Local Safeguarding Children Board

Hammersmith & Fulham | Kensington and Chelsea | Westminster

ANNUAL REPORT

2016 / 2017

FOREWORD BY LSCB INDEPENDENT CHAIR

It is a great honour and privilege to be able to introduce myself as the new Chair for the LSCB. I took up the post as from May 2017. I am thrilled to have been appointed into this role and very much look forward to progressing the important work described in the report, as well as supporting the work outlined under our new priorities for the future.

The work outlined in this report took place before my appointment and was led by the previous chair, Jean Daintith. The report provides an overview of the activities of the LSCB, including the programme of work developed in response to the latest successful OFSTED inspection. I convey enormous thanks to Jean Daintith for her excellent leadership of the board and for the comprehensive work achieved.

Shortly after my appointment, the tragic fire happened at Grenfell Tower. This meant that the following, immediate focus of the work of the board was placed on ensuring that partner agencies were supported in safeguarding all those affected. This, rightly, became the utmost and essential priority.

In addition to this ongoing work, the activities for 2017 to 2018 will focus on reviewing and consolidating the work of the LSCB sub–groups and on creating a programme of activities planned to address our two new main priorities: 'Domestic abuse and coercive control' and 'Peer on Peer abuse'. Following an assessment of all of our work, these two priorities were recognised as having significant impact on a number of children, their families and carers.

This prioritised programme of work will develop over the next two years, aiming to enhance partnership arrangements on service development, delivery and training. Alongside this, it is my specific aim to enhance the engagement of children and young people within all activities of the LSCB, supporting the process of accessing, listening and responding to the child and young person's voice in safeguarding matters.

A number of learning events and engagement activities will take place throughout the next two years to ensure that all ongoing work of the board is consultative and fully engages with all partners; is focused on the specific priorities as they are determined; will be flexible and open to new emerging issues and proprieties if and when they occur and will maintain an accountability to service users.

This next few years will present specific challenges as the new Children and Social Work Act (2017), including the recommendations of the Wood Review of Local Safeguarding Children Boards (2016) come into force.

I embrace the challenges presented by these new initiatives and look forward to working with the excellent colleagues within the three boroughs to ensuring that the safeguarding of children is maintained as of highest importance and priority.

Jenny Pearce
Jenny Pearce, Independent Chair

Contents

EXECUTIVE SUMMARY

This report, as required of the Independent Chair through “Working Together to Safeguard Children 2015”, provides an overview of the effectiveness of child safeguarding and promoting the welfare of children in the areas of Hammersmith & Fulham, Kensington and Chelsea and Westminster in 2016/17. It includes a self-assessment of the performance and effectiveness of many of the local and regional agencies represented on the LSCB and identifies a number of areas where improvements are required. The report also summarises a number of reports that have been published following reviews of incidents where children have died or been seriously injured and where abuse or neglect is thought to have been involved. The learning that has resulted from such reviews and how these have been communicated to those who work with children is also included.

The Safeguarding Plan for 2016/17 is reviewed with an overview of where progress has been made as well as areas where further work or attention is required. The Report also provides an outline of the priorities of the LSCB for 2017/19.

LOCAL BACKGROUND AND CONTEXT

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

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

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

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

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

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

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

Key performance indicators	**Hammersmith & Fulham**	**Kensington and Chelsea**	**Westminster**	**Total**
Children subject to a child protection plan (at 31st March 2017)	92	67	82	241
Children subject to a child protection plan (at 31st March 2016)	105	66	89	260
Comment: At 31st March 2017, all three boroughs had maintained the planned reductions in the number of child protection plans and numbers continue to be at their lowest for over four years.				

[1] ONS Mid-Year Estimates 2014

[2] End Child Poverty 2014

Key performance indicators	Hammersmith & Fulham	Kensington and Chelsea	Westminster	Total
Children in the care of the local authority (at 31st March 2017)	215	81	182	478
Children in the care of the local authority (31st March 2016)	198	105	166	469
Comment: At the 31st March 2017, the numbers of looked after children had increased in Hammersmith and Fulham and Westminster, whilst reducing in Kensington and Chelsea. These changes are in part linked to the increase in unaccompanied asylum seeing children arriving as the number of indigenous looked after children has remained relatively stable in both Hammersmith and Fulham and Westminster and reduced in Kensington and Chelsea.				

THE EFFECTIVENESS OF LOCAL SERVICES

London Borough of Hammersmith & Fulham

The Borough's Family Services directorate coordinates a range of services for vulnerable children including statutory social work for children and families and early help.
A number of services are provided by shared arrangements with the Royal Borough of Kensington and Chelsea and Westminster City Council. This includes specialist support for children involved in the criminal justice system delivered via the local Youth Offending Team which is managed by a single management team across three boroughs.
There is also a single Fostering and Adoption service which recruits, approves and supports foster carers, connected persons and adoptive parents who care for children from all three boroughs.
The borough's services for children in need of help and protection, children looked after and care leavers were inspected by Ofsted under its unannounced single inspection framework in January and February 2016.
This resulted in a "Good" judgement by Ofsted. The department has continued to develop the Focus on Practice project – using systemic methodology to strengthen interventions with families, supported by a clinical team of therapists; IDVAs provide support to the child protection teams regarding the highly prevalent issue of domestic violence.
In the coming year the department will be developing a pilot multi agency adolescent team to deal with the growing numbers of adolescents that are at risk.

Royal Borough of Kensington and Chelsea

As is the case with Hammersmith & Fulham, the Royal Borough's Family Services directorate coordinates a range of services for vulnerable children including statutory social work for children and families and early help and also shares a number of specific services with the other two boroughs.
The Royal Borough of Kensington and Chelsea has also embedded clinicians as part of the focus on practice initiative, which is supported by the innovation fund administered by the Department of Education.
Following the unannounced single inspection framework in January and February 2016, which resulted in an overall "Outstanding" judgement by Ofsted, the Royal Borough of Kensington and Chelsea has responded to the four recommendations contained within the report. This has resulted in greater analysis of children who go missing, increased capacity

contained within the children's provision of the Emergency Duty Team, the creation of an independent advocate post for looked after children and ongoing monitoring of strategy meetings.
In addition, The Royal Borough of Kensington and Chelsea has reduced the transfer points for Care Leavers who now maintain the relationship that they have formed with their allocated social worker as they remain allocated to them throughout their care and leaving care journey.

Westminster City Council

As is the case with Hammersmith & Fulham and Kensington and Chelsea, Westminster's Family Services directorate coordinates a range of services for vulnerable children including statutory social work for children and families and early help and also shares the same services. Westminster's services for children in need of help and protection, children looked after and care leavers were inspected by Ofsted under its unannounced single inspection framework in January and February 2016. This resulted in an "Outstanding" judgement by Ofsted, one of the first two authorities to have received this judgement to date. The inspection report included a sub-judgement of "Good" regarding the experience and progress of children needing help and protection. In response to the four recommendations made by Ofsted there has been regular audit and analysis of children who have gone missing, resulting in improved understanding of themes and reasons for children going missing which has strengthened practice. Practice in relation to children in need cases has been reviewed and a new approach is being used to ensure planning and intervention is purposeful and timely. Support for care leavers who are in custody has been strengthened through increased focus by management.

Metropolitan Police

The current policing response to safeguarding concerns across the LSCB area is delivered via a combination of specialist units and local Borough based teams. In the future, it is likely that some specialist units such as the Child Abuse Investigation Teams and Sapphire units will be realigned and fall under local Borough policing building on the existing partnership arrangements. In line with the Police and Crime Plan 2017 priority of keeping children and young people safe, both MPS and local strategies have embedded safeguarding at the core of policing with an enhanced focus on achieving positive outcomes and prevention.

In December 2016, the HEMIC published the report detailing their inspection of the Metropolitan Police Service response to child protection which included a range of recommendations. Assistant Commissioner Martin Hewitt has been named as the single management board lead for safeguarding and is overseeing the MPS response to the report. The LSCB and partners have been briefed at regular intervals on the progress being made both at an organisational and local level in response to the recommendations. Within the LSCB area, officers have received additional training via their professional development days to enhance their safeguarding response to issues including missing children and child sexual exploitation. Performance and tasking forums have seen an increased focus on tackling vulnerability and safeguarding which includes reality testing to ensure the above mentioned training has positively impacted on service delivery.

Child Sexual Exploitation across the LSCB area continues to be subject to oversight via the police led Tri-Borough Multi Agency Sexual Exploitation Panel which is well supported by a range of crucial statutory partners. The work of the panel continues to build on the outstanding feedback provided within the 2016 Ofsted inspection report and remains of model of excellence across London.

NHS England (NHSE)

NHS England London region is responsible for ensuring that the commissioning system in London is working effectively to safeguard children and adults at risk of abuse or neglect. There are several Acts that govern the ways in which NHS England safeguard and help to ensure the wellbeing of children, young people and adults at risk of harm.

Over the past year, the London region Safeguarding Programme has delivered on several key pieces of work that reflect these commitments as listed in the Accountability and Assurance Framework. The Programme team has worked to ensure that safeguarding is continuously being embedded across the health care system. Especially as contemporary safeguarding trends come to light, we must have the leadership and direction, and also the flexibility to adapt to safeguarding changes across the region. Over the past year the team have worked to strengthen previous safeguarding work, while also adapting to regional trends and working with our Police, Social Care, Charity sector, and other colleagues, to ensure we are all working towards safeguarding together.

Key pieces of work that the programme has continued to strengthen across the region have included:

- Female Genital Mutilation (FGM)
- Child Sexual Abuse (CSA), including Child Sexual Exploitation (CSE)
- Prevent
- Mental Capacity Act (MCA)/Deprivation of Liberty Safeguards (DoLS)
- Looked After Children (LAC), including Unaccompanied Asylum Seeking Children (UASC)
- Child Protection Information System (CP-IS)

Emerging pieces of work that the team has commenced work on include:

- Modern slavery
- Human trafficking
- Domestic violence
- Breast ironing

While the Safeguarding Programme have specifically worked on several key projects as listed above, we have supported the Designated and Named Safeguarding leads across London. In addition, the programme team have consulted on strategic pan-London level policies/frameworks that will guide the future of safeguarding practices into the future.

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

CCGs are statutory NHS membership organisations that bring together General Practices, in a specified locality; to commission NHS funded services for their registered populations and for the unregistered patients who live in their area.

As commissioners of local health services, CCGs must assure themselves that the organisations, from which they commission health services, have effective safeguarding arrangements in place.
Each CCG has a statutory requirement to be a partner member of the Local Safeguarding Children Boards (LSCB) and the Safeguarding Adults Board (SAB) to collaborate with overseeing the effectiveness of the multi-agency safeguarding work for the borough based (Local Authority) areas.

CCGs are responsible for securing the expertise of Designated Professionals to provide advice and support to commissioners and services on behalf of the local health system. These roles undertake a whole health economy role.

During 2016–17 the Designated Professionals played an integral role in all parts of the commissioning cycle, from procurement to quality assurance to ensure appropriate services were commissioned in a way that supports adults and children at risk of abuse or neglect, as well as effectively safeguard their well-being.

The key achievements of the CCG during the reporting year:
The three CCGs facilitated a workshop with the health partners of the LSCB to consider a local response to the options proposed in "Developing a Local Safeguarding Arrangement in the Context of the Alan Wood Review and the Government's Response" and presented their response for how the LSCB might develop in the future.
The response acknowledged:

- The value of an independent chair. The role in their view provided a number of functions including independent scrutiny, challenge and support and the holding to account of partners. Following the retirement of the incumbent chair, a new independent chair has been recruited.
- One of the real strengths of the current arrangements is that it allows all of the health partners come together, in one place, as equal representatives.
- The current arrangement provides the CCGs with a level of system wide oversight across the partnership, providing a level of assurance. It suggested that any new arrangements included wider representation, from health partners, on the executive than just the CCG. The response also suggested a review of the current subgroup structure – to potentially include greater alignment with the adult safeguarding board and where advantageous the potential for linking subgroups across North West London.
- That future arrangements need to be outcomes focused and manageable within existing resources. Furthermore, will need to take account of the requirements such as Joint Targeted Area Inspections.
- The Designated Nurses have chaired the Safeguarding Children's Health sub-group throughout the year.
- The Designated Nurses provided supervision and support to Named Professionals within NHS Provider organisations.
- The Designated Drs proposed to the Safeguarding Children's Health Sub-group that the structure for Designated Drs should be changed in that the two posts should merge and that one post should be created across the three boroughs, this was supported by the CCGs and will be progressed in 2017-18.
- The Designated Nurse for Safeguarding Children and the Designated Nurses for Looked after Children (LAC) collaborated closely during the reporting period specifically in relation to the children and young people who arrived as Unaccompanied Asylum-Seeking Minors from Calais.

