Redbridge Local Safeguarding Children Board (LSCB)

ANNUAL REPORT

2016 – 2017

Contents

Chair's Foreword

I am pleased to introduce the Local Safeguarding Children Board's report for 2016/17.

As described in the statutory guidance, Working Together to Safeguard Children, the LSCB's Annual Report should

> "provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action. The report should include lessons from reviews undertaken within the reporting period."

The report should also include information on the LSCB's assessment of the effectiveness of Board partners' responses to child sexual exploitation, and appropriate data on children missing from care, and how the LSCB is addressing the issue. Fundamentally, the report should seek to answer the question, 'How well are children in Redbridge protected?'

This is the third Annual Report for which I have been responsible since I began chairing the Board in August 2014. I have to say that I probably have more anxiety about the robustness of safeguarding activity in Redbridge now than I did at the point of producing the last two reports. In part this is simply a reflection of a more general concern about the cumulative impact of years of austerity on public services, and the ever increasing pressure on professionals and services which is driven by demand and increasing pressures on some of our most vulnerable families – some of the evidence for which is documented later in this report. There are however other causes for concern.

2016/17 was a year in which a substantial amount of inspection evidence about the quality of public protection work more broadly, and children's safeguarding work more specifically, was delivered. While some of this was extremely positive, some gave considerable cause for concern. Ofsted reported in November 2016 that the Council's children's social care services were good – reading the report in detail, I would say very good – and getting better. There have been encouraging improvements in performance, as assessed by independent inspection, in our health partners. Barking Havering and Redbridge University Hospitals NHS trust (BHRUT) came out of special measures in March 2017. Services for children were judged to be good, and staff were assessed as having a good understanding of safeguarding responsibilities. Whipps Cross Hospital remains 'inadequate' in the judgement of the Care Quality Commission. However services for children and families, and in maternity and gynaecology, are good, and safeguarding arrangements are robust. NELFT (formerly North East London Foundation NHS Trust) was inspected in April 2016, and while overall it was judged to require improvement, it was judged to have good systems and processes in place for safeguarding children.

However the quality of public protection work by the National Probation Service in eight London boroughs, including Redbridge, was judged to be mixed. The service provided by the Community Rehabilitation Company was found to be extremely poor. Perhaps most worryingly in relation to an agency with absolutely central child protection responsibilities, the inspection judgement on the child protection work of the Metropolitan Police in November 2016 was extremely critical. To quote a passage from the inspection report which is included in the body of this report, but which bears repeating here:

> "Too many cases fell well short of the expected standards required for a good investigation. Many took too long to progress and had no effective supervisory oversight, resulting in a lack of protection for victims, loss of evidence, and continuing risk from offenders. Staff whose job it is to respond to and investigate such challenging and often distressing cases need to be competent, trained and supported. This is not consistently the case in the MPS."

This finding did not reflect the experience of the LSCB or of partner agencies in Redbridge. Indeed Ofsted had described the joint working they found in place in Redbridge between social care and the police as the best they'd seen anywhere. But at the very end of 2016/17 a radical police restructuring across Redbridge, Barking and Dagenham, and Havering was implemented which has major implications for the management and delivery of child protection work. The lack of any consultation or engagement with partners, in particular children's social care, on how the structure could work effectively at an operational level with three very different local authorities was very disappointing. It is not possible yet to be confident that the gold standard partnership working that Redbridge and its children have enjoyed in the past can continue to be assured under the new arrangements. It would be tragic if the end result of police reorganisation was that children were less well protected under the new arrangements than they were under the previous borough based ones. We must – all of us, everybody involved – make sure that this does not happen.

The other great cause for concern I have is what I think is emerging as the crisis in mental health services for children and adolescents – a crisis which, without being melodramatic, could place some of our most vulnerable young people at substantially increased risk. In the body of the report we describe the impact on these services of a range of pressures in 2016/17 and the restrictions on access to these vital services that those pressures required. There is a radical plan on paper for the transformation of services and access in this area, but progress towards its delivery seems to be agonisingly slow, and in the meantime there must be a risk that the outcome will be fewer young people getting the service that they desperately need and waiting longer for it. If young people in Redbridge are to be adequately safeguarded, we have to see dramatic and rapid improvements in a system that promotes resilience in all young people and provides appropriately intensive and timely help for those young people in most need.

Stepping back, I do not hesitate to say, as I have said in the last two Annual Reports, that overall children in Redbridge remain well protected through a huge amount of passionate and skilled work by professionals and others across all partner agencies. Partnership

working, as reflected in engagement with the LSCB and in much evidence of good multi-agency working on the ground, remains strong. But the pressures that I have described above do sometimes make that partnership feel a little more fragile than it has in the past.

John Goldup

Independent Chair,

Redbridge Local Safeguarding Children Board

1. Redbridge Local Safeguarding Children Board (LSCB): purpose, effectiveness and future

What is the LSCB?

The Local Safeguarding Children Board (LSCB) is a multi-agency body whose role is to oversee, co-ordinate, challenge, and scrutinise the work of all professionals and organisations in Redbridge to protect children and young people in the Borough from abuse and neglect, and to help all children to grow up safe, happy, and with the maximum opportunity to realise their potential. It is a statutory body established under the Children Act 2004. However, when the Children and Social work Act 2017 is fully implemented, the requirement to establish and maintain an LSCB will be repealed. This is discussed further below. Under the 2004 Act, still in force, every local authority in England is required to establish a LSCB with two primary purposes:

- to co-ordinate what is done by each person or body represented on the Board to safeguard and promote the welfare of children in the local authority area; and
- to ensure the effectiveness of what is done by each such person or body for those purposes.

The Local Safeguarding Children Board Regulations 2006 and Working Together to Safeguard Children (2015), which is statutory Government guidance, further expand on the role and responsibilities of LSCBs. In particular, Working Together states that LSCBs should, as a minimum:

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

However, Working Together also makes clear that

> "LSCBs do not commission or deliver front line services though they may provide training. While LSCBs do not have the power to direct other organisations they do have a role in making clear where improvement is needed. Each Board partner retains its own existing line of accountability for safeguarding."

Every LSCB is required to publish an Annual Report.

Ofsted's review of the effectiveness of Redbridge LSCB

Legislation, regulations, and guidance set out the minimum requirements of LSCBs. However, Redbridge LSCB has been ambitious to go beyond minimum requirements, in order to ensure that safeguarding services in Redbridge achieve the highest standards and that all children in Redbridge have the best possible life chances and opportunities. The effectiveness of LSCBs is subject to review by Ofsted.

Ofsted conducted a review of the effectiveness of the Redbridge Local Safeguarding Children Board in 2016/17 at the same time as they carried out a full inspection of the Council's services for children in need of help and protection, children looked after and care leavers. The inspection took place between 12 September and 6 October 2016, and the report was published on 25 November 2016.

