wider check. **Update CR WG 4th July 2016** AP to request an update from Jonathan Taylor: this was requested on 12.07.16

Havering YOS has ensured whenever a bail address is proposed in Court we have a Police check done on the residence to ensure we know who lives there and if any red flags come up for the address. The further conversations to be had in this arena are when the YOS and social care have different views on an appropriate placement for bail. The YOS has also fed back to the Court users group regarding youths appearing on non-youth Court days – however as explained in the LSCB notes above, we are reliant on the magistrates and legal system to support us in this. All has been fed back to magistrates via the Court Clerk in charge of the Court users group meeting.

The above actions have been completed and the YOS was informed the learning we received from this review has been evidenced and action as requested.

Havering College of Further and Higher Education

Safeguarding and promoting the welfare of children is defined in the Department for Education's Information for Schools and College Staff. Part 1 of Keeping Children Safe in Education 2016 states that:

> *"Safeguarding and promoting the welfare of children is **everyone's** responsibility"* and that…*"they should consider, at all times, what is in the **best interests** of the child".*

KCSiE 2016 also states that schools and colleges are responsible for:
…*"protecting children from maltreatment; preventing impairment of children's health or development; ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and taking action to enable all children to have the best outcomes"*

Havering College aims to ensure that all learners, wherever possible, achieve their learning goals and are not disadvantaged by barriers to learning such as financial, personal, health or social circumstances.

Review of Safeguarding Activity 2016-17

Please see attached Safeguarding and Prevent Action Plan for information regarding what Havering College of Further and Higher Education has done in terms of our safeguarding priorities and the manner in which we have utilised the views of learners and appropriate others.

Havering College has contributed to the Havering SCB vision statement and strategic aims in the following ways:

Ensuring that all staff receive regular safeguarding training by attending in house training and appropriate external training offered by the local authority, regional and national bodies. Training attended includes:

- Optimus Safeguarding Conferences: Practical Strategies for Safeguarding in Schools, Mental Health & Online Safety
- NSPCC 2 day Safeguarding Training (Safeguarding Lead)
- Supporting Students with Caring Responsibilities
- Impact of Domestic Abuse
- Achieving Better Outcomes for the Child
- Modern Day Slavery

Training is cascaded through Safeguarding Team Meetings and Staff Development Training days. 98% of staff are up to date with compulsory Safeguarding Training; this figure is not 100% due to the outstanding 2% being hourly paid staff or long term leave. 93% of staff have attended workshops to raise awareness of Prevent (WRAP); further details on Safeguarding & Prevent Action Plan. The Safeguarding Team and Senior Managers are level 3 trained. Local authority school/college nurses have attended all three campuses and offered support for learners.

Timely interventions are made with regards to safeguarding concerns and all cases of alleged abuse are referred in accordance with the college Safeguarding Policy and Child Protection and "at risk" Adults' Policy. Eleven referrals were made to relevant boroughs in this academic year; 2 domestic abuse, 2 family difficulties and drug abuse, 3 Foundation Skills learners (ill-health concern and 2 inappropriate relationships), 3 inappropriate social media activity and 1 case of neglect. All cases were actioned by Social Services effectively. PEP meetings and professionals meetings have also been attended, as required, ensuring maximum support is available and

prompt action is taken. Records are kept and shared according to the Information Sharing Protocol, enabling us to monitor effectiveness of interventions and outcomes for young people and "at risk adults". The college is represented on the Children`s and Adults Safeguarding Operational Board and the Havering Mental Health Partnership Board. The college also has three college representatives who attend the Tri-borough SGV monthly meetings.

Good practice is shared through the schools and colleges Pastoral/Behaviour and Attendance Partnership (BAP) and effective communication is maintained with the Education Inclusion and Support Service to try and ensure that Looked After children receive personal education plan (*PEP*) meetings to help track and promote their achievements. All Looked After Children (LAC) have a key worker in the college who monitors and ensures that all LAC receive help as required and receive their entitlements. Of the 46 Looked After Children attending the college in 2016/17, 21 reside in Havering with 18 out of the 21 completing their course.

Individual agency responses to key risks and priorities:

On line safety continues to be a concern. The college has now contracted E-safe to continue with the Forensic Monitoring service next academic year. The service was introduced with the intention of safeguarding learners against the more unsavoury risks posed by online interactions. Designed to fulfil the legal obligations under the Prevent Duty and Ofsted`s Safeguarding Children and Young People Policy, e safe protects users by monitoring keystrokes as they are entered and imagery as it is accessed. Designated staff in Estates and Student Services receive daily encrypted reports via e mail and telephone calls are received if the company detect serious incidents.