- The post of Designated Nurse for Looked after Children was reviewed across the three CCGs and this role will be brought in house during 2017-18 to provide assurance advice and support to the commissioners for service pertaining to LAC.
- The Named GPs held network meetings in each borough throughout the year to ensure GPs and primary care are updated about safeguarding processes and the requirements around supervision.

Imperial College Healthcare NHS Trust

Imperial College Healthcare NHS Trust has a well-established children's and maternity safeguarding service which has now been added to by a Consultant Nurse for Safeguarding Children, Unborns and Young People.
This post was created as the Trust feels it is an important step forward as it is raising the profile and leadership within the team and across the Trust.

There remains a Named Doctor and Named Midwife as well as clinical nurse specialists, safeguarding lead midwives and administrators.

There remains safeguarding and domestic abuse link staff throughout the Trust including in maternity, children's services, the A&E departments and Urgent Care Centres.

There is a quarterly safeguarding children committee meeting that provides assurance around safeguarding practice. Strong links have been established and remain with organisations and charities, to provide joined up support in areas such as domestic violence (Standing Together) and youth gang violence and child sexual exploitation (Red Thread). Red Thread workers are based in the A&E department and sexual health clinic at St Mary's Hospitals.

Close working has also been developed with adult safeguarding services to ensure that children are protected in situations where there are adult safeguarding concerns.

An extensive programme of training and supervision has been established to ensure that staff are prepared and supported when dealing with safeguarding issues.

Chelsea and Westminster Hospital NHS Foundation Trust

Within Chelsea & Westminster Hospital there is a full safeguarding children's team – liaison health visitor, named nurse, named midwife and named doctor, supported by an administration post. This year a Consultant Midwife with a responsibility for safeguarding also joined the team.

Quarterly Children's Safeguarding Boards are chaired by the Director of Nursing, and there is also an annual Joint Adult and Children's Safeguarding Board within the Trust. A social work team based within the hospital supports children's safeguarding. Child Protection medicals are undertaken within the hospital, and there is good attendance at case reviews by the safeguarding team along with the lead nurse for paediatrics.

The team has worked with the Designated Nurses and safeguarding leads within the three Local Authorities in a number of serious case reviews with learning shared across the organisation and with other agencies. The relationships developed through the LSCB enable the organisation to provide best practice, up to date safeguarding training, supervision, and care to children and families. Domestic abuse continues to be a theme within SCRs and training within this area has been a priority, led by our Domestic Abuse lead. We are

delighted to have an Independent Domestic Violence Advocate in post to offer support and advice to families and staff.

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

The Trust has seen an increase in compliance with all 3 levels of safeguarding children training and continues to strengthen the number of staff who have attended prevent training.

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

Central London Community Health Trust

Central London Community Healthcare NHS Trust (CLCH) provides community services across nine London Boroughs and the county of Hertfordshire. CLCH is committed to working in partnership to support the wellbeing and safety of children and young people in Hammersmith and Fulham, Kensington and Chelsea and Westminster.

CLCH has a nurse-led Safeguarding Children Service in covering the three boroughs, providing advice, support, in-house safeguarding training and mandatory safeguarding supervision. The CLCH Safeguarding team is managed by the Head of Safeguarding who reports directly to the CLCH Chief Nurse and Director of Quality Governance) who reports to the CLCH Board, as the CLCH Executive Lead for Safeguarding. The CLCH Board receives an annual safeguarding report and a mid-year update to assure CLCH meetings its statutory duty under the Children Act 2004.

There are two Named Nurses for Safeguarding Children (NNSC), one covering Westminster, the other covering Kensington and Chelsea and both jointly covering Hammersmith and Fulham. The NNSC are supported by Safeguarding Children Advisors who support the delivery and development of the CLCH safeguarding service and to progress the LSCB work and priorities.

CLCH has participated in Board meetings, Section 11 audits, the LSCB multi-agency audit on domestic abuse and has contributed to serious case review action plans and the delivery of the Luton Child J Serious Case Review. CLCH has also achieved a minimum of 90% compliance for Level 1 and 2 Safeguarding Children training, and staff also attend WRAP Workshop to Raise Awareness of Prevent) training. CLCH has updated internal policies, including FGM, Domestic Abuse and Safeguarding Supervision, and continues to escalate concerns with partner agencies where there was a difference in professional decision making. CLCH continued its high uptake and evaluation of safeguarding supervision, achieving 95-100% compliance with safeguarding supervision targets.
Challenges in the past year have included managing the impact of change within the NHS and partner agencies, as well as the acquisition and loss of services within CLCH itself.

CLCH will continue to support the work of the LSCB in preventing the harm and abuse of children, young people and families in Hammersmith and Fulham, Kensington and Chelsea and Westminster.

Central and North West London NHS Trust (CNWL)

Compliance of safeguarding children training continues to improve and at the end of the financial year had reached 95%. Embedding this learning in practice has been supported by both the Internal Auditors who reported reasonable assurance that controls were in place. They noted an improved use of the internal safeguarding children helpline for staff, increased referrals to Children's Social Care and Early Help and audits of frontline staff demonstrated that staff have a good understanding of safeguarding.
The Trust has consistency of safeguarding children processes with a cohesive Named Nurse Team who now understand each other's portfolio of services and who to contact at an operational level regarding safeguarding queries.
Development work on SystemOne Read coded templates and questionnaires on safeguarding activities, including supervision, means that reports can be generated automatically without distracting staff from frontline work. In future this will allow benchmarking across teams/services.
Key Challenges:
Despite considerable training on domestic abuse, coercive control and peer on peer abuse, routine enquiry across all services is not in place robustly, so this is a priority across adult and child safeguarding for the coming year. Communication regarding the revised Domestic Abuse Protocol will be used as one of a range of ways to promote this.
NHSE recommissioned Child Health Information Services starting in April 2017 to a new specification, but did not address risks that had been flagged to them prior to launching these. This has resulted in a delays of new birth notifications being received by the Health Visiting Teams and A& E notifications not being sent for over 6 year olds to School Nursing. Additional admin support and systems have been established to address the risks although this has not been funded so is an extra unexpected pressure on budgets and further work is taking place with NHSE to mitigate these concerns.
Priorities for CNWL Safeguarding Children in 2017/18:

- Ensure preparation for the JTAI and on the specific theme being reviewed
- Revising LSCB membership and support following the Wood Review
- Improving the Trust awareness of Domestic Abuse, rolling out routine enquiry and looking at evidence based interventions to address the growing body of research that DA includes many types of abuse with respect to partner dynamics, context and consequences.
- Improving SystmOne support for safeguarding good practice

Probation

The National Probation Service (NPS) continues to work with partners agencies across the three Boroughs. NPS chairs MAPPA and contributes to MARAC, MASH and MASE. All practitioner staff are trained to work with cases and are expected to update their skills and knowledge in 2017-18 by attending one course on child protection during the year.
Locally, we will be conducting an audit of all cases where there is known to be a child on a child protection plan to ensure that children are being effectively protected. There is continuing work between NPS Court teams and Local Authority safeguarding teams to ensure that necessary information around safeguarding children is available to sentencers where this is appropriate.
NPS has, and will, maintain its commitment to the Local Safeguarding Children Board in the coming year.

Community Rehabilitation Company (CRC)

London's Community Rehabilitation Company (CRC) has seen a return to borough based offender management, alongside a re-structured and new senior management team.
The CRC has strengthened the lines of accountability resulting in increased management oversight for all cases with a child safeguarding concern. Monthly one-to-one meetings between Senior Probation Officers with Safeguarding as a fixed agenda item ensure oversight of all safeguarding cases. There are also monthly one-to-one meetings between Senior Probation Officers and Area Manager reporting on all safeguarding cases.
There is monthly monitoring of all child protection and child in need cases, alongside monthly monitoring of all referrals made to social services.
The CRC has increased auditing of all cases. This includes monthly audits across the business plus each Offender Manager having two cases audited by managers per month. There is also greater oversight from our Quality and Performance team to ensure no cases are unmanaged or not seen at appropriate intervals.
A new recording convention to ensure that all records are kept up to date in a timely fashion has been introduced. Safeguarding training is available for all staff and is a requirement for all staff that have not had training within the last two years.
Looking forward, a HMIP (HM Inspectorate of Prisons) Inspection is due place in October and November 2017. 150 cases will be inspected across the whole of London CRC, with five cases selected from Hammermith and Fulham to be inspected.

Children and Family Court Advisory and Support Service (Cafcass)

Cafcass is a non-departmental public body, sponsored by the Ministry of Justice. It works in the family courts in circumstances where children have experienced or are at risk of experiencing abuse, neglect or trauma. Cafcass also work with families in circumstances where there is a dispute about where a child should live or with whom they should spend time, often following divorce or separation.

The role of Cafcass is to make recommendations to the court about the right courses of action for children and young people. Cafcass was inspected by Ofsted in 2014 and judged to be good with outstanding leadership and management. Since then Cafcass continues to prioritise safeguarding activity and internal audit reveals that the organisation is making good progress.

Cafcass's recent annual report detailed work with 125,230 children and young people across England. Cafcass's key performance indicators were met 2016-2017 despite a private law increase by 9.1% compared with the previous financial year, and 19.7% compared with two years previously and a public law increase by 13.8% compared with the previous financial year, and 30.4% compared with two years previously. Cafcass received a number of sector and industry awards including Gold for Practice Educator of the Year and Silver for Children's Team Leader of the Year at the Social Worker of the Year Awards.

Community Safety

Community safety across the three Local Authorities has continued to provide a significant focus around safeguarding young people during the last 12 months. This has included a number of projects:

- The safer schools project, which is a collaborative approach between schools, police and the council that focuses on establishing and developing effective working relationships between partners and the local community, reducing crime and anti-social behaviour in schools / locality, providing a visible and familiar contact with their assigned school, contributing to improvements in school attendance, working with school staff to prevent truancy and reducing the fear of crime amongst students. There are slight differences in modelling across the three Authority areas, which includes funding support but their aims are consistent. One of the significant outcomes in terms of this programme of work has been the breaking down of barriers between teachers, pupils and partners that has given individuals the confidence to come forward and seek help. Examples of other outcomes have included weapon sweeps, engagement projects, class presentations and working groups.

- Safeguarding through the Channel process. This is a statutory, early intervention and multi-agency process designed to support those who are at risk of radicalisation. Work has taken place to enhance the current referral process, developing an integrated approach to receiving and assessing those referrals to ensure an appropriate support plan has been put in place for vulnerable young people. This has included officers from the prevent team, Child protection and early help. In addition, much work has taken place in partnership with local schools to cascade knowledge and awareness of prevent and how officers can work with local schools to tackle areas of concern.

- Development of a more creative framework that will support a preventative strategy for schools focused on partnership contribution. This includes a directory of contacts that can be used to enhance communication between schools and partners. This links into the safer schools project outlined above.

- Development of an anti-social behaviour policy and protocol for managing and supporting young people involved in anti-social behaviour.

- Tackling youth violence through an integrated model that includes developing multi agency work to safeguard young people and those at risk of violence. There are many examples of providing or commissioning services to support those involved in gangs, prevention in schools, joint workshops to support women or those at risk of being exploited by potential sexual exploitation perpetrators.