The LSCB was judged to be **good**. In their Executive Summary, inspectors said:

> "This is a good Local Safeguarding Children Board (LSCB) that provides effective and robust challenge to partner agencies in order that they provide sound, coordinated services for children, young people and families in Redbridge.
>
> The review took place at a time of interim cover arrangements, with the LSCB chair activing as interim director of children's services (DCS) and the vice-chair of the board acting up temporarily as the chair. Both have worked highly effectively and flexibly to ensure a continuous strengthening of the work of the board. The chair and partners have accurately harnessed widespread partnership commitment to ensure that they are being addressed through a comprehensive action plan. This includes the refinement of the data set available to the board, which is in progress.
>
> The independent chair of the LSCB provides clear leadership, direction and guidance. He has facilitated a forward-thinking board and created a culture where constructive challenge and scrutiny are welcomed in order to improve service provision effectively.
>
> The board is appropriately constituted and attendance at board meetings is consistently high, with representation from a full range of key statutory agencies at an appropriately senior level, as well as exceptionally good engagement and representation from the voluntary sector. This is evidenced by increased financial contributions from some partner agencies and the effective chairing of sub-groups by others. The diversity of the local communities is appropriately represented through lay members, who are an integral part of the board.
>
> The board has successfully implemented a multi-agency audit programme, demonstrating a clear understanding of the key issues in Redbridge. The audit programme needs to become further embedded for the board to be fully assured that the services provided and work undertaken by agencies to keep children and young people safe are consistently robust and effective.

> The board uses both national and local learning reviews and auditing activity effectively to ensure that policies and protocols are regularly updated. Training is comprehensive and of a high quality, but evaluation of training courses is underdeveloped. The LSCB annual report is thorough, evaluative and well written. It outlines the priorities, current context, progress made, areas for improvement and challenges across safeguarding services in Redbridge."

By the end of 2016/17, reports on the effectiveness of 127 LSCBs had been published. 27 (21%), including the Redbridge Board, were judged to be good in terms of overall effectiveness. Three were judged to be outstanding.

The inspectors identified a number of areas for further development for the Board, and made the following recommendations:

- Extend the range of the performance data set to include data on child sexual exploitation, children missing and female genital mutilation, in order to better identify patterns and issues to be addressed.
- Strengthen the evaluation of training to ensure that it is longitudinal, robust and can evidence positive impact on outcomes for children and families.
- Embed the multi-agency audit programme in order for the board to have greater assurance of the quality of frontline safeguarding practice.

These were all areas for development that the Board itself had identified and on which at the time of the review substantial work was in progress. All have now been fully implemented. The Chair believes that if the review were to be repeated in 2017/18, the LSCB would now be judged by Ofsted to be outstanding. However, Ofsted will not be conducting any follow-up reviews of LSCBs.

The Children and Social Work Act 2017

The Act received Royal Assent on 27 April 2017, shortly before Parliament was dissolved for the General Election that took place on 8 June. It repeals the statutory requirement contained in the Children Act 2004 for the establishment of an LSCB in each local authority area. It defines a set of 'safeguarding partners' for each area – the local authority, the Clinical Commissioning Group (CCG), and the police. The onus for agreeing local arrangements for co-ordinating local arrangements for multi-agency work to safeguard children, and for ensuring their effectiveness, is placed on the statutory safeguarding partners, working with other 'relevant agencies that they consider appropriate' under Section 16 of the Act:

> "The safeguarding partners for a local authority area in England must make arrangements for (a) the safeguarding partners and (b) any relevant agencies that they consider appropriate, to work together in exercising their functions, so far as the functions are exercised for the purpose of safeguarding and promoting the welfare of children in the area.

The arrangements must include arrangements for the safeguarding partners to work together to identify and respond to the needs of children in the area."

The Act also provides that two or more local authorities may combine in a single set of arrangements, and that "the arrangements must include arrangements for scrutiny by an independent person of the effectiveness of the arrangements." It makes significant changes to the statutory framework for Serious Case Reviews (SCRs). "Serious child safeguarding cases in England which raise issues that are complex or of national importance" will be reviewed by a new national Child Safeguarding Practice Review Panel. The Act also replaces the current requirement for Child Death Overview Panels (CDOPs) in each area with the potentially less prescriptive requirement that "The child death review partners for a local authority area in England must make arrangements for the review of each death of a child normally resident in the area". Child death review partners are defined as the local authority and the CCG.

At the time of writing, it is anticipated that draft regulations governing the setting up of these arrangements, and a draft of a revised edition of the statutory guidance Working Together, will be published for consultation by the Department for Education (DfE) in Autumn 2017; that local partnerships will agree the arrangements to be put in place by April 2018; and that those arrangements will be in place by Summer 2019. It is expected, based on discussions during the passage of the legislation, that one of the options available to local partnerships will be the continuation of current LSCB arrangements.

Again at the time of writing, there has been little substantive discussion as yet about the form these new arrangements might take from, at the latest, Summer 2019. We have taken the view that such discussion is likely to prove premature without sight of the proposed regulations and statutory guidance. Clearly, one issue for discussion will be the extent to which the arrangements might cover a wider area than the single local authority area of Redbridge, either in relation to safeguarding arrangements, or the review of child deaths, or both. The CCG, the police, Barking Havering and Redbridge University Hospitals NHS Trust (BHRUT), and NELFT as the main community health services provider, all now operate or are structured across Barking and Dagenham, Havering and Redbridge. Whatever the form of arrangements eventually agreed, it will be essential to ensure that the high standards of children's services delivered by the London Borough of Redbridge and its partners, and the effective challenge and scrutiny provided by the Redbridge LSCB, both independently validated by Ofsted, are not in any way compromised.

2. Redbridge LSCB: membership, structure, funding and governance

Membership: who are we?

The legislation specifies a number of agencies that must be represented on the Board, including the local authority, the police, the CCG, NHS hospitals and community health services providers, NHS England, probation services, and the Children and Family Court Advisory and Support Service (CAFCASS). However, the Board has the power to include in its membership wider representation, and in Redbridge this includes schools, the voluntary and faith sector, and lay members. The Board also has strong links with the Redbridge Youth Forum and Schools Council, representing young people directly, and works with a LSCB Youth Forum made up of young people.

Regulations require that the LSCB has an Independent Chair. In August 2014, John Goldup was appointed as Independent Chair. He acted as interim Director of Children's Services for Redbridge between August and October 2016, and in that capacity managed the Ofsted inspection of services for children in need of help and protection, children in care and care leavers, that took place between 12 September and 6 October. From 2009 to 2013 he was National Director of Social Care in Ofsted, and from 2012 Deputy Chief Inspector. As well as chairing the LSCB in Redbridge, he is also a Children's Services Intervention Advisor to the Department for Education. In March 2017, he became Independent Chair of the Redbridge Safeguarding Adults Board.

LSCB Membership (as at March 2017)
Independent Chair
John Goldup
Local Authority Representatives
Adrian Loades, Corporate Director of People
Caroline Cutts, Operational Director, Children and Families
Catherine Worboyes, Head of Child Protection Service and Early Intervention
Dr Dianne Borien, Head of Early Years
Gladys Xavier, Deputy Director of Public Health (Vice Chair)
Jackie Odunoye, Operational Director, Housing Services
Ruth Holmes, Head of Youth Offending and Targeted Prevention
Health Representatives
Bob Edwards, NELFT Integrated Care Director for Redbridge **NELFT**
Kate Byrne, Named Nurse Safeguarding Children **NELFT**
Jacqui Himbury, Nurse Director **Redbridge CCG**
Caroline Alexander, Chief Nurse **Bart's Health NHS Trust**
Nicci Wotton, Named Nurse Safeguarding Children **Bart's Health NHS Trust**
Dr Sarah Luke, Designated Doctor for Safeguarding Children and Child Death Reviews