Learners are not always aware of the danger they are placing themselves in. Cases this year have included sexual exploitation and we have worked with the Borough Child Sexual Exploitation staff and police, both of whom have come into the college to meet with students. Grooming was also detected and interventions made to safeguard all learners involved.

247 safeguarding related tutorials were delivered this academic year and in total 3138 learners attended these tutorials. We will continue to prioritise this throughout the next academic year.

Mental ill-health amongst our learners is also of concern. 16 Student Services staff who attended a two day training course in Mental Health First Aid have been cascading the training to teaching and support staff from November 2015. To date, 54% of staff total have received this training. The training is now compulsory for teaching staff due to concerns raised at portfolio meetings regarding the increasing numbers of students presenting with mental ill-health. The college promoted National Mental Health Awareness Week with displays, activities, leaflets and tutorials.

395 counselling sessions delivered over the 2016-17 academic year and a total of 201 learners with complex issues were intensively supported by Student Services staff. Out of 597 learners who received financial assistance from the 16-19 Bursary Fund, 93% were retained and able to complete their course.

Referrals from the Student Services Team, including the counsellors, this year have included Addaction, East London Rape Crises Centre, Havering Talking Therapies (IAPT), Children and Adolescents Mental Health Services (CAMHS), Social Service, Multi Agency Safeguarding Hub, Havering Disability Team, Tavistock Gender Identity Clinic, Paul Hannaford Drugs Service, Havering PASC, Alone in London, Havering Carers, Havering MIND and Havering Recovery Community.

Concerns around possible gang affiliation and pressures on young men are a concern and the counselling service has been focussing on breaking down the stigma of males accessing emotional support at our Construction Site on the Rainham Campus.

Ardleigh Green campus ran a weekly Anxiety Support Group during lunch breaks. This group has had positive outcomes for learners who attend enabling them to deal with their anger and stress more effectively thus removing barriers to learning and improving overall behaviour.

Ensuring that we have effective Learner Voice mechanisms in place is a priority for the college. Learner's views on safeguarding are collected in a number of ways including Student Academic representative's (StARs) events, which includes a Made a Difference Conference and 3 other major events. The Students' Union also collect learner's views throughout the year but particularly during Learner Voice Week. 7 learners were trained as Peer Advice Leaders (PALs) offering other learners the opportunity to seek out their help or advice on any issues of concern. Other activities include forums, surveys and feedback/evaluation forms. Learner views fed back to Senior Managers via the Learner Voice Committee, Student Governors Committee and the Equality and Diversity Committee with responses recorded and fed back as appropriate.

The College will continue to prioritise Safeguarding and Prevent throughout the 2017-18 academic year.

Example of Effective/Emerging Practice

E-safe has proved a very effective method to monitor learners' online activity and further ensure their safety. This system has also proved to be an effective way of learners flagging up their need for support. The sensitivity of the system picks up key words and due to all learners being aware of e-safe, there has been incidents where learners have typed in text related to emotional difficulties and overwhelming feelings, knowing this would be picked up and individual support given. This gives our learners another way of receiving help by removing potential barriers with approaching staff for support.

Havering Housing Services

Introduction

This update has been pulled together with the view that Housing Services, as a service area within the London Borough of Havering, is a service area within the wider corporate partner status that the Council has on Havering's Safeguarding Children Board.

Referrals

As a service area, our officers will refer any cases or concerns involving the children of our residents as and when these arise. Our frontline officers have a very visible presence within the community and any concerns they raise is made through our dedicated Housing MASH Link Officer. The Housing MASH Link Officer reports on a weekly basis back to our Tenancy Sustainment Management and will feedback directly to officers about the progression of any cases that have been referred.

Training

Housing Services officers regularly undertake safeguarding training (covering both children and adults). There are also opportunities available to participate in online training activities which staff are encouraged to complete. Training sessions have included for example, Self-neglect, Hoarding and Private Fostering.

Contribution

Since March 2017, managers from Housing Services Tenancy Sustainment team meet regularly with Children Services' Leaving Care team. Housing Services is acutely aware of the difficulties that some young people may face when leaving care and making that transition towards an independent adult life, especially when facing the challenge of looking after themselves and the responsibilities of running their own home for the first time.

The meeting provides Housing Services with an opportunity to gauge the support needs of young care leavers in need of social housing; to scope the appropriate level of support they need through the first stage of becoming a secure council tenant – during that initial Introductory (probationary) period of their tenancy. Through working closely with young people from the outset, we are encouraging long-term independence and tenancy sustainment.