Housing and Housing providers

A wide range of housing services are provided to vulnerable households including providing:

- Housing advice and assessment services to those households in housing need and at risk of homelessness

- Temporary and long-term accommodation for the homeless households

- Specialist supported housing, predominantly through the voluntary and community sector, for vulnerable to support moves from hospital and residential care into more independent housing

- Direct help to support rough sleepers off the streets

- Housing Pathways for vulnerable groups such as young people leaving care and at risk of homelessness to support moves into independent housing

- Provision of large numbers of social and affordable housing whether owned by authorities or through Registered Providers (Housing Associations)

All the organisations involved in the provision of such housing and advice services have a strong focus on safeguarding, (for example within job descriptions, induction plans and commissioning arrangements) and made use of the available safeguarding training via the LSCB training programme and in-house.

Voluntary / Faith Sector

Although the LSCB has not has a member of staff in post in this role owing to the departure of the previous post holder, the LSCB team has retained its commitment to engaging with diverse groups across our local communities. The LSCB Business Manager has met with local supplementary schools to deliver basic safeguarding awareness sessions and to brief them on LSCB priorities and key safeguarding contacts, as well as the wider training programme available though the LSCB.

The LSCB Business Manager has also worked in partnership with a local children's social care social work team in north Kensington to deliver a 'family fun' day at the local Al Manaar Mosque and Community Centre, to raise awareness of local partners and key safeguarding messages such as neglect and how parents and carers can request help and support if this is an issue for them.

The LSCB team will also continue to work with key colleagues such as our Prevent teams on community engagement events in the future. For example, the 'Community Question Time' type events that are in keeping with some of the concerns or requests raised by local community members. Importantly, the vacant post for the LSCB Community and Children and Young People role is being recruited to so that further work to engage other 'hard to hear' groups can be progressed.

Schools

As of January 2017[3], there were there was a total of 256 schools across the three boroughs. 157 of these were state funded including 12 nursery schools, 105 primary schools, 31 secondary schools, 10 special schools (1 non-maintained) and 5 settings which were either pupil referral units or alternative provision.
There is a significant independent sector (93 schools) across the three boroughs, with 22 in Hammersmith and Fulham, 42 in Kensington and Chelsea and 29 in Westminster.

Safeguarding Work with Schools 2016/17

The Safeguarding Lead for Schools and Education has a key role in advising schools and building links between them and other key partners. Some of the work carried out this last year has included preparing information briefings and highlighting changes in the updated Keeping Children safe in Education (KCSIE) in September 2016.

A centralised programme of training for Designated Safeguarding Leads (DSLs), Governors and Newly Qualified Teachers (NQTs) was made available, and further sessions for Designated Safeguarding Leads were delivered to meet demand. A termly DSL network forum is also an opportunity for all DSLs to come together a receive key safeguarding updates, air concerns and challenges and share best practice.

Alongside these sessions, safeguarding training was delivered to individual schools, including priority schools. In-house safeguarding training was delivered to schools in the independent sector also.

All schools can participate in multi-agency training provided by the Local Safeguarding Children Board. For example, they can attend Safer Recruitment workshops, and all local schools were invited to participate in the Southbank International School Serious Case Review learning event, co-ordinated by the Learning and Development Subgroup, in March 2017.

Particular schools linked to recent serious case reviews have been supported throughout the process (eg Clare and Ann Serious Case Review).

The Safeguarding Lead in Schools and Education has also completed safeguarding audits at individual school level, including priority schools. Factors which contribute to schools being identified as a priority include having a new Headteacher and/or DSLs; emerging significant safeguarding themes eg challenge from parent community; Ofsted reports identifying any issues around safeguarding; significant changes in the Governing Body and feedback from the School Standards team regarding the school performance and profile (including attendance and persistent absence levels).

The Safeguarding Lead for Schools and Education attends the MASE Panel, and has a focus on specific safeguarding issues such as CSE and Peer on Peer Abuse.

The Safeguarding Lead for Schools & Education attends Tri Borough Prevent Steering Group meetings, including Channel Panel, and supports schools to access Prevent training, liaising with Prevent to consult on individual scenarios and materials to include in curriculum delivery.

[3] DfE "Schools, pupils and their characteristics: January 2017"

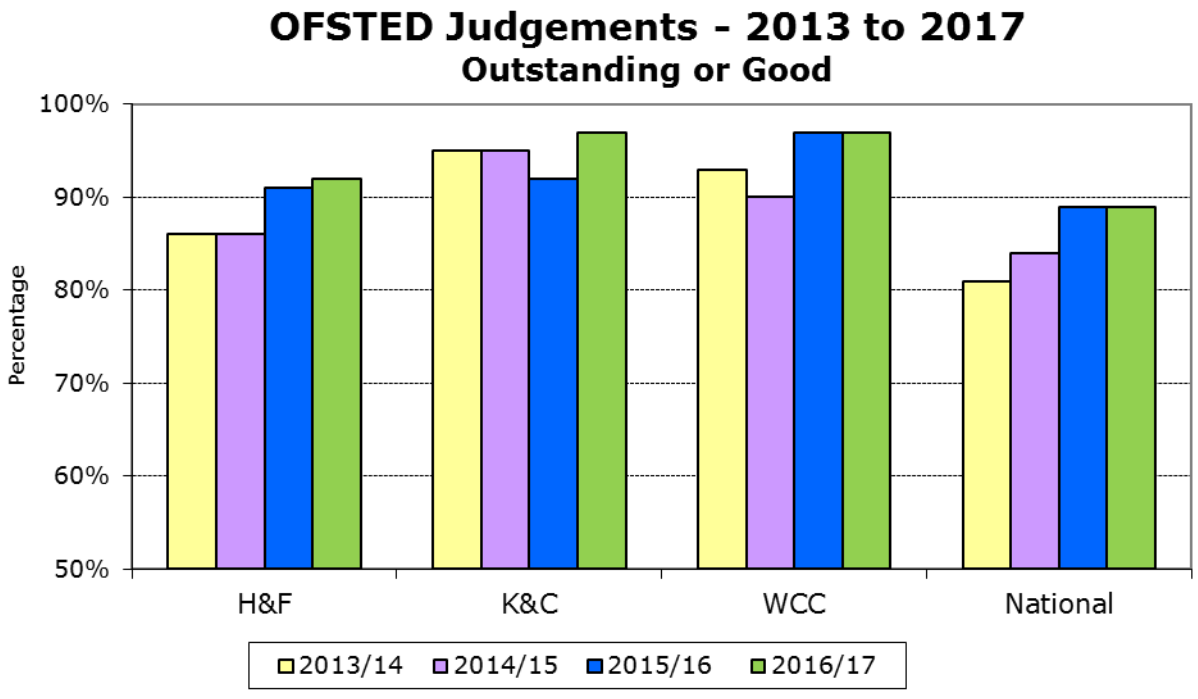
Other areas of focus in 2016/17 were Elective Home Education (EHE) and Children Missing Education (CME) in collaboration with the local authority ACE team (Attendance, Child Employment and Elective Home Education) and clear systems are in place for schools to give feedback on starters and leavers.

Future work in 17/18 will include Section 11 (Section 175 audits) to be rolled out in the summer term 2017 and a self-audit tool will be revised for schools to use from September 2017. A safeguarding workshop tailored for HR staff with a focus on LADO processes is planned for May 2017. A small selection of schools will participate in the LSCB multi-agency audit on Neglect in the summer term 2017. Guidance on promoting safeguarding for services commissioned by schools will also be shared with schools later in 2017, and we aim to build on the Safer Schools partnerships with the Police in each of the three boroughs.

Ofsted Inspections of Schools 2016/17

The percentages of schools in the tri-boroughs which are rated outstanding or good by Ofsted inspectors have remained consistently high during the last three academic years. Four schools are currently judged inadequate (Hurlingham Academy and Phoenix, in Hammersmith & Fulham, and Wilberforce and Harris Academy in Westminster), while four of the 157 schools are judged to require improvement which is a reduction from last year.

The percentages ranked outstanding or good at the end of the last three academic years is shown below; overall judgements for all three boroughs were above the national average and have remained consistently high during the last four academic years.



During 2016/17 academic year, there have been eleven full inspections of schools across the three local authorities. There have also been short inspections of a further 26 schools. The reports from such inspections include specific commentary from Ofsted regarding the effectiveness of safeguarding arrangements in individual schools and these reports are all publicly available.

Children's Homes

The Haven in Hammersmith and Fulham is a local authority children's home, registered to provide care for up to seven children who have learning disabilities and/or physical disabilities. The home provides a mix of short-break placements, shared care placements and permanent placements. The Haven has moved towards an increased focus on longer-term placements in order to support young people with complex needs to remain at home wherever possible.

A successful recruitment process took place in July 2017 which resulted in the appointment to two newly created senior residential care worker posts.

A recent Ofsted inspection took place in September 2017 and found a previous recommendation (from July 2016 inspection report) regarding safeguarding training has been met and Ofsted noted that:
'Staff have appropriate safeguarding knowledge, and are clear about what to do if they have a concern about a young person. Several staff have recently attended safeguarding training, and they are enthusiastic about practising their new learning. This helps keep young people safe from possible harm.'

Ofsted also noted an increased training focus:
'Training is a major positive factor for staff. A new training programme for working with disabilities has recently begun and staff are enthusiastic about this and very keen to participate.'

The Royal Borough of Kensington and Chelsea maintained two children's homes in the area (Olive House and St Marks). Olive House had an interim inspection in January 2017 and Ofsted judged it had sustained its effectiveness since the previous full inspection where it had received a rating of 'Good'. Ofsted noted that listening to and acting on the views of young people are strengths of this service. For example, young people are effectively involved in staff recruitment. The home has since undergone a major re-organisation with a creation of a specialist social work practitioner post and a social work qualified team manager post both to enhance and embed systemic practice within the home. The home is now registered as a 7 bedded unit combining long, medium and short term beds.

St Mark's ceased to be a children's home at the end of June 2017. It has since undergone some refurbishment and opened its doors mid-September as a low to medium support care leavers hostel. There are plans in place to develop care leaving services to be delivered from St Mark's. There are currently two group programmes operating from St Mark's providing support around developing independent living skills and crucial soft skills and equip them with tools to strengthen their emotional wellbeing and improve self-esteem. It is planned that housing, immigration and virtual school support will be delivered from this hub from the New Year.

HM Prison Wormwood Scrubs

Safeguarding comprises a significant part of the work carried out by HM Wormwood Scrubs Prison with families and children of offenders. A lead administrator, who is also an attending statutory member of the LSCB, is in place for safeguarding. Her role includes liaison with other departments in prison, visitor centre staff, social workers, schools, charities and families regarding children's visits to the prison and discussing any safeguarding issues. There are also links between the prison and external Multi-Agency Public Protection Arrangements (MAPPA) and other agencies and charities which provide training for

prisoners with parenting responsibilities. The administrator has attended Level 3 multi-agency safeguarding training provided by the LSCB and the Academy of Justice and has a NVQ level 2 in health and social care. Furthermore, she provides a basic training to the officers who supervise visits and there is a family officer who deals with the operational side of the training and visits.

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

A recent Justice Inspectorate inspection in August 2017 noted that public protection procedures were adequate and that applications for contact with children were assessed appropriately and suitable levels of contact approved where possible.

ANNUAL REPORTS

Child Death Overview Panel (CDOP)

The 2016/17 Annual Report for CDOP provided analysis of cases reviewed over the course of the year, rather than those notified during the same period. These included reviews of cases of children who died between April 2014 and March 2017. Timings of reviews are subject to the information available from agencies involved, other processes including police investigations, serious case reviews or inquests and the number of cases relating to particular themes.

Nineteen deaths of children who had lived in the LSCB area were reviewed by CDOP. Of these, nine were unexpected. The key themes for the unexpected deaths were related to life limiting disease and perinatal events. The main category of death has been those born with congenital and chromosomal abnormalities.

In addition, a further eight deaths that occurred in local private hospitals were also reviewed in this period. All of the deaths that occurred in private hospitals were of children who normally resided abroad. The majority of the children died in private hospitals having accessed care in the UK for on-going complex medical issues.
Reviewing the deaths has enabled the panel to scrutinise their processes, seeking further information as to how families and children who reside abroad are managed in relation to end of life care and the bereavement process. This process gives the panel an insight into the quality of service provision in private hospitals which are part of the local health economy and falls under the jurisdiction of the Local Safeguarding Children's Board.