Redbridge CCG
Kathryn Halford, Chief Nurse **Barking, Havering and Redbridge University Hospitals NHS Trust**
Sue Elliott, Deputy Nurse Director **Redbridge CCG**
Sue Nichols, Designated Nurse for Safeguarding Children **Redbridge CCG**
Michaelene Holder-March, Assistant Director, Operations & Nursing **Partnership of East London Co-operatives (PELC)**
Vacancy (Resignation January 2015) **Named GP for Safeguarding Children**
Police
John Ross, DS, Safeguarding **Redbridge, Barking & Dagenham, and Havering Basic Command Unit (BCU)**
Probation Representatives
Andrew Blight, Assistant Chief Officer **London Probation Service**
Lucy Satchell-Day, Area Manager (NE London) **Community Rehabilitation Company**
CAFCASS
Alice Smith, Service Manager **CAFCASS**
Schools Representatives
Graeme Brooker **Redbridge College of Further Education**
Debra Webb, Head Teacher **Grove Primary School**
Merherun Hamid, Head Teacher **Apex Primary School**
James Brownlie, Head Teacher **Little Heath School**
Rebecca Drysdale, Head Teacher **Ilford County High School**
Dawn Hallybone, Deputy Head Teacher **Oakdale Junior School**
Susan Johnson, Head Teacher **SS Peter and Paul's Primary School**
Terese Wilmott, Head Teacher **Beal Academy Trust**
Voluntary Sector Representatives
Louise Coulson, Service Manager **Refuge**
Reanne Turner, Specialist CSE Project Manager **Safer London**
Suzanne Turner-Jones, Assistant Director **Barnardo's**
Ravi Dagan-Walters, Manager **Norwood, representing Redbridge Children and Young People's Network**

Vinaya Sharma **Redbridge Faith Forum**
Lay Members
Hilary Kundu
Nahim Hanif
Shabana Shaukat
Participant Observer
Cllr Elaine Norman Lead Member for Children's Services and Deputy Leader of the Council
Advisors to the Board
Bahia Daifi, Assistant Solicitor, Redbridge Legal Services
Lesley Perry, LSCB Business Manager

The membership of the Board should include a named GP, as a key source of professional expertise and an important link into the wider GP community. This role, however, has been vacant since January 2015, in spite of efforts to recruit to it led by the CCG. Recruiting to this important position continues to be a priority for the LSCB. This is the same position as was reported in the Annual Report for 2015/16, and it is frustrating that it has not been possible to resolve it during 2016/17. However, the Board has also continued to explore alternative avenues for engagement with GPs in the borough. Since July 2016 the LSCB has had a quarterly slot on the borough-wide GP Practice Learning Events. Two presentations were delivered in 2016/17, one on multi agency safeguarding referral arrangements and the MASH (Multi-Agency Safeguarding Hub), and one on private fostering. The LSCB has also secured a regular safeguarding feature in the monthly CCG newsletter, which goes to all GPs in the Borough.

As we reported in the Annual Report for 2015/16, NHS England, although a statutory partner, are not represented on the Board. NHS England's view is that their attendance at individual LSCBs in London should be based on a risk assessment. In a document published in 2016, Safeguarding Children and Adults across London: Accountability and Assurance Risk Assessment, NHS England London Region classified each LSCB in London as Red ('NHS England should attend'), Amber ('NHS England should work with the Designated Professionals and/or the Chair of the Board to determine if and how often attendance may be required'), or Green ('NHS England should not need to attend the Board'). The Redbridge LSCB was assessed as Green.

Other organisations with a pan-London brief face similar capacity constraints in ensuring consistent attendance at individual LSCBs. Of the four Board meetings held in 2016/17, Cafcass were only able to attend two; and the London Community Rehabilitation Company (CRC) (the private sector component of the probation service) did not attend any. The London CRC formally adopted a policy from August 2016 that it would no longer attend individual borough LSCB meetings. As part of this strategy, the CRC made a commitment that "in order to ensure that independent chairs remain up to date on London CRC's performance and priorities, a partnership newsletter will be submitted to each LSCB chair every quarter." This has not however happened. The Board regards this lack of

engagement and information flow on the part of a statutory partner as wholly unacceptable, particularly in light of the extremely critical report from Her Majesty's Inspectorate of Probation on CRC performance in eight north London boroughs, including Redbridge, published in December 2016.

However, generally the level of engagement and participation in the Board's work by partner agencies in 2016/17 has continued to be very high, with excellent attendance at all Board meetings. There is very strong commitment in Redbridge to the principle that the safeguarding of children is everyone's business and everyone's priority, and this is clearly a core strength. This was confirmed in a number of contexts in the Ofsted inspection report published in November 2016.

A review of the membership of voluntary and community groups was undertaken in April 2016. The Board identified as a strategic priority in its Business Plan for 2016//17 the need to align representation more closely with its service improvement priorities. As an outcome of this review, Redbridge Victim Support and the Diocese of Brentwood, both of whom had given strong and much appreciated support to the LSCB over some years, stood down from membership. Refuge, Safer London, and Barnardos, between them bringing a wide range of expertise in areas of violence against women and girls, child sexual exploitation, and young people who go missing from home or care, all joined the Board. The Redbridge Faith Forum and the Redbridge Children and Young People's Network (RYCPN) continue to be members of the Board.

Structure

The full **Board** meets four times a year. In 2016 – 2017, it met in April, July, October and January.

The terms of reference include a set of core values and principles as the basis for all the Board's work:

- The Board exists to improve outcomes for children. The welfare of children and young people is paramount. Under no circumstances will professional or organisational interests or sensitivities be allowed to get in the way of that paramount focus.
- The experience and voice of children and young people is central to all the LSCB's work. The Board will work closely with the LSCB Youth Forum, and seek to ensure that the voices of children and young people are heard in everything it does.
- Similarly, the Board will at all times seek to understand, listen to and engage with front line practitioners.
- The Board is concerned with the safety and welfare of children at all stages in the child's journey including early help and early intervention.
- The Board will pay particular attention to safeguarding and promoting the welfare of the most vulnerable children and young people, including (but not restricted to) children who are or at risk of abuse, neglect or sexual exploitation, children at risk of female genital mutilation, children who are living away from home, who have run

away from home, or are missing from education, children in the youth justice system, including custody, children who are vulnerable to being radicalised, disabled children, and children and young people affected by gangs.

- The Board will conduct all its business in a spirit of transparent and constructive debate, challenge, and respect. All members accept a responsibility to challenge and to accept challenge. The contribution of all partners and all members is of equal value.

An Executive Group and a number of Sub Groups have ongoing responsibility for driving forward the business of the LSCB through their strategic or detailed work in key areas, reporting to the main Board. Partner agencies have committed themselves to ensuring that the work of chairing and managing sub groups is shared equally across the local authority, the police, and NHS partners. The Board has welcomed this as a really concrete demonstration of partnership in action.

The **Executive Group**, chaired by the LSCB Independent Chair, provides strategic leadership to the LSCB. It monitors and challenges the work of the LSCB's sub groups. It scrutinises key areas of work in detail prior to consideration at the full Board, deals with budget issues, sets the agenda for board meetings, and co-ordinates the development of the LSCB Business Plan. It met six times during the year under review.

The **Child Death Overview Panel (CDOP)** was chaired in 2016/17 by Gladys Xavier, Deputy Director of Public Health and Vice Chair of the LSCB. Under the Local Safeguarding Children Board Regulations 2006 and Working Together to Safeguard Children 2015, the Panel is responsible for reviewing all deaths of children aged between the ages of 0 and 17 in the Borough, with the exception of stillbirths and planned terminations of pregnancy. It identifies patterns and trends in local data and reports these to the LSCB. It assesses whether a death could have been prevented, and makes recommendations to the LSCB or other relevant bodies so that action can be taken to prevent future such deaths where possible. The Panel has a particular responsibility for ensuring a rapid response to any unexpected death of a child. The Panel held seven scheduled meetings and eight Rapid Response meetings in 2016 – 2017. On a single borough basis, the numbers of deaths to be considered is, fortunately, too low to allow any reliable conclusions to be drawn or trends identified.

The **LSCB Youth Forum** is a group of young people, supported by the LB Redbridge Positive Activities (Youth) Service, who work to raise awareness of safeguarding issues among young people in the borough and to make sure that young people's voices are heard and acted upon by the LSCB.

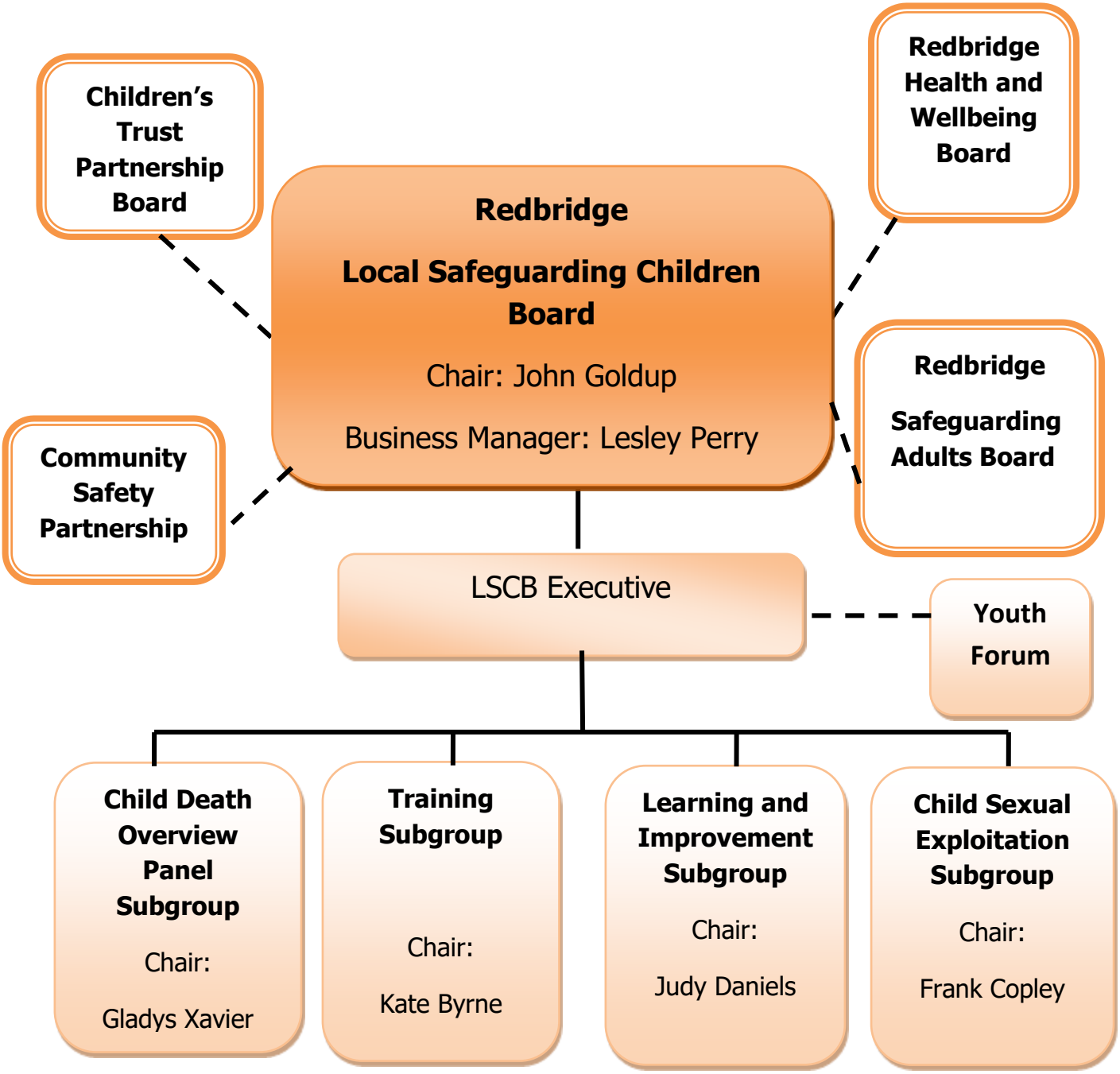
The **Child Sexual Exploitation Subgroup** was chaired in 2016/17 by DI Frank Copley from the Metropolitan Police and met six times. Protecting young people from sexual exploitation has continued to be a major focus of the LSCB's work throughout the year under review. The CSE Sub Group oversaw the implementation and completion of a comprehensive multi-agency action plan focused on improving the protection and support of children who are sexually exploited, and strengthening work to identify, disrupt and

prosecute child sexual exploitation. The Sub Group ceased to meet in March 2017, as it was anticipated that the revised Pan London Child Sexual Exploitation Protocol, led by the Metropolitan Police and due for publication in early 2017/18, would refocus strategic work on CSE on a revised Multi-Agency Sexual Exploitation Panel to be co-chaired by the police and the local authority.

The **Training Subgroup** was chaired in 2016 – 2017 by Kate Byrne, Named Nurse Safeguarding Children, NELFT. The subgroup is responsible for undertaking training needs analysis across partner agencies, commissioning the LSCB's own Training Programme and quality assuring safeguarding training, including an evaluation of its impact on frontline practice. The Group met four times during the year.

The **Learning and Improvement Subgroup** was chaired in 2016 – 2017 by Judy Daniels, Principal Child and Family Social Worker and Head of Safeguarding and Quality Assurance in LB Redbridge. The role of the subgroup is to ensure continuous improvement in line with the LSCB's Learning and Improvement Framework. It is responsible for the development and delivery of the LSCB's Multi-Agency Audit Programme, through a Working Group, reporting on the strengths and areas for improvement in front line multi-agency practice, and for identifying and disseminating the lessons to be learned. It is charged with commissioning and overseeing Learning Reviews on cases of concern (including child protection incidents which fall below the threshold for a Serious Case Review (SCR)) or cases referred by individual partner agencies from which lessons may be learned about the way organisations are working together to safeguard and promote the welfare of children, and with maintaining an overview of key lessons to be learned from national research and publications, including SCRs undertaken by other LSCBs. The Group met five times during the year.

LSCB STRUCTURE CHART (as at March 2017)



The LSCB Budget: what do we spend it on?

The LSCB's work is funded by partner contributions, with some income from training activity. Apart from a Child Death Overview Panel (CDOP) Grant, there is no dedicated funding from central Government. The table shows the contributions from partner agencies in 2016 -17, and the expenditure incurred.

Income		Expenditure	
Balance brought forward	0	Office Expenses	1008.47
CDOP Grant	54,000	Publicity & Communications	3,494.38
Training attendance fees	8,680	LSCB Training Programme	14,620.91
Training non-attendance fees	3,360	Hire of Venues	100
LB Redbridge, Children's Services	30,199	Recruitment	2,422.50
LB Redbridge, Corporate funding	50,000	LSCB Independent Chair	25,525
LB Redbridge, Adult Services	1,076	LSCB Business Manager	69,277.04
LB Redbridge, Early Years	5,253	LSCB Quality Assurance Manager	77,140.88
LB Redbridge, Housing	1,076	LSCB Training Manager	28,441.20
Public Health	28,000	LSCB Senior Admin Officer	37,183.82
LB Redbridge, Youth Offending	1,076	LSCB Apprentice	14,660.53
Metropolitan Police	5,000		
National Probation Service	1,100		
London Community Rehabilitation Company	1,000		
Cafcass	550		
Redbridge Clinical Commissioning Group	35,000		
Barking, Havering & Redbridge University Hospitals NHS Trust	3,231		
Barts Health NHS Trust	5,000		
NELFT	3,230		
Total Income	**231,831**	**Total Expenditure**	**273,874.73**

It should be noted that staffing costs include employers' 'on-costs' (National Insurance and pension contributions), and agency costs and fees where relevant.