The CCGs have continued to lead on the work of CDOP on behalf of the LSCB, which enables the CCGs to scrutinise and act on issues of service quality and provision, whilst working in partnership with the LSCB with quarterly updates submitted to the Board and with good links maintained with other subgroups.

Progress from 2015-16 priorities and action plan

1. The CDOP panel is now chaired by the Deputy Director of Public Health who is actively engaged in adding a public health perspective to the work that is being undertaken.

2. The issue of child deaths abroad is being addressed by the Foreign Commonwealth Office who is planning to produce guidance on deaths which occur abroad.

3. Information for a web page on the LSCB website has now been circulated to the CDOP members. This information will be uploaded shortly.

4. A Specialist Nurse for Child Death Reviews has been recruited and will work in collaboration with the Designated Doctor for Child Death. It is envisaged that the work of CDOP will be further enhanced and developed.

Priorities for 2017/18

- The Chair, Designated Doctor and the Specialist Nurse for Child Deaths are to work with the Healthy London Partnership in the work streams that are being undertaken for CDOPs across London.

- An audit schedule is to be developed. The first audit will be looking at the number of reported deaths from private hospitals, the demographics and cause of deaths followed by an audit on risk factors associated with Sudden Unexpected Deaths in Infancy.

- A literature review and analysis by Public Health, of deaths that have occurred in children as a consequence of infection, to assess if the guidance on prescribing antibiotic therapy has had an adverse impact.

- To establish links with CDOPs across Northwest London, so that patterns and trends can be identified across a wider geographical area and shared learning and initiatives can be established and implemented.

- The Specialist Nurse to work more collaboratively with Provider services, both in the acute and private sector to raise awareness of the CDOP process and to establish links with the bereavement team.

- CDOP leaflet and letter to communicate the CDOP process with bereaved parents

- Review, analyse all child deaths reviewed by the CDOP panel since 2013 to identify if the recommendations proposed in "Why children die: death in infants, children, and young people in the UK Part B"[4] are applicable in those cases identified as having modifiable factors to determine local actions or recommendations for change.

Looking ahead to 2017/18 and possibly beyond, the CDOP panel will await the outcome of the Public Enquiry and criminal investigations following the Grenfell Tower Fire before it will review the deaths of the children in this very sad and unprecedented event. The CDOP panel is keen to capture any local learning now from practitioners to assist with the reviews in due course.

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[4] A policy response for England to the report Why children die: death in infants, children and young people in the UK - Part B. Royal College of Paediatrics and Child Health National Children's Bureau 2014.
http://www.rcpch.ac.uk/sites/default/files/page/Why%20children%20die%20part%20B.pdf

Local Authority Designated Officer (LADO) – Safer Organisations

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

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

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

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

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

In 2016/17, the local LADO service has been strengthened and developed. Referral points have been rationalised to facilitate referrals getting to the right person in a timely manner. Child protection advisors in each of the boroughs handle incoming cases on a duty basis with support from the Safe Organisation manager /LADO lead. The majority of Child Protection Advisors are now permanent members of staff which means practice is embedded and there are opportunities to take advantage of discussing emerging themes and thresholds across the three boroughs. Guidance and toolkits have been developed to support key aspects of the safeguarding system; for example guidance for schools on applying safer recruitment ideas to organisations who wish to rent their facilities or deliver services to their pupils.

Safe Recruitment and leaning from Serious Case Reviews

The LADO has continued to offer accredited safe recruitment training as part of the LSCB training programme. This has been well attended as have sessions on learning from SCRs and 'meet the LADO' events. The LADO service continues to contribute to the overall development of awareness of abuse by professionals via learning events like the Southbank Learning Event.

Raising the profile of the role

The LADO has worked closely with the Safeguarding Lead for Schools and Education officer and the LSCB Training Officer to raise the profile of the role with schools and in particular in the independent school sector (in part prompted by the learning from the Southbank International School SCR). The LADO has also continued to promote collaboration of good practice and relationship building in other sectors such as sports organisations, human resources teams, and the voluntary sector.

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

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

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

Another trend in the LADO referrals is an increase in referrals relating to sexual abuse or misconduct. This includes grooming behaviour, blurring of professional boundaries with the intent of forming relationships and abuse of positions of trust. This trend is in line with national trends and is likely the result of a greater awareness in all organisations from recent media coverage of non-recent abuse such as with Jimmy Savile or the recent Football Abuse Scandal. Generally, organisations are more aware than they were previously about what grooming looks like and the importance of listening to children as a way of offering them protection from abuse. This has resulted in more referrals but also in referrals at an earlier point when protective action can be more effective.

Upcoming Project: Changes to the London Child Protection Procedures
The LADO is contributing to update of the London Child Protection Procedures in relation to the area of managing allegations against professionals and volunteers and these are anticipated to be published in the autumn of 2017. The updates will be shared across the multi-agency partnership.

Private Fostering

A lead practitioner undertakes assessments and holds all identified private fostering arrangements, which include carrying out visits for the duration of the arrangement, direct work, maintaining a Child in Need plan and ‘stepping down’ arrangements as they come to an end, and implementing post 16 plans.
Approvals of assessed private fostering arrangements are made through a multi-agency Panel which meets quarterly. Interim approval is given by Designated Manager within the MASH Team. The private fostering role ensures that all children who are privately fostered in the three boroughs receive a consistent response with good quality assessments ensuring that the needs of those children who are privately fostered are met. Having the role based in the MASH ensures that awareness is raised and all opportunities to identify cases are taking place.

The lead practitioner is also responsible for raising awareness across the LSCB area and raising the profile of private fostering within the organisation, partner agencies and the community, as well as providing advice and consultation to partner agencies as any private

fostering enquiries arise. The lead practitioner has worked with the LSCB trainer to ensure that the appropriate information is cascaded to the multi-agency workforce in core training.

The lead practitioner also attends The Private Fostering Special Interest Group facilitated by CoramBAAF (formally facilitated by BAAF), which meets on a six monthly basis. The group provides an important forum for private fostering practitioners across Greater London and the West to discuss practice issues, legal advice, raise awareness, best practice and inform and influence policy wherever possible.

Independent Reviewing Officers (IRO)

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

Over the course of 2016/17, the IROs have been working as part of a unified service. The teams have remained relatively stable, with caseloads within the recommended limits set in the IRO Handbook. This allows IROs to know their children well, and to monitor cases between reviews. They have continued to work in collaboration with the social work teams to resolve issues and concerns about children's care plans in an informal manner wherever possible. There is a positive working relationship between IROs and front line teams across the three authorities, and this has kept the need for recourse to the formal Resolution Protocol to a minimum.

The looked-after children figures have increased in two of the boroughs. There is evidence of a high turnover of children within the figures. 54% of the total looked-after children population across the three local authorities had been in the care system for less than 12 months at 31st March 2017, with 37% having been looked after for less than 6 months.

The percentage of children looked after for less than 6 months is broadly similar in Westminster City Council (35%) and the London Borough of Hammersmith and Fulham (37%) compared with 10% in Royal Borough of Kensington and Chelsea. Numbers in care for 12 months or less is higher in London Borough of Hammersmith and Fulham indicating that 57% of looked after children have been in care less than 12 months compared with 47% in Westminster and 17% in Royal Borough of Kensington and Chelsea.

The anticipated decrease in the looked-after children numbers has not continued, partly as a result of the recent increase in the number of unaccompanied asylum seeking children in Westminster and Hammersmith and Fulham.

The age profile of the children and young people in care has continued to be biased towards children 10 and over, consistent with higher numbers of unaccompanied asylum seeking young people and a continued increase in young people entering care as older adolescents. The options for permanence for some of these young people are often limited, and the complexity of their needs presents challenges in ensuring stable placements and optimising outcomes for them as a result of their late entry to the care system. Late entry into care tends to be associated with complex emotional and psychological challenges arising out of family stress. This necessitates careful placement planning. IROs actively engage in oversight in this regard and there is clear evidence from their records of ongoing consultation by front line teams to ensure that the IROs are both aware of the challenges and able to monitor the plans effectively as a consequence.

Across the three authorities, 78% of the looked-after population is over 10, with figures in the individual authorities ranging from 77% in London Borough of Hammersmith and Fulham and Westminster City Council to 83% in the Royal Borough of Kensington and Chelsea.

The ethnic profile of the looked-after children across the three authorities is diverse. 28% of looked-after children identify themselves as White British, while 30% identify themselves as Black / Black British. In Westminster, 24% of looked-after children are categorised as identifying with 'other ethnic groups'.

Across the three local authorities 96% of looked after children reviews were held within statutory timescales. Over 97% of looked after children participated in their review meetings over the year. They have also been involved in key service development initiatives through their Children and Young People's Panel / Children in Care Councils. These included engagement activities and a number of events to celebrate key achievements

Violence Against Women and Girls (VAWG) Partnership[5]

In April 2015, the VAWG Strategic Partnership for the London Borough of Hammersmith & Fulham (LBHF), the Royal Borough of Kensington and Chelsea (RBKC) and the City of Westminster (WCC) launched a three-year Strategy. The Strategy was written after considerable consultation with survivors, service users, stakeholders from a range of statutory and voluntary organisations as well as elected members across the three councils. The Strategy details how the Partnership will deliver a Coordinated Community Response (CCR) to VAWG; it keeps survivors and children at the centre of its aims and objectives, whilst also holding perpetrators accountable for their actions.

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

In year two of delivery, the Partnership made considerable progress against 31 out of 43 (72%) actions, achieving **GREEN** status. This represents an increase of 16% from last year. For 9 of the 43 actions, the Partnership made some progress against the actions and 21% of actions achieved **AMBER** status (decrease of 14%). Finally, for 3 out of 43 actions, the Partnership has not made any progress or has encountered considerable challenges; those actions have given **RED** status and actions will need to be taken in the final of the strategy to achieve against those outcomes.

Successes include the roll out of the #SpeakSense campaign for young people, which aimed to encourage young people to learn more about relationship abuse, how to best support a friend, and details of both local and national support services for victims and perpetrators. The Angelou Partnership held training on consent in schools, and held young women's

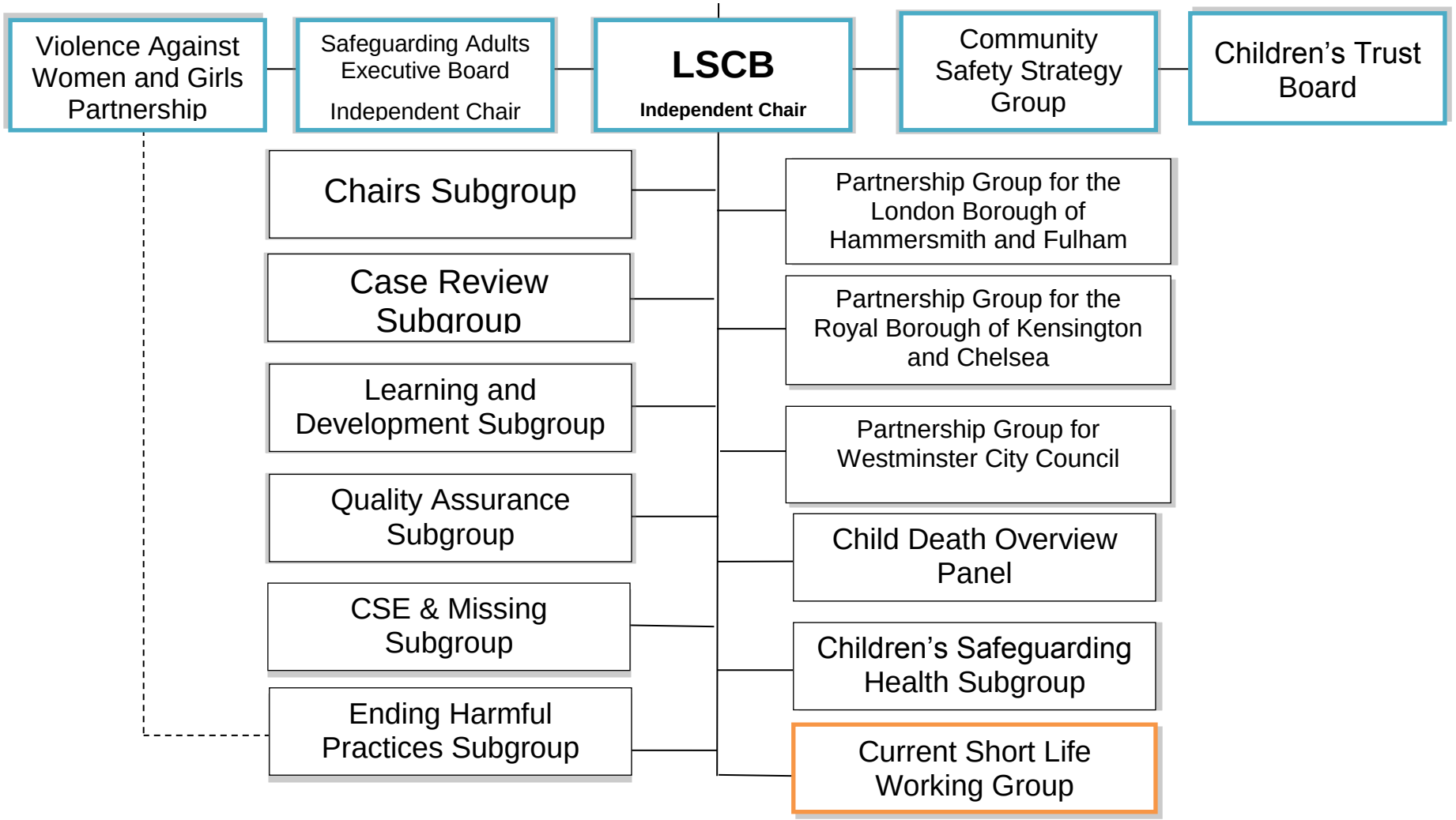
5 https://www.rbkc.gov.uk/lscb/sites/default/files/atoms/files/Violence%20Against%20Women%20and%20Girls%20Partnership%20Annual%20Review%202016-17.pdf