There was an overspend in 2016/17 of £42000 which was met by the Local Authority. However, it is clearly important that the LSCB achieves balance in future years between its expenditure and its income. Working Together 2015 is clear that LSCB member organisations "have an obligation to provide LSCBs with reliable resources (including finance) that enable the LSCB to be strong and effective. Members should share the financial responsibility for the LSCB in such a way that a disproportionate burden does not fall on a small number of partner agencies."

The contribution from the Metropolitan Police is determined centrally by the Mayor's Office for Policing and Crime (MOPAC), and is set at a flat rate of £5000 for each LSCB in London. Given the absolutely central role of the police in the effective safeguarding of children, this is a disproportionately low contribution, estimated by the London Children Safeguarding Board Chairs to be 45% lower per head than the police contribution in all other large urban police forces in England. London LSCB Chairs continue to pursue this actively with the Metropolitan Police Service and MOPAC.

The LSCB Team

As of 31 March 2017, the LSCB Team was fully staffed with permanent employees:

- Business Manager – Lesley Perry
- Senior Administrator – Andrew Reed
- Quality Assurance Manager – Andrea Barrell
- Training Manager – Amanda Jones
- Business Admin Apprentice – Rabiya Rehman

Governance

The LSCB Chair is accountable to the Council's Chief Executive for the effective functioning of the LSCB. The Chair meets with the Chief Executive after every Board meeting to report on the work of the LSCB and issues arising from it.

The LSCB is part of a broader partnership architecture which promotes the health and wellbeing of all Redbridge residents. As well as the LSCB, this includes the Health and Wellbeing Board, the Children's Trust Partnership Board, the Community Safety Partnership Board and the Safeguarding Adults Board. The Council and its partners agreed in October 2014 an inter-board governance protocol which sets out the principles underpinning how the Boards will work across their defined remits, how communication and engagement will be secured across the Boards, and the practical means by which effective co-ordination and coherence between the Boards will be secured. There are four underpinning principles:

- Safeguarding is the business of all Boards
- It will enhance the work of each Board if members know and understand the business of the other Boards
- A culture of scrutiny and constructive challenge will exist across the Boards
- The Boards will work together to avoid duplication and ensure consistency

The LSCB Chair is a member of both the Health and Wellbeing Board and Children's Trust Partnership Board. He took up the role of Independent Chair of the Safeguarding Adults Board in March 2017. This Annual Report will be presented to the Health and Wellbeing Board, the Children's Trust Partnership Board, the Safeguarding Adults Board and the Council's Cabinet.

The LSCB has particularly prioritised the importance of joint working with the Community Safety Partnership Board. Priorities for action shared between the two Boards include child sexual exploitation (CSE), female genital mutilation, violence against women and girls, and the prevention of radicalisation and violent extremism. In May 2015 the two Boards agreed a specific protocol to promote effective joint working.

Business Planning

The Board is strongly committed to effective business planning, with a defined number of key priorities, and a set of clear actions, responsibilities, target timescales, and outcomes expected, against which success could be judged. In April 2016 the Board agreed that the priorities for the 2016/17 Plan should be unchanged from those agreed for 2015/16, as there was further work required in each of these areas. These agreed priorities were:

- To improve the protection and support of children who are at risk of, or who have been, sexually exploited, and to strengthen our work in identifying, disrupting and prosecuting child sexual exploitation (CSE).
- To improve the protection and support of children at risk of Female Genital Mutilation (FGM) and those living with domestic violence, substances misuse, and adult mental ill health.
- To improve the protection of young people from involvement with violent extremism.
- To strengthen the safeguarding of children with disabilities, and to reduce the incident of disability by increasing awareness of the risks of consanguineous relationships.
- To strengthen our work in preventing, identifying and protecting children from neglect.
- To increase the effectiveness of the LSCB in co-ordinating and ensuring the effectiveness of the work of all agencies to safeguard and promote the welfare of children and young people.

Progress against the Business Plan was reviewed at every Board meeting in 2016/17, with slippages identified and corrective actions agreed. At the final review in April 2017, of the

29 discrete actions in the Plan, 24 were assessed as 'Green' - fully completed and five as Red' – not completed. The five 'Red' actions related to:

- Updating the 2015/16 CSE problem profile did not take place due to lack of available analyst resources.
- Training for social workers on the use of the CSE flag on Protocol, the local authority's children's social care information system, had not happened, as the identified trainer had left the service and an alternative was being sought.
- It proved impossible to link the Health database (RiO) and Protocol in relation to cases involving domestic abuse, parental mental ill health, and / or substance abuse, due to technical issues.
- The development of an integrated early help pathway for children in families with adults with identified additional needs had been delayed due to a planned review of the Early Intervention and Family Support Service (EI&FSS) in Redbridge.
- The partnership had not succeeded in rolling out the use of the Redbridge Neglect Toolkit across all agencies.

In determining the Business Plan priorities for 2017/18, the Board agreed to focus on those areas of service and practice where it was clear, in the context of the extremely positive inspection report and the many areas of strength identified by Ofsted in November 2016, that further improvement was still needed. The agreed priorities for 2017/18 are:

- To improve services for young people experiencing mental ill-health.
- To strengthen the protection and support of children and young people exposed to exploitation and harmful practices.
- To strengthen quality and impact of the Independent Reviewing Officer (IRO)/Child Protection (CP) Chair role, particularly with references to cases of neglect.
- To develop and implement a robust multi-agency action plan to substantially increase private fostering notifications.
- To strengthen and improve support to children and young people on e-safety and peer on peer sexual harassment.
- Further develop and improve safeguarding arrangements for children and young people that go missing from home or care.
- Monitoring and ensuring the effectiveness of the arrangements for safeguarding children and young people in Redbridge in the new Metropolitan Police structure.
- To further strengthen the LSCB's monitoring and oversight of practice.

The 2017/18 Business Plan is attached as **Appendix A** to this report.

3. Safeguarding in Redbridge: need, risk and demand

We reported in the Annual Report for 2015/16 that the number of referrals to children's social care had fallen slightly for the first time since 2012/13. This trend continued and accelerated in 2016/17. Compared to 2015/16, the number of referrals fell by 18.9%. Comparative national figures will not be available until November 2017.

Referrals to Children's Social Care						
2010/11	**2011/12**	**2012/13**	**2013/4**	**2014/15**	**2015/16**	**2016/17**
4019	3691	3648	4718	5175	5086	4125

This is the lowest number of referrals received since 2012/13, and only 2.6% higher than the number received six years ago, in 2010/11. However, as in 2015/16, other indicators of social care and multi-agency activity continued to increase, in some cases sharply.