groups in schools. Advance worked with Action on Disability to create a training package for their workers who work with young people.

Looking forward to 17-18 and beyond, a key aspect of the work will be linking with children and young people services and delivering provision that focuses on trauma and gender informed approapches to supporting survivors and their families. The Partnership will continue to highlight gaps in access to specialist services for survivors, children and perpetrators alongside consultation and analysis in order to have a better understanding to develop future services. The Partnership will continue to hold community engagement and school based events around FGM. The Partnership aims to continue to promote a 'Whole School Approach' via preventative and education programmes that improve attitudes towards conducting healthy relationships and VAWG from primary school to adult education.

GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS

The current structure of the LSCB is as follows *



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

PRIORITIES OF THE LOCAL SAFEGUARDING CHILDREN BOARD – 2016/17

The headline priorities of the Local Safeguarding Children Board for 2016/17 were as follows:

Priority	Action	Outcome
1. Build on partnerships to improve the capacity of vulnerable parents to safeguard their children effectively	• Maximise partnership arrangements to evaluate and increase the impact upon safeguarding children of multi-agency approaches to parents affected by domestic violence and abuse, mental health problems and substance misuse. • Improve links and, where appropriate, hold to account key partnerships[6] to demonstrate that strategic work has a positive impact upon frontline practice and	The Safeguarding Plan sought to renew the Board's focus on parental needs which have a significant impact on children's safeguarding. There has been significant activity reviewing and addressing the impact of domestic abuse and parental mental health. Multi-agency auditing activity on domestic abuse (Jan 2017) and the parental mental health working group have contributed to a more comprehensive understanding of frontline service delivery and its challenges to address. The Borough based Partnership Groups have sought to gain opinions on the effectiveness of services to meet the needs of parents with substance use issues, and to map the changing delivery landscape of specialist commissioned services. The Violence Against Women and Girls Group (VAWG) have provided the strategic overview of our partnership response to domestic abuse across the three Boroughs. This has strengthened our knowledge and response to this key safeguarding area, with regular MARAC reporting to the Borough based Partnership Group, and escalation of blocks and concerns to key strategic leads enabled appropriate responses e.g. regular agency attendance at monthly MARAC meetings. Our learning from serious case reviews and the work of the VAWG has highlight need for further learning in respect to coercive control, which has been transferred to a priority in 2017-18. Significant activity has continued to engage a number of community groups in safeguarding developments including the Somali community in Hammersmith,

	outcomes for children.	Madrassahs, mosques and supplementary schools. The lead worker for this activity left her role in the LSCB and action is being taken to recruit a replacement. The work of the joint FGM project in partnership with Midaye (Somali Development Network) has enabled an enhanced offer to a wide range of FGM affected communities. This has supported the promotion of the wider safeguarding agenda across a wider audience. Action for 2017-18: The Board should develop a view on where to focus any future targeted work to better engage vulnerable families from particular communities.
2. Improving communication and engagement	• Develop a comprehensive communications strategy for all Board activity. • Listen to and review issues raised by multi-agency staff about safeguarding and confirm action taken by the LSCB in response. • Listen to feedback from vulnerable	There is an ongoing need to coordinate our overall approach identifying key audiences, in respect to the most effective methods of communication and ensuring such communication has an impact. Particular priorities for better communication have been via the respective Partnership Group to the frontline workers in all partner agencies and children and families. The development of the LSCB website has enabled the use of it as an efficient communication channel, supplying information and providing resources to professionals primarily. For example, the website was used to promote the work of the joint NSPCC & LSCB Neglect Campaign which lead to convening a conference with leading academics and practitioners in the field participating. Action for 2017-18: While this may not need to be a headline priority in the forthcoming year, it is important to ensure that other priorities are expressed and

	children and young people about the impact of safeguarding upon their lives and ensure the Board responds to this where required. • Build upon progress and further develop an interactive LSCB website.	communicated in a way that is accessible and understandable to staff and wider communities. The LSCB recognises that there is more work to do in order to hear the voice of children and young people across our partnership in a meaningful way and the recruitment of a community and children and young people's engagement officer will be key to assisting with this.
3. Demonstrating our impact and knowing where more effective practice is required	• Develop a shared outcomes framework and other approaches (including dip sampling and focus groups) to better measure our impact, progress and where we need to improve.	1. The Focus on Practice programme has had a major impact upon children's social care and early help practice across the three boroughs. The most significant impact has been in how social care practitioners develop relationship with families to work alongside to create opportunities for positive change, and in the use of Signs of Safety model in the delivery of child protection conference. The Programme has lead into the establishment of the Centre for Systemic Social Work, and delivers the practice leaders programme across England. 2. Following a joint LSCB & NSPCC campaign around neglect, considerable efforts have been made to ensure professional and public awareness is sufficient about

	• To inform the dataset that is aligned to the Board's priorities. • To measure the impact of actions arising from data scrutiny, audits and case reviews. • Maximise impact and of learning from serious case reviews across the three boroughs by coordinating subsequent action plans. • Review how the impact of the Focus on Practice programme is experienced by agencies responsible for safeguarding children and the opportunities for	identification, and sources of support and advice. The LSCB website provides information, and NSPCC distribution of posters and leaflets to raise awareness across a wide range of health and community settings was also undertaken. 3. Significant changes to Early Help provision have continue in the boroughs. The impact is being experienced by wider agencies and will continue to be discussed at Partnership Group level. Evidence of this is documented in the Partnership Group minutes of the three Boroughs. 4. There was a priority to review multi-agency action and planning to improve outcomes for children and young people whose needs are difficult to meet, and who may pose risks to other children. This stemmed from particular cases which were discussed at sub-group level but was not specifically progressed at Board level. Evidence is located in discussions at the Case Review Subgroup. Action for 2017-18: There is a need to review and agree whether further Board action is needed to evaluate the degree to which developments over the year in relation to a number of areas are understood by the partner agencies and whether more is needed to embed these.

	multi-agency learning from the programme. • Promote the best outcomes for children who have experienced neglect. • Assess the effectiveness of multi-agency early help partnership work at a borough level in improving outcomes for children, ensuring the LSCB is sighted on service changes that may impact on safeguarding. • Review multi-agency action and planning to improve outcomes for children and young people whose needs are difficult to meet, and who may	

	pose risks to other children.	
4. **Improving the effectiveness of the Board**	• Continue to monitor attendance of partners at Board meetings taking effective action when attendance is infrequent or turnover of key members is anticipated. • Develop a forward plan to include key Board activities and scheduling in other required reports. • Develop a work plan for the LSCB business support team that coordinates activities arising from the Board and partnership groups and drives through the priorities for children. • Ensure there is an analysis of the impact of multi-agency safeguarding training at a tri-borough level.	The outgoing Independent Chair has been proactive in monitoring the attendance of partners at Board meetings and subgroups and challenging partners where appropriate, and this continues with the new LSCB Chair, with timely requests for support from partners in relation to chairing LSCB subgroups as the need arises. Whilst it is recognised that this was not a headline priority, there was an ongoing need to develop a forward plan for Board activity for the business team and Independent Chair. This was important to ensure the different elements of the Safeguarding Plan were delivered over the course of the year. There were some challenges this year with the analysis of the impact of the multi-agency training provided by the Board. The LSCB Business Manager was also covering the role of the Multi--agency Trainer for much of the year and a priority was the delivery of the training programme, which continued to be well attended. This came at the expense of the longer term monitoring of the impact, however, evaluations received from delegates on the day of training was positive. Looking forward, a key area of work will be to re-energise the multi-agency training programme with a new training lead in place. The learning and development subgroup will ensure that the Board's priorities are reflected in training content along with learning from Serious Case and other reviews. Finally, a "watching brief" has been kept to alert the Board of changing requirements of LSCBs and safeguarding arrangements from the Government and legislation with consideration of the potential to make changes in the short and longer term in the light of available resources and the views of partners. The implications of the Wood Review and the Children and Social Work Bill (now Act 2017) have been considered by the Board and a working group of key members had been set up to reflect on the questions posed and opportunities for innovation.

KEY ACHIEVEMENTS FROM LSCB SUBGROUPS

Hammersmith and Fulham Partnership Group

The partnership group has continued to engage the community and voluntary sector and has sought to strengthen collaboration and partnerships by bringing them into the core of safeguarding work. The ongoing attendance by voluntary partners such as QPR Football Club, is having a positive impact. For example; there has been an increase in referrals to 'QPR in the Community' activities following a presentation to the Partnership Group. QPR are also supporting Children's Services in finding missing young people by providing soft intelligence.

The partnership group has routinely sought to encourage challenge among partners in a measured and proactive way. All challenges are recorded on the challenge log, which is regularly reviewed to measure outcomes and the impact of any action taken. Challenges have included inclusion of Health in strategy meetings/discussions; the inclusion of fathers in assessments and key safeguarding meetings such as Child protection Conferences; and ensuring that referrals are made to MAPPA. The Board is kept informed about all challenges that are raised.

'What are you concerned about' has remained a standard item on the partnership group agenda. This item facilitates the raising of key safeguarding issues which can then be escalated to the Board. These discussions help members consider safeguarding in the wider context and can prompt particular actions. For example; In response to the increase in knife crime, the Partnership Group made a recommendation to the Board for a short life working group to be set up to develop a multi-agency strategy in relation to knife crime and other serious offences such as acid attacks. This is now being taken forward.

The partnership group has continued to work to maintain the link between front line services and the Board. The partnership Group has been key in facilitating the dissemination of information to front line staff, including LSCB newsletter and SCR newsletter.

There has been a focus on ensuring that lessons from Serious Case Reviews, Domestic Homicide Reviews and other relevant reviews are shared with Partnership Group members and disseminated to front line staff. A half day event 'learning from Serious Case Reviews' was held in September 2016 to which all Partnership Group members were invited.

The partnership group has continued to develop strong partner relationships. There has been good and consistent attendance and contribution by partners.
Key issues such as DV, substance misuse and adult mental health have remained high on the agenda and are standing items for discussion.

Kensington and Chelsea Partnership Group

Throughout 2016 – 2017 the partnership group has benefited from continued commitment from a diverse and experienced multi-agency professional group. Four

meetings have taken place over the year, with one in each quarter of the year ahead of the main LSCB meeting.

Organisational change has been a main theme of our safeguarding discussions, with partners presenting updates on changes to their operational delivery model, key personel or commissioned arrangements to provide services directly to children, families and communities. Changes within the Police and their capacity led to a number of discussions about attendance at Child Protection Conferences and strategy meetings. The Partnership has also been kept up to date in respect to the school nursing and health visiting changes from Public Health, CLCH and CNWL, as well as the organisational changes within Children's Services and the commissioning arrangements within Public Health to deliver upon the substance use offer.

The partnership group plays a key role in creating the opportunities for continuous learning and development, and to be the connection between their own agencies and other partners to lead upon this. Over the year the group has reviewed all three boroughs' Serious Case Reviews (SCR) and learning reviews. Significantly for partners working within the Borough, the SCR for the children 'Clare and Ann' had specific impact as many services had been involved with the family. Whilst the process for the SCR took some time due to twin holding of a domestic homicide review and matters being reviewed with the Coroner's Court, learning and reflection evolved as findings from the case became clearer and the Partnership Group were able to fully contribute at all stages.

A cycle of annual updates on key safeguarding themes and service areas continues to take place, with Early Help, the Multi-Agency Public Protection Arrangements (MAPPA), the Multi-Agency Risk Assessment Conference (MARAC) on domestic abuse, and private fostering being examples considered with a local focus and opportunities explored to contribute to strengthening responses. The child protection activity data had a renewed focus in this last year, with a need for the partnership group to utilise its experience, skills and capacity to be the 'critical friend' and challenge multi-agency practice where appropriate.

The LSCB partnered with the NSPCC to deliver a Neglect Campaign across the three boroughs. The campaign group consisted of many members of this partnership group from a wide range of services, and considerable contribution was obtained to deliver a multi-agency conference on Neglect in May 2016, with a number of academic and campaign specialist in this field speaking. The conference feedback was very positive and the partnership group assisted in the productive delivery of a key learning and awareness raising event.

Westminster Partnership Group

The Westminster LSCB partnership group have continued to host guest speakers who have provided presentations, answered questions and shared information on topics pertinent to practice across the multidisciplinary membership. Topics have included, Prevent, FGM, Missing, Child Sexual Exploitation, changes to Police bail, pressures on practice resulting in changes in Probation, transition of vulnerable children to Adults Services, Home Education and the work of the ACE team and the new Family Services Multi Agency Referral Form which included an online demonstration.

Learning from audits conducted in various areas of practice has been shared with the group. Imperial health presented an audit undertaken in relation to children referred into their hospitals as a result of falling from windows. The Tri Borough Quality Assurance Manager has presented learning from LSCB multi agency audits into Domestic Abuse, Neglect and single agency audit within children's services on Missing Children.

The Luton Serious Case Review (Child J) has been shared and the findings discussed.

Changes within Family Services have been presented to the group in particular Transformational Changes within the Early Help Service, changes of management structure within the Youth Offending Service and changes to the way Child Protection Cases Conferences are conducted after adoption of the Signs of Safety approach.

A new standing agenda item entitled 'What's Keeping You Awake at Night' has elicited much discussion and helpful information sharing regarding topics of concern practitioners are encountering in their day to day practice across the multidisciplinary forum.

Priorities for 2017-2018 have been discussed and agreed and are as follows:

- Peer on peer abuse including CSE and serious youth violence
- Radicalisation
- Internet safety (underpinning both areas above).

A working group is now to be formed to progress work in these areas outside the quarterly meetings.

Case Review Subgroup

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

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

Serious Case Reviews

During the year, the LSCB has published two serious case reviews (SCR). The first, regarding Baby Rose, was published on the LSCB website in September 2016, the second, regarding Clare and Ann, was published on the LSCB website in January 2017. Alongside this report, a domestic homicide review (DHR) for Robert and Clare was also published by the Safer K&C Partnership.
This year, the LSCB has also worked in partnership with Luton and Ealing LSCBs in regard to the Luton Child J serious case review, which was published in June 2017.

The Baby Rose review involved a young mother who gave birth abroad and returned to the UK four months later with the intention of taking the baby to a specialist eye hospital for an operation. The mother informed her parents, who lived abroad, that Children's Services had removed the baby from her care, and they were so concerned that they came to the UK immediately and took their daughter to the Police to report the baby missing. Following a Police investigation, the mother was charged and convicted of murder. Police advised that she had accepted that she suffocated and disposed of the baby's body.
The report author made three recommendations for heath partners to consider:

- perinatal and maternity services must audit referrals made to the service to provide assurance that their systems are robust and vulnerable women are identified and followed up.
- midwifery services must demonstrate that there is a plan in place to implement a centrally held electronic record system
- health services should work together to develop a communication pathway locally to improve outcomes for service users

The Clare and Ann review involved a mother who, whilst acutely unwell, killed her partner and eldest daughter, and seriously injured the couple's youngest child. The serious case review concluded that there were significant levels of good quality practice across a range of agencies involved in this case; that any risk of harm to the children was very difficult to predict; and that opportunities to intervene further to help the mother, were very limited. Two findings in particular have been given attention with staff: the first is to ensure the focus given to safeguarding children is fully integrated into systems for responding to parents who present in crisis with serious mental health problems. The second is to ensure there is shared understanding across the partner agencies about the purpose and processes for undertaking urgent welfare checks on children whose carers present with significant concerns.

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

- One finding highlighted that current transfer arrangements within health visiting, and between Family Nurse Partnership (FNP) and health visiting, assume a degree of co-operation from families which means that when avoidant families with vulnerable children move, it is easy for them to avoid contact with services, leaving the children at risk of possible harm. Our local Family Nurse Partnership (FNP) have been working with the National FNP Unit to seek further clarification on procedures when a family stops engaging with the programme (which is voluntary for parents to participate in).

- Another finding highlighted that there is no requirement (in England) to do an assessment when a family with a Child in Need plan moves into the area, which increases the possibility that decisions to cease providing social work services have no relation to the risks to the child and needs of the family. The Cabinet Member for Children's Services in Hammersmith and Fulham has written to the

responsible Minister within the Department of Education to escalate this matter.

- There were three findings relating to domestic abuse within the report. One queried whether current national emphasis on the emotional harm to children of domestic abuse leads professionals to under-estimate the risk of physical harm to young children in domestic abuse situations involving physical violence. The second queried whether practitioners fail to identify risks to children when the violence is between adults, who are not living in the family and does not involve children and therefore it may not be seen as a core issue. The third finding in relation to domestic abuse stated that services for victims of domestic abuse are predicated on one model around 'coercion and control' meaning that there is a formulaic response that fails to recognise other aspects of domestic violence which may require a more nuanced reaction. This finding has more recently been the subject of a challenge from Standing Together and Respect. At the time of writing this report, the final response from the commissioning LSCB was unavailable, however, this matter will be explored further to ensure that appropriate learning can be shared with the workforce.

COMPLETED REPORTS RECEIVED AND REVIEWED

The subgroup reviewed the action plans in relation to the Southbank International Serious Case Review, as well as the Clare and Ann Serious Case Review.

Adult Z

A case management review was held in relation to Adult Z, aged 18 when he stabbed a peer and was subsequently found guilty of manslaughter. One of the learning points from this review was provided by Adult Z himself: he thought practitioners could have challenged him more and been clearer about their concerns during early interactions with him. The deterioration in his behaviour as he moved from minor school attendance issues to petty and them more serious crime, without the services involved making effective changes meant he continued with impunity. The case review group discussed how he had seen drug dealing as a victimless crime; there were also few incentives for him to stop, especially when he made more money from selling drugs than other opportunities.

Other learning included gaining a better understanding of which interventions might work with young people like Adult Z – perhaps using older peers who have gone through similar experiences – and ensuring that younger siblings are stopped from following the same pathway.

Mr S

The case review subgroup looked at two reports on a young man who had been in our care, and killed another man during a burglary.

The report found that the early assessments for Mr S could have been more holistic. More attention could have been paid to Mr S' journey, given the background features of his life and presenting issues that were already apparent by age 13, particularly the relationship with his mother. By the time he was 13, he had been looked after for two years and was beginning to accumulate a long offending history. Youth Offending and

Probation risk assessments concluded that he was at high risk of re-offending and of harm to himself and others. By the time he was 16, concerns increased as his offending had escalated, and efforts to reduce this did not have an impact.

Mr S was assessed by mental health services as not having a mental illness but a personality disorder. Earlier assessment with more flexible engagement in therapy might have helped him deal with his difficulties sooner. Had the Local Authority obtained parental responsibility for Mr S, this might have helped with seeking a Child and Adolescent Mental Health Service assessment, and certainly with attending appointments. It may also have been appropriate to have considered a welfare secure or a residential therapeutic placement for him, in order to achieve some stability and therefore a better opportunity to secure ongoing treatment. Moreover, if skilled foster carers had been found who could have offered him a sense of belonging, family life and stability, he may not have progressed so rapidly through an escalating criminal career. There is, however, no evidence to suggest that different approaches recommended in retrospect would definitely have led to the necessary changes.

Youth Offending Team assessments had previously indicated that Mr S was at a high risk of further violent offence and he had been subject to MAPPA oversight at both Levels 1 and 2. There is evidence that a violent assault had been predicted; unfortunately, neither this information, nor his mental health history was known to adult mental health staff treating him before the fatal incident. However, had the relevant information been available, adult mental health staff would have been better placed to be able to predict a further violent offence.

External Serious Case Reviews

Sutton Child D

This was a case of Child D, girl aged 6 years and 10 months who died. Child D's father was convicted of murder and her mother of child cruelty and perverting the course of justice in the cover-up of her death. There was a long history of physical injury and her father was convicted of grievous bodily harm when Child D was a small child. However, his conviction was quashed on appeal and a High Court Hearing overturned the previous Finding of Fact, which meant the parents were found not to be culpable of involvement in Child D's injuries.

The Judge appointed an Independent Social Work Agency (ISWA) to carry out an assessment of the parents – and Child D and her sibling went back to live with their parents. A number of concerning events followed but, despite these, the ISWA continued to regard the parents positively, even though they were hostile to Sutton Children's Services. Most professional contacts with Child D in the last few months of her life were with universal services.

The Serious Case Review found that the case was particularly unusual due to:

- the extreme level of avoidance, deception and resistance from the parents, who were often evasive, contradictory and aggressive
- the use of an ISWA for reunification of the children with their parents and the exclusion of the council's Children's Services

- the fact that despite significant concerns being documented, the effect of the court judgement and exoneration, combined with the parent's refusal of any voluntary engagement with support services, was that no intervention that might have made a difference was possible.

The review identified 14 learning points for multi-agency partnerships, some of which include:

- to be aware of the bigger picture and to use a wide lens to consider information and expertise in complex cases
- the importance of focusing on the children and their voices
- concentration on the behaviour, demands and challenges of the adults must not to the detriment of the focus on the child
- never lose sight of how the child experiences behaviours of parents who are resistant and hostile to outside support.

Other reviews/subject brought for discussion

The case review subgroup heard from colleagues in health about a complex case involving fabricated and induced illness and working with difficult and challenging parents carers. Working with fabricated and induced illness and chronic ill-health in children, especially in hospital settings can be a considerable challenge for front-line staff. The LSCB is keen to explore ways to help staff deal with parental behaviours that obstruct access to therapies and recovery for children. Aggressive behaviour toward professionals when children are present, and children hearing defamatory allegations against professionals, both contribute to the child's mistrust of their professional team.

The case review subgroup considered the difficulties encountered by practitioners where the child becomes isolated from social interactions and if professionals are unable to care for the child without fear of repercussions, the child can become serially 'let down' as the parental behaviour blocks any ongoing professional relationship with the child – and it can reinforce the child's belief that they are too unwell to access therapies. In some cases, criminal investigations can be taking place simultaneously making the child's situation very complex to manage.
Often many hospitals are involved with such children, as well as social workers and other health staff in the community.

The case review subgroup is working in partnership with the learning and development subgroup to explore how we can put together a learning event /conference on the topic of fabricated and induced illness and come together to share best practice regarding this very complex subject and a learning review is being explored to extract the specific learning from the case discussed at the subgroup (this will take place in 2017-2018).