'Section 47 inquiries' are inquiries undertaken under Section 47 of the Children Act 1989, following a multi-agency strategy meeting and information gathering, when there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm. We reported in the Annual Report for 2015/16 that the number of Section 47 inquiries undertaken that year had increased by 53% from 2014/15. In spite of the 18.9% fall in the number of referrals received, the number of S47 inquiries undertaken continued to increase, from 1038 in 2015/16 to 1173 in 2015/16 – an increase of 13%. During the year, the Board was concerned to establish whether this continuing rise might be a sign of an over-cautious response to referrals. Clearly, the S47 process is resource intensive, and a potentially very stressful experience for families. It is important to ensure that the 'reasonable cause to suspect significant harm' test is being rigorously applied. In response to this concern, the Council's children's social care service introduced for a period a tighter management oversight of decision making in this area, and over the course of the year the number of S47 inquiries started to fall – 341 in Quarter 1, 334 in Quarter 2, 277 in Quarter 3, and 221 in Quarter 4. It is also important, and reassuring, to note that, on the basis of their fieldwork undertaken in September2016, Ofsted described the 'front door', where these decisions are made, as "exceptionally strong, demonstrating a clear understanding and response to risk, strong multi-agency working and a timely, well-assessed understanding of need."

> "Inspectors found that clear analytical reasoning underpinned every decision that they observed in the duty team … Sufficient and capable management capacity, combined with swift multi-agency input and good use of information systems, means that all children's cases are dealt with in a timely and appropriate manner. This is a very high level of performance."

In their verbal feedback, inspectors described their findings as "the right decision is made for every child, every time".

On 31 March 2017, 380 children in Redbridge were subject to a child protection plan, compared to 349 a year earlier and 268 on 31 March 2015. Again, this is a significant rise, and has implications for workload and pressure at the front line across all agencies. 459 children became newly subject to a child protection plan in 2016/17, compared with 409 in 2015/16 and 309 in 2014/15. National comparative data will not be available until November 2017. However, it is likely that, relative to population, the number of children subject to child protection plans in Redbridge is now above that for both national and 'statistical neighbour' authorities, having historically been significantly lower. The rate in Redbridge at the end of March 2017 was 51.1 per 10,000 children. In 2015/16 it was 43.1 per 10,000, and for statistical neighbour authorities it was 41 per 10,000.

Nationally and locally, there has been a consistent year on year increase in the number of care proceedings applications to court by local authorities over a significant period. According to Cafcass data, the number of applications in 2016/17 in England was 14% higher in 2016/17 than in 2015/16, and had increased by 30.8% since 2014/15. The increase in Redbridge was much more dramatic. The number of applications, at 71, rose by 77.5% in 2016/17 – up from 23, a 228% increase, in 2014/15. The total number of children involved in these applications doubled from 2015/16 to 2016/17. Relative to its population, Redbridge is also making more care applications. In 2015/16 there were only two London boroughs with a lower rate of applications per 10,000 population than Redbridge. In 2015/16, there were thirteen. An increased number of children entering court proceedings reflects a sharp rise in the number of children judged to be at most risk. It also represents an equivalent rise in the demand on social work and other professional capacity; and of course behind the figures there are an increased number of children, and an increased number of families, experiencing some of the most stressful and invasive state intervention in their lives, however essential and ultimately positive that intervention may be.

At the same time as rates of 'high level intervention' activity (Section 47 inquiries, child protection planning, and court proceedings) have increased, there appears to have been some decline in levels of some, though not all, early help activity. The number of early help assessments completed using the Common Assessment Framework (CAF) fell from 1211 in 2015/16 to 789 in 2016/17.

There is clearly an apparent paradox when the number of referrals received by children's social care is down by almost 20% and yet, following on from those referrals, the volume of 'high level' intervention in families' lives continues to increase. In its discussions, the Board has explored two hypotheses. Is this a reflection of higher levels of need and risk in the community – fewer referrals but a significantly greater concentration of need, risk and complexity in the lives of those children who are referred? Or is it a reflection of professional anxiety in a workforce struggling with the impact of austerity, resource constraints, and frequently hostile media coverage? The Board is satisfied that on the whole the evidence supports the first hypothesis; but it is important to continue to scrutinize the data and to ask that question.

Number of children who became the subject of a child protection plan during the year by category of risk							
	2010/ 11	**2011/ 12**	**2012/ 13**	**2013/ 14**	**2014/ 15**	**2015/ 16**	**2016/ 17**
Neglect	69	81	65	108	111	140	146
Physical abuse	3	17	9	16	17	8	24
Sexual abuse	11	2	12	15	11	11	7
Emotional abuse	60	85	66	89	170	248	282
Multiple categories	41	4	1	0	0	2	0
Total	184	189	153	228	309	409	459

There has been little change in the percentage of the total number of plans made under each category of risk. The percentage of plans made under the category of physical abuse has increased from 2% in 2015/16 to 5% in 2016/17; and the percentage made under the category of sexual abuse has fallen form 3% to 1.5%. However, the absolute numbers involved are too small to allow any conclusions to be drawn about trends. National and statistical neighbour comparative data is not yet available; but it might be noted that in 2015/16, emotional abuse was the category of abuse in only 35.4% of new plans nationally and 37.6% in Redbridge's statistical neighbours, whereas in Redbridge it has stabilised at 61%.

The ethnic background of children subject to a child protection plan on 31 March 2017, compared to the profile of the borough's child population, is shown in the table below. The ethnicity descriptions used are those set by the Department for Education (DfE) in their annual data collection. The population profile figures are drawn from the 2011 census.

Ethnicity	**As a % of children subject to a CP Plan 2016/17 (to nearest whole number)**	**As a % of children subject to a CP Plan 2015/16**	**As a % of the 0-17 population in Redbridge**
White	25%	26%	24.0%
Mixed	10%	21%	7.6%
Asian or Asian British	49%	35%	54.0%
Black or Black British	14%	15%	11.4%
Other ethnic groups	1%	1%	2.0%
Unknown (unborn)	1%	1%	1.0%

Great caution should be exercised in interpreting this data. Clearly, however, it does indicate a significant increase in the percentage of new plans made in relation to children of an Asian or Asian British background, and a fall in the percentage relating to children of mixed parentage and heritage.

The rise in the number of older young people made subject to plans, commented on in the 2015/16 Annual Report, has continued. 25 young people aged 16+ were made subject to child protection plans in 2016/17, compared to fifteen in 2015/16 and five in 2014/15. As we commented last year, this may reflect the increased focus on and understanding of CSE as a major safeguarding issue, although is notable that only a very small number of plans were made specifically under the category of sexual abuse. It may also reflect a growing understanding that 'neglect' can be as much an issue for adolescents as it can be for younger children.

4. Safeguarding in Redbridge: performance, quality and outcomes

Broadly, performance has remained strong against a set of standards or targets set out in national guidance and comparative data.

Indicator	Redbridge 2016/17	Redbridge 2015/16	National 2015/16*	Statistical Neighbours 2015/16*
% of repeat referrals within 12 months	17.9%	19.5%	22.3%	17.1%
% of assessments completed within 45 days	93.5%	95.3%	83.4%	85.8%
% of initial child protection case conferences held within 15 days of strategy meeting	86.0%	91.4%	76.7%	75.8%
% of child protection plans reviewed within required timescales	96.3%	99.6%	93.7%	94.1%
% of children becoming subject to a second or subsequent child protection plan	4.1%	14.7%	17.9%	15.8%
% of children with a plan ending during the year who had been on a plan for two years or more	1.7%	1.5%	3.8%	4.2%

*Most recent data available

There has been a minor drop in performance on timeliness of both assessments and case conferences. However, the percentage of referrals where there had been at least one other referral in the previous twelve months has fallen – a high figure here is usually taken to suggest that too many referrals are not responded to effectively in the first instance, leading to a high rate of repeat referral. Even more significantly, the number of children subject to repeat child protection plans has fallen sharply. Redbridge appears to have the 'revolving door' that too often characterises the experience of children and families in the child protection system firmly secured.