Communication of the Lessons

As a matter of routine, all three local partnership groups in the three local authorities take the review reports to their meetings to ensure there is wide dissemination of the lessons. The LSCB training offer is amended where required to incorporate learning.

In addition, all LSCB members are expected to communicate and cascade lessons back to their agency networks as appropriate. A key task for the future will be to ensure the LSCB's Learning Review newsletter, which includes a summary of the lessons from cases discussed in the subgroup, is re-launched and that we track the dissemination of this to ensure it reaches practitioners on the front line.

Quality Assurance Subgroup

Reports and recommendations from the Missing Children and CSE and Domestic Abuse audits carried out in 2016-17 were discussed at the QA group and shared with the full LSCB Board. Key learning points and recommendations from published reports:

Missing Children and CSE

- The majority of children were known to services, vulnerable to a variety of influences, often showing signs of substance abuse and self-harm. Practitioners generally found the young people difficult to engage.
- Practitioners working with these children are often in need of support, and are most effective when they are able to build a strong relationship with the young person.
- CSE leads in each borough and Missing Person's Co-ordinator were roles valued by practitioners who appreciated the opportunity to consult with specialist workers.
- Return Home Interviews were more effective when carried out by someone independent of the child's care and has the best relationship with the young person (e.g. teacher, school nurse, CAMHS worker).
- When done well, return home interviews can help to identify triggers and push pull factors, or who a child is associating with. Other practitioners found a return home interview was duplicating information from the Police debrief with the child and can lead to child / family feeling frustrated as they are repeating themselves.
- The audit has demonstrated the clear link with CSE and Missing cases.

Domestic Abuse

- Agencies demonstrated an awareness of the serious risk and as a result of some dedicated work children are safer and positive changes have been made with families.
- More joint working and intelligence sharing was required around supporting early referrals, agreeing how information will be cascaded during a case and between Police CSU and Family services to support children and survivors.
- In working with families there is a need for creative approaches where traditional routes are not working and for the use of clear and meaningful language.
- The information loop needed also to be tightened to ensure regular updates and progress is known by all.

- A *danger statement* or similar was recommended when communicating concerns to both parents and the full professional network.
- MARAC referrals needed to be considered on all cases by agencies and eligibility reviewed within supervision highlighting the analysis of risk and whether a referral to this forum is appropriate – this should take into account any recommendations by MASH.
- Consideration needed to be given to starting a working group to include agencies involved with completing work with survivors and perpetrators around the abusive behaviours to map the different services available and consider potential gaps/creative working opportunities to the work we complete with families.

Section 11 Audits

Section 11 of the Children Act 2004 details the responsibilities that agencies have for safeguarding children. In 2016-2017, a revised online audit tool was launched and returns were received from CNWL and CLCH. The audit tool was rolled out to schools, however there was poor take up in the first round, therefore the audits were revised again and sent out via email in 2017-18. The next round of partners to be audited in 2017-18 include Imperial, the private health providers, and Children's Services, including commissioned services. Returns from the independent schools and private, voluntary and independent nursery providers, will also be scrutinised, with the assistance of our LSCB Lay Members.

Next steps with multi-agency audits

The QA subgroup recommended that there would be two full audits a year: one a new topic and one a 'revisit' of a previous theme focused on progress with the recommendations that were made. Future audit topics will align with the Joint Targeted Area Inspections themes and Board priorities.

In addressing the Ofsted action that recommendations from multi-themed audits are carried out and used to improve practice, it is the expectation that each agency takes responsibility for the actions identified from the case audits, and report by exception. As part of the new Audit schedule, repeat audits will also take place in order to measure impact.

New organisation of sub-group meetings

The QA subgroup this year reviewed the meeting structure to strengthen the schedule and relationship with the key work around audits and dataset development. It was agreed that:

- Two of the meetings (June and December) across the year would link to the multi-agency audit workshops and a discussion on the initial findings. This would allow the QA members to hear directly from the practitioners involved. We will also seek data that relates to the audit theme for those meetings.

- The remaining two meetings a year (September and March) will continue to scrutinise the core data set that we collate and produce by exemption key data reports for the LSCB board, particularly around the LSCB priorities.

Harmful Practices Steering Group / FGM Early Intervention Pilot

The Harmful Practices Steering Group was formed in June 2015 as part of the new governance structure to deliver the 2015-2018 Shared Services Violence Against Women and Girls (VAWG) Strategy and regularly reports to the VAWG Strategic Board and the LSCB.

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

The two year MOPAC Harmful Practices (HP) pilot ended in March 2017. The pilot aimed to improve the way agencies identify and respond to Female Genital Mutilation (FGM), so called Honour Based Violence (HBV), Forced Marriage (FM), and Faith Based Abuse (FBA), with a focus on early identification and prevention, safeguarding and support, and community engagement. The pilot was delivered by the Partnership to End Harmful Practices (PEHP, a consortium of seven women's organisations) in Westminster, Kensington and Chelsea, Hammersmith and Fulham and two other London Boroughs.

Ending Harmful Practices Training

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

Attendance in the second year of the training programme locally was less successful than in the first year, however, a process evaluation of the pilot undertaken by the MOPAC Evidence and Insight Team found that the training element was widely recognised as the key success of the pilot. During the course of the pilot, the training courses that were delivered were received well by attendees in terms of quality, content, and improving practitioner knowledge around harmful practices. Respondents to an evaluation survey felt the training had improved their ability to identify and respond to harmful practices, and often highlighted examples or plans to share learning with colleagues back in their respective workplaces.

Female Genital Mutilation Early Intervention Project:

The Female Genital Mutilation Early Intervention Model (MOPAC FGM EIM[7]) pilot was established to implement and refine an effective strategy to prevent new cases of FGM among women and girls, while supporting those affected by FGM. In order to achieve this, the pilot brought statutory health and social services together with community organisations to develop an effective and sustainable intervention delivering support to women who have undergone FGM and safeguarding those at risk of FGM. The pilot was delivered across Hammersmith and Fulham, Kensington and Chelsea and Westminster (alongside two other London boroughs).

This work included developing FGM clinics located within hospital midwifery services (at St Mary's Hospital, Chelsea and Westminster Hospital and Queen Charlottes Hospital) and staffed by a specialist FGM social worker, therapists, community and health advocates drawn from community organisations, and specialist FGM midwives. Women identified by health and other professionals as having undergone FGM – and, in particular, pregnant women identified by midwives – were referred to the clinics for support and safeguarding services. Women who have undergone FGM were also able to self-refer to the clinic.

The specialist FGM social worker has provided advice on the law around FGM and safeguarding children, as well as more general support with accessing services. Emotional support and therapeutic interventions have been provided by the therapists, and community advocates have acted as mediators between clinic staff and the women who attend the clinic. The specialist FGM midwives provide advice on the type of FGM that women have; and health issues women may face (including during pregnancy and labour) as a result of their FGM. Issues dealt with in the clinics have ranged from housing problems, to mental health, extreme isolation due to forced immigration or being refugees and also the devastating impact of FGM on women. There is also a more proactive element focussing on Child Protection, where women who have had FGM and have girls or give birth to baby girls have been assessed by Children's Services. This assessment seeks to speak to wider family members and also take into consideration other cultural and systemic factors that influence the belief behind the practice. This is done in conjunction with the community advocates, providing the families with a voice and a familiar figure and also providing social workers with a better cultural understanding.
This approach demonstrates a more systemic model recognising, that survivors of FGM don't always have the power to be able to protect their daughters. It also acknowledges that FGM is a traditional hidden practice, steeped in culture and it is different from other types of Child Abuse in two main ways:

a. With FGM, prevention is protection. Once a girl has been cut – there is no going back and we have failed in our duty to protect her.
b. Unlike other types of abuse, girls who come from FGM practicing families do not show signs that we usually look out for in other types of child abuse; such as low school attendance or neglect; in fact, they usually come from families who are invested in their daughters.

It was acknowledged that midwives are often best-placed to identify women who have undergone FGM, while social workers have the most highly developed expertise in

[7] The Mayor's Office for Policing and Crime Female Genital Mutilation Early Intervention Model: An Evaluation

safeguarding and direct work with families. The clinic aims to bring together the skills and expertise located within these professions in order to offer a high quality intervention that is developed alongside and facilitated by community advocates.

Alongside work in the FGM Clinics, the specialist FGM social worker and colleagues have delivered training to local professionals; engaged with members of potentially-affected communities to continue to raise awareness of FGM-related issues; provided support and information to men affected by FGM; and engaged with local school pupils to raise awareness about FGM.

An evaluation of the pilot was undertaken by the Department for Education [4] and overall found that the project has been successful in embedding safeguarding within an early help approach that is supportive to both women and children.

Safeguarding Children Health Subgroup

The Safeguarding Children Health Subgroup (SCHS) provides a forum for sharing good practice, learning, innovation and raising concerns regarding safeguarding children. The Designated Professionals for Safeguarding Children chair the LSCB Health Subgroup, which meets on a quarterly basis.

The SCHS has facilitated and aligned collaboratively with health partners reporting requirements and developed quality improvement initiatives for safeguarding children across the child's journey in the health economy.

The SCHS has facilitated a discussion between providers and a joint approach in relation to responding to and promoting national initiatives in meeting targets and performance indicators which enable clinical benchmarking and peer review, with guidance from NHS England (London) when appropriate.

Key achievements of the group during the reporting year

- The Terms of Reference and membership of this sub-group were reviewed: thus improving group's quoracy by identifying the key organisational representatives who should attend, rotating meeting days and setting dates for the year ahead to enable the right representatives to attend.
- The standing agenda items were revised to ensure meeting outcomes were robust and relevant to group members.
- Serious Case Reviews have been added as a standing agenda item whereby the recommendations for health agencies and action plans incorporated into practice to ensure learning is embedded across the health economy.
- The group achieved the use of a standardised referral form to children's social care developed by Imperial Healthcare Trust and shared with the acute NHS Providers.

- In collaboration with the LSCB Business Manager, the Designated Nurses strengthened the Section 11 audit tool to support a health focus so that providers can demonstrate the fulfilment of their statutory duties.
- Strong links were developed with the Public Health representative on the subgroup to ensure that both providers and commissioners who attend the LSCB Board discuss the whole economy.
- The Designated Drs proposed that the structure should be changed and that there should be one post across the three boroughs, this was supported by the CCGs and will be progressed in 2017-18.
- The CCGs facilitated a workshop with the health partners of the LSCB to consider a local response to the options proposed in "**Developing a Local Safeguarding Arrangement in the Context of the Alan Wood Review and the Government's Response"** and presented a range of proposals for how the LSCB might develop in the future.
- Guest speakers were invited to meetings to raise awareness of changes across the NHS landscape to the group members and how these changes will have an impact on safeguarding children examples of this are:
    - Sustainable Transformational Plans
    - Accountable Care Partnership

Priorities of the Safeguarding Children Health Subgroup for 2017 -18

- To review the model of 2 Designated Doctorss for the LSCB and propose the establishment of one post.
- For health partners to undertake internal audits to evaluate the learning from SCRs ensuring it is embedded in practice.
- To ensure the Named Doctors from providers organisations are engaged in the SCHS in some way.
- To hold an annual learning event for the group to ensure group's work is captured effectively and feedback to the LSCB.
- To develop formal feedback mechanisms for subgroup members to their respective organisations as currently feedback is only via the LSCB
- Undertake a root cause analysis on how the group can strengthen and influence changes across health and social care.

Learning and Development Subgroup

This has been a particularly challenging year for the learning and development subgroup, as following the departure of the LSCB trainer, the delivery of and co-ordination of the training programme fell to the Business Manager.
Despite this, the LSCB has continued to provide a wide-ranging training offer. This year, a total of 9 Introduction to Safeguarding Children workshops, and 36 Multi-agency Safeguarding and Child Protection courses were offered, alongside 3 multi-agency Safeguarding and Children Protection Refresher workshops. Specialist workshops included in the programme included two sessions on domestic abuse,

parental mental health and parental substance misuse, and also one on working with difficult and evasive families.
In partnership with the Women and Girls Network, we continued to offer a series of five workshops on child sexual exploitation.
The LSCB continued to facilitate the roll out of the Partnership for Ending Harmful Practices Pilot (PEHPP) training. This included eight half day multi-agency workshops (open to all agencies) covering FGM, forced marriage, honour based violence and faith based abuse.

Working in partnership with the Safer Organisations Manager and Tri-Borough LADO (Local Authority Designated Officer), we hosted accredited Safer Recruitment Workshops and Meet the LADO workshops to raise awareness of this important role, although it was noted that attendance at these workshops was low. This may be a reflection of the demands on delegates, such as headteachers and managers who get called away from training at short notice.

The LSCB published an e-learning course on private fostering and continues to signpost to free external e-learning on FGM, Forced Marriage and CSE as well as promote other key training such as the WRAP (Workshop to Raise Awareness of Prevent) sessions offered by the Prevent teams.

A well-attended conference learning event on the Southbank International Serious Case Review was hosted in March 2016.

Evaluation of the training courses was carried out by a pre and post workshop evaluation form, to show how much learning has taken place on the day. Further longer-term evaluations were not possible this year without the LSCB trainer being in post.

Our priorities for 2017-18 include improving the way we evaluate training workshops, by holding focus groups to further measure the impact of training. The specialist course offer will be reviewed and additional workshops on safeguarding adolescents, gangs, Working with Perpetrators of Domestic Abuse, Child Sexual Abuse, Parental Substance Misuse and the Impact on Children, Parental Mental Health and e-safety will be explored.

A learning event on the Clare and Ann serious case review is also being developed.

NEGLECT CAMPAIGN, IN PARTNERSHIP WITH THE NSPCC

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

A number of follow up workshops to raise awareness of neglect with key frontline practitioners were delivered, and neglect video and resources were published on the LSCB website.

The Board is working with the NSPCC to complete an evaluation of this project.

Short-life Work Group on Parental Mental Health

Parental mental health and wellbeing is a key factor in determining the life circumstances, wellbeing and safety of a child. Parents with mental health problems need support and recognition of their responsibilities as parents and their children's needs must also be addressed. The LSCB completed a short life working group on parental mental health this year. The aims of the group were to collate relevant national and local learning on the topic of parental mental health, including learning from published case reviews, the confidential enquiry into maternal deaths and any local relevant initiatives that could be identified.

The short life working group made several recommendations to the Board:

1. *Joint Audits should be conducted between partner agencies in respect of mental health functions.*

   The Board agreed to continue with an audit programme to include work identifying practice in respect of parental mental health. Mental Health Trusts and other providers should ensure support for completing, analysing and reporting results is provided to ensure the work load is shared by all partners.

2. *Development of relevant metrics for all agencies to ensure the 'Think Family' approach is delivered*.

   The Board agreed that this is challenging in the current climate. However, the Board must consider how it includes assurance, from across the agency network, on issues relating to parental mental health and gathering evidence on the implementation of the 'Think Family' principles.

3. *Engagement with private mental health providers to support their engagement with best practice.*

   The Designated Nurses for Safeguarding Children continue to engage with private healthcare providers through the private health network that meets quarterly.

4. *Developing an offer of training for the co-existing issues of mental health problems, substance misuse and domestic abuse*.

   The 16-17 LSCB training programme included training on the 'trio' of concerns. An area to develop going forward will be more in-depth workshops on each of those topics separately, as well as reviewing and challenging what single agency training needs are in this area. The learning from a recent serious case review (Clare and Ann) has been incorporated into our core multi-agency safeguarding and child protection course. Additionally, a larger conference learning event focussing on this serious case review is planned for early 2018.

LSCB PRIORITIES FOR 2017-2019

Following a review by the Board and consideration of developing needs across the three local authority areas, the following four priorities with associated outcomes and actions form the basis of LSCB's Safeguarding Plan for 2017/2019, whilst not losing sight of key 'business as usual' for safeguarding across the partnership.

Priority 1: Domestic Abuse and Coercive Control	
Outcomes	**Actions**
An evidence-based response to coercive control with a focus on protecting and reducing risk to children and supporting those abused	• Identification of resources to strengthen work with perpetrators. • Review mechanisms to identify various types of coercive control and assess provision of interventions • Identify training needs of multi-agency professionals. • Raise awareness of coercive control in relationships. • Strengthen the co-ordination of the activity of both the LSCB and the VAWG partnership to deliver better outcomes for children and young people.

Priority 2: Peer on Peer Abuse and Serious Youth Violence	
The LSCB is providing oversight and scrutiny of the effectiveness of services in preventing and tackling peer on peer	• Peer on peer abuse - assess the access to support and therapeutic services • Coercive control – assess and identify gaps in support services for young people at risk. • Review resources for intervening with young perpetrators. • Work with agencies to develop a strategy around knife crime and serious youth violence.
Priority 3: Increase the Board's meaningful engagement with children and young people	
The LSCB is engaging with children and young people to ensure their representation on key matters that impact upon them.	• Appoint the new post holder for community and children and young people's engagement. • LSCB Chair and relevant subgroup members to visit existing young advocate groups, youth representation panels or orther designated youth leaders. • LSCB Chair to assess representation of children and young people from diverse, marginalised or excluded groups. • Maximise the available participation forums across the three boroughs and via partner agencies, to engage a wider audience of children and young people. • Consult young people to plan and deliver a youth engagement plan for the LSCB • Ensure representation, in appropriate formats, of children and young people in LSCB events and activities.

Priority 4: Working with the Safeguarding Adults Executive Board (SAEB) and linked strategic partnerships	
There are clear and understood transition pathways from child to adult services, especially where there are concerns about ongoing vulnerability	• Work with the SAEB to promote a more holistic 'Think Family' approach to identifying safeguarding needs • Work jointly with agencies to establish set transition pathways including mental health. • Create a co-ordinated response to legislation and guidanc on 'Modern Slavery' • Conduct a review of how effectively agencies work together to support problematic parental substance misuse to minimise its impact on children. In particular

A coordinated response to new legislation that includes adults and children's safeguarding issues. A co-ordinated approach to safeguarding linked to parental and young peoples' substance misuse.	○ How Public Health consider safeguarding in their commissioning of services ○ Assess the clarity amongst commissioners regarding their responsibilities. Identify gaps / duplication and safeguarding impacts. • Jointly ensure agencies have structured processes to identify the support needs of vulnerable parents and that a child's views and concerns are at the forefront of the assessment process. • Work jointly on the quality, safety and safeguarding aspects of substance misuse by young people

LSCB Budget 2016-2017

	2016/17 Actual Outturn				2016/17 Corrected Outturn			
	LBHF	**RBKC**	**WCC**	**TOTAL**	**LBHF**	**RBKC**	**WCC**	**TOTAL**
CONTRIBUTIONS								
Sovereign Borough General Fund	**-79,169**	**-59,462**	**-76,930**	**-215,561**	**-79,169**	**-59,462**	**-76,930**	**-215,561**
Metropolitan Police	-10,000	-10,000	-10,000	**-30,000**	-10,000	-10,000	-10,000	**-30,000**
Probation				**0**				**0**
CAFCASS	-550	-550	-550	**-1,650**	-550	-550	-550	**-1,650**
CCG (Health)	-20,000	-20,000	-20,000	**-60,000**	-20,000	-20,000	-20,000	**-60,000**
Total Partner Income	**-30,550**	**-30,550**	**-30,550**	**-91,650**	**-30,550**	**-30,550**	**-30,550**	**-91,650**
Total Funding (excluding reserves)	**-109,719**	**-90,012**	**-107,480**	**-307,211**	**-109,719**	**-90,012**	**-107,480**	**-307,211**
EXPENDITURE								
Salary expenditure	14,669	56,918	27,030	**98,618**	32,873	32,873	32,873	**98,618**
Independent Chair	0	0	0	**0**	0	0	0	**0**
Training	0	6,219	6,600	**12,819**	4,273	4,273	4,273	**12,819**
Peer review/consultancy	0	0	0	**0**	0	0	0	**0**
Multi-agency Auditing	0	0	0	**0**	0	0	0	**0**
Other LSCB costs	1,123	24,282	2,871	**28,277**	9,426	9,426	9,426	**28,277**
Total expenditure	**15,792**	**87,420**	**36,502**	**139,713**	**46,571**	**46,571**	**46,571**	**139,713**
Serious Case Review related expenditure in-year								
Forecast variance	**-93,927**	**-2,592**	**-70,978**	**-167,498**	**-63,148**	**-43,441**	**-60,909**	**-167,498**
Moved to B/S for partner income					**63,148**	**43,441**	**60,909**	**167,498**
Final outturn variance	**-93,927**	**-2,592**	**-70,978**	**-167,498**	**0**	**0**	**0**	**0**
BALANCE SHEET								
Reserves Brought Forward	-5,500	-70,689	-55,226	**-131,415**	-5,500	-70,689	-55,226	**-131,415**
Adjustment in year				**0**				**0**
Contribution to LSCB balance sheet accounts	**0**	**0**	**0**	**0**	**-63,148**	**-43,441**	**-60,909**	**-167,498**
Reserves to take forward	**-5,500**	**-70,689**	**-55,226**	**-131,415**	**-68,648**	**-114,130**	**-116,135**	**-298,913**

The tables above show the reported outturn at the end of the year and a revised outturn after errors were identified. Corrections are being made to re-attribute costs appropriately in 2017-2018.

GLOSSARY OF TERMS

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

CONTACT DETAILS

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APPENDIX A: LEGISLATIVE AND STATUTORY CONTEXT FOR LSCBS

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

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

(b) to ensure the effectiveness of what is done by each such person or body for those purposes.

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

1(a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

(i) the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;

(ii) training of persons who work with children or in services affecting the safety and welfare of children;

(iii) recruitment and supervision of persons who work with children;

(iv) investigation of allegations concerning persons who work with children;

(v) safety and welfare of children who are privately fostered;

(vi) cooperation with neighbouring children's services authorities and their Board partners;

(b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;

(c) monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;

(d) participating in the planning of services for children in the area of the authority; and

(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

APPENDIX B: LSCB BOARD ATTENDANCE 2016-2017

Role	19th April 2016	19th July 2016	11th October 2016	31st Jan 2017
LSCB Chair	y	y	y	y
Executive Director of Children's Services (Tri-borough)	y	y	y	y
Director of Family Services (H&F)	y	y	y	y
Director of Family Services (RBKC)	y	y	y	y
Director of Children's Services (WCC)	y	x	y	y
Director of Schools (Asst Director)	y	y	y	y
Head of Combined Safeguarding & Quality Assurance	y	y	y	y
LSCB Business Manager	y	y	y	y
Director of Adults Safeguarding (or rep)	y	y	y	y
Housing	y	y	y	y
Police Borough Command	x	y	y	y
Police CAIT	y	y	y	y
Probation	y	y	y	y
Community Rehabilitation Company	y	y	y	x
CAFCASS	x	x	y	x

Prisons	x	x	y	x
Ambulance Service	y	x	x	x
Voluntary Sector	y	y	y	y
Lay member	y	y	y	y(2)
NHS England	x	y	x	x
Health CCGs	y	y	y	y
Designated Doctor INWL/Designated Doctor Chelwest	x	y	y	y
Designated Nurse	x	y	y	y
Head of Safeguarding, CLCH	y	x	x	y
CLCH Director of Nursing	x	x	x	x
Imperial Director of Nursing	y	y	x	y
Chelwest Director of Nursing	y	y	y	y
WLMHT	y	y	y	y
CNWL	x	x	y	y
Public Health	y	y	x	y
Community Safety Team (Commissioning)	x	y	y	y
Policy Team (Commissioning) (advisory)	y	y	y	y
Head Teachers	y	x	y	x
Cabinet Member for Children's services, H&F	x	x	x	y

Cabinet Member for Family and Children's Services, RBKC	y	y	y	y
Cabinet Member for Children's Services, WCC	y	y	y	y

Please note for the purpose of this table 'y' means attendance of the LSCB Member or a representative, 'o' means a representative was not expected and 'x' that no representative attended.

This report was prepared by the LSCB Independent Chair, Jenny Pearce, with support from Emma Biskupski (LSCB Business Development Manager).
We would like to thank the many members of the LSCB who made contributions to the report.

Approved by LSCB : xxx October 2017

Published on xxx 2017