During 2016/17, the LSCB agreed a new performance data scorecard against which it regularly reviews the performance of the local multi-agency safeguarding system. This includes the data on child sexual exploitation, children missing and female genital mutilation which was referred to by Ofsted in their recommendations to further improve the effectiveness of the LSCB.

In addition to the performance data discussed above, there has been a substantial volume of external evaluation of performance in 2016/17 through a wide range of inspection activity.

Ofsted's inspection of the London Borough of Redbridge – services for children in need of help and protection, children looked after and care leavers

The report of this inspection, published on 25 November 2016, has already been referred to in relation to the review of the effectiveness of the LSCB conducted at the same time as the inspection and reported on in a single publication. However, the main activity of the team of inspectors, who carried out the inspection between 12 September and 6 October 2016, was a comprehensive inspection under the Single Inspection Framework of the full range of children's social care services delivered by the Council, working with its partners.

Overall, children's services in Redbridge were judged to be **good**. Services for children in need of help and protection services for children looked after and achieving permanence, and leadership, management and governance were all judged to be good. Inspectors also make two sub-judgements – one on adoption performance, judged as good, and one on the experiences and progress of care leavers, judged to require improvement.

By the end of 2016/17, reports on the inspection of 127 local authorities had been published. 35 (28%) were judged to be good, including Redbridge, in terms of overall effectiveness. Two were judged to be outstanding.

In their Executive Summary, inspectors said:

> "Children's services in Redbridge are good and improving. Senior leaders and elected members demonstrate passion, ambition and commitment in order to improve the lives of children and their families. Services continue to be well managed and resourced. Sound practice has been further strengthened since the last inspections for children in need of protection in 2012, when services were judged to be good, and for children looked after in 2010, when services were judged to be adequate.
>
> The chief executive officer has been in post for eight months. He is already demonstrating a clear strategic vision to drive forward change and service improvement, with a particular focus on the council's corporate parenting responsibilities. He is keen to maximise the involvement of young people and work in partnership with them as services evolve. During the period of the inspection, there was an interim director of children's services who, supported effectively by a stable senior management team, has ensured that the service continues to work

well and be strengthened. The clarity provided by the transition arrangements has protected local authority children's services at a potentially vulnerable time.

A responsive senior management team is led by an assured and reflective operational director. Elected members have recently approved significant investment to ensure that caseloads remain manageable. Morale within the workforce is high and staff feel valued. Frontline practitioners are well trained and supported effectively by diligent and available frontline and middle managers. Management oversight is strong. Recent necessary recruitment activity, while commendable, has meant too many changes of social worker for some children and higher support needs for newly qualified social workers.

The 'front door' services are exceptionally strong, demonstrating a clear understanding and response to risk, strong multi-agency working and a timely, well-assessed understanding of need. Inspectors found that clear analytical reasoning underpinned every decision that they observed in the duty team. Children and their families are well supported by the offer of a wide range of early intervention and assessment services. Thresholds to services are very clear, appropriately applied and embedded across all agencies.

Children looked after in Redbridge live in stable homes and achieve good outcomes in their education, including when placed out of the local authority area. The virtual school is proactive and has a very positive impact. Tenacious efforts are made to achieve adoption for children who require this, and changes of plans away from adoption and the disruption of adoptive placements are few. The quality of assessment for children requiring adoption is a strength, including considering of placing brothers and sisters together. Permanency planning needs to be further strengthened to ensure that the progress for every child is regularly monitored.

Particular strengths are evidence in consultation and partnership working with young people and the quality of advocacy services for both child protection and children looked after. The local authority is in the process of expanding the availability of this valued service. The local authority is excelling in practice under the 'Prevent' duty and in work undertaken in 'Families Together', Redbridge's 'Troubled Families' service. Broader partnership working is strong, as demonstrated through the commissioned services for adopter recruitment, domestic abuse services and well-embedded relationships with the voluntary sector.

The combined role of the child protection conference chairs and independent reviewing officers is not consistently effective, as evidenced by written plans that are not always clear about what needs to be achieved, when and by whom. The escalation process is not consistently used to raise concerns and the annual report on the effectiveness of the service is overdue. Senior managers have already identified this as an area for improvement.

A wide range of data and performance information are routinely collated and used to guide and inform service delivery. This could be further enhanced in order to

develop a clear understanding of the effectiveness of practice for children who go missing or are at risk of child sexual exploitation. Senior managers have an appropriate overview of the growing issue of young people affected by and at risk, due to gang activity and affiliations.

The understanding and delivery of services for those affected by domestic abuse are very strong. Within a safe standard of practice overall, the local authority needs to give greater focus to the specific and separate issues in honour-based violence and ensure that health professionals are directly involved in safeguarding from the outset in cases of female genital mutilation.

Senior managers understand and celebrate the diverse population within Redbridge, and practitioners routinely record and consider this in their work. Diversity is clearly recorded for every child and considered sensitively in work undertaken. Individual needs of large groups of brothers and sisters are carefully considered. Practice could be strengthened further to understand consistently the individual experience of each child in casework in relation to ethnicity, culture and religion.

Services for care leavers have a number of strengths, but are not yet consistently good. The local authority is in touch with the vast majority of care leavers. They know their entitlements and the majority are appropriately placed and in employment, education or training. Support from personal advisers is variable, pathway plans are not yet consistently helpful and the service needs to have a closer oversight of outcomes. A small number of care leavers report that they do not always feel that their successes are celebrated. A small minority have expressed concerns regarding their accommodation, which the local authority has responded to promptly."

Inspectors also made a number of recommendations for further improvement:

- Strengthen the quality and impact of the role of the child protection chair/independent reviewing officer so that there is more effective monitoring and challenge on the progress of plans, ensuring that all plans that they review contain specific actions, achievable timescales and clear, measurable outcomes.
- Ensure that cultural characteristics that affect the lived experienced of children are fully explored in all assessments and plans, particularly the risks associated with honour-based violence. Ensure also that health professionals are directly involved in considering safeguarding risks at the earliest opportunity in all cases of female genital mutilation.
- Prioritise the recruitment of independent visitors and increase the capacity of the advocacy service so that all children who would benefit from these services are able to do so. Ensure that children's voices are heard in child protection conferences if an advocate is not involved.
- Ensure that life-story books of high quality are provided to children in a timely way.
- Strengthen service and action plans to ensure that they drive and support the progress and planning of individual service areas.

- Ensure that performance management information is captured, analysed, presented and use in a way which enables the local authority to achieve greater consistency in the quality and effectiveness of the support and services provided.
- Ensure that data on missing children provides real-time information about 'missing' episodes and the offer and completion of return home interviews.
- Ensure that the care leavers' service has an up-to-date overview of the educational progress and attainment of every care leaver, and that care leavers feel that their achievements are fully celebrated.

The Council has drawn up an action plan to address these recommendations. The LSCB will monitor implementation of relevant aspects of the action plan as part of its 2017/18 Business Plan.

Care Quality Commission inspection of Barking, Havering and Redbridge University (BHRUT) Hospitals NHS Trust

The LSCB received a full report on the 2016/17 re-inspection of BHRUT at its meeting in April 2017. In 2014, services at BHRUT were judged by the Care Quality Commission (CQC) to be inadequate, and the Trust was made subject to special measures. Further inspections took place in September and October 2016, and the report was published in March 2017. Overall, the Trust was graded as 'requires improvement'. The CQC reported that the Trust had demonstrated sustained and significant improvement, and as a result BHRUT came out of special measures in March 2017. Services for children and families were rated as good overall, and good across four of the five domains judged. Inspectors reported that staff were aware of their responsibilities for safeguarding children, and knew and were confident about contacting the safeguarding team. They also reported that staff had a good understanding of female genital mutilation. The LSCB welcomed the inspection findings, and will continue to monitor progress and offer appropriate challenge and support.

Care Quality Commission inspection of Whipps Cross Hospital (Barts Health)

The LSCB received a full report on the 2016/17 re-inspection of Whipps Cross at its meeting in April 2017. Although in Waltham Forest, Whipps Cross is a significant provider of hospital care to Redbridge residents. The hospital was judged to be inadequate in 2015, with services for children and families also judged inadequate, and maternity and gynaecology services judged to require improvement. Re-inspection in July 2016 again judged the hospital overall to be inadequate, in a report published in December 2016. However, services for children and families, and in maternity and gynaecology, had improved significantly and were now good. Staff fully understood how to activate safeguarding policies and procedures, and were able to describe national best practice guidance. "A culture of safeguarding patient safety was transparent amongst nursing, allied health care professionals and medical staff alike…. The children's service had good arrangements in place to keep children and young people safe. The safeguarding team were highly visible."

Care Quality Commission inspection of NELFT (formerly North East London Foundation NHS Trust)

NELFT provides community and mental health services for people living in Barking & Dagenham, Havering, Redbridge and Waltham Forest and community health services for people living in the south west Essex areas of Basildon, Brentwood and Thurrock. They also provide an Emotional Wellbeing Mental Health Service for children and young people across the whole of Essex, and all age eating disorder services and child and adolescent mental health services across Kent and Medway.

NELFT were subject to a full CQC inspection in April 2016, with the inspection report published in September 2106. Overall the Trust was judged to require improvement. Inspectors found that in the community health services there were major staffing shortages and recruitment challenges across all staff groups and localities. There were high caseloads for staff, high use of agency and bank staff, all which had an impact on the delivery of the services. However, they reported that the trust had good overall systems and processes for managing safeguarding children.

In the 2015/16 Annual Report, we referred to the significant concerns that the LSCB had throughout the year about a number of safeguarding issues at Brookside, an inpatient psychiatric unit for adolescents run by NELFT on the Goodmayes Hospital site in Redbridge. The CQC inspection in April 2016 found the provision to be inadequate, with insufficient staffing, a poor quality physical environment, poor care planning and risk assessment, and a lack of staff supervision. In early 2016/17, the Unit was temporarily closed. Substantial refurbishment took place and a revised treatment model developed, with a reduction in the number of beds provided and a new Home Treatment Service developed. Following the re-opening of the Unit, a further re-inspection took place in October 2016. Inspectors found that the trust had fully addressed, or significantly improved, the problems that caused the CQC to find it in breach of regulations at the earlier inspection. The service was now judged to be good overall, and good in each of the five individual judgement domains – safe, effective, caring, responsive and well-led.

Care Quality Commission inspection of the Courtland GP Surgery

This practice was inspected in January 2017 and the report was published in March. The practice was found to be inadequate overall, and inadequate in the specific domains of safety, effectiveness and leadership. Among other concerns, a number of staff had not received adequate safeguarding children training, the safeguarding policy contained out of date information and contact details, and there was a lack of evidence of safe recruitment practices. The practice is now closing.

Her Majesty's Inspectorate of Probation inspection of probation services in North London

This inspection report was published in December 2016 and reported on the effectiveness of probation services in eight London boroughs, including Redbridge. It assessed performance in two main areas – public protection, and reducing reoffending. In public protection work, the performance of the National Probation Service was found to be mixed. Overall, most public protection work was carried out sufficiently well but the quality of assessment, planning and interventions was mixed. Attention needed to be focused more sharply on public protection and in particular on the formal review of cases, and recognising and responding to significant changes in individuals' circumstances.

However, the service provided by the London Community Rehabilitation Company was extremely poor:

> "The proportion of work carried out to a sufficient standard did not meet our expectations and was low when compared to our findings to date in other parts of the country.
>
> Assessment, planning and interventions were not carried out well enough. Significant information was not always recognised as such and there was a lack of awareness of domestic abuse and child safeguarding issues.
>
> Individual caseloads varied significantly. Some were, in our view, unreasonable and unmanageable. Low levels of contact with service users, coupled with inadequate systems to monitor the frequency of contact inevitably and materially affected the quality of work to protect the public.
>
> The inexperience of some staff coupled with a lack of management support made this problem more acute in some cases. Senior management appreciation of these difficulties, and plans to resolve them were either absent altogether or else inadequate in our view."

Given these findings, the lack of engagement by the CRC with the LSCB, previously commented upon, is extremely concerning. In response to the inspection, CRC have restructured their operation and developed an 'Ambition 2020 Change Plan'. In a presentation to London LSCB Chairs in March 2017, they indicated that they would "revisit their engagement with LSCBs once the new structure is embedded". This is not acceptable.

Her Majesty's Inspectorate of Constabulary inspection of child protection work in the Metropolitan Police Service

As part of a national programme of child protection inspections, HMIC carried out an inspection of the Metropolitan Police response to child protection between February and May 2016. The report was published in November 2016.

The report was extremely critical. Conclusions included:

"Too many cases fell well short of the expected standards required for a good investigation. Many took too long to progress and had no effective supervisory oversight, resulting in a lack of protection for victims, loss of evidence, and continuing risk from offenders. Staff whose job it is to respond to and investigate such challenging and often distressing cases need to be competent, trained and supported. This is not consistently the case in the MPS. The response to children who regularly go missing from home needs improvement, with a focus on early intervention and on ensuring that officers and staff understand the link between children who regularly go missing and sexual exploitation……

There is a lack of child protection performance data in boroughs, and of oversight and therefore leadership in the context of children detained in custody, or subject to CAIT or Sapphire investigations. The strongest evidence in this report comes from the findings of the case audit reviews conducted by HMIC. They clearly demonstrate a gap between child protection policy and procedures, and what happens on the front line."

However, it should be stressed that none of the fieldwork for this inspection took place in Redbridge, and there is good reason to suggest that the situation in Redbridge in 2016/17 was very different. Indeed, Ofsted inspectors commented during the inspection of children's services in September and October 2016 that the joint working they observed in Redbridge between the police and children's social care was 'the best we have seen anywhere'.

One of HMIC's major criticisms was the lack of a single line of accountability for all child protection matters across the force. Historically, accountability at a local level in the Metropolitan Police has been fragmented between Borough, sub-regional, and various specialist and force-wide structures. The introduction of the One Met model, for which Redbridge became a 'pathfinder' site at the end of 2016/17, is intended to address this. On 27 March 2017, a 'tri borough' Basic Command Unit (BCU), covering Redbridge, Barking and Dagenham, and Havering, and with a single senior officer responsible for child safeguarding work across the three Boroughs, went live. This is discussed further in the next section.

5. Safeguarding in Redbridge: themes, concerns, challenges, and scrutiny

This section reports on some of the key areas of work and provision with which the LSCB has been concerned during the year.

Accessing help for children, young people and families

In June 2016, the LSCB published a revised edition of what had previously been described as its 'Thresholds Document', setting out how anybody who is working with children who is worried about a child can access help, and what the thresholds are for a referral to social care. The revised document – 'Are you worried about a child? How to access early help, and thresholds for referral to children's social care' – did not fundamentally change where the thresholds were set, although it did give clearer guidance about potential referrals of young people at risk of sexual exploitation or of radicalisation, and some particular triggers of concern for children with disabilities. It was however intended to be more user friendly and accessible than previous versions had been, so that it could become a real reference point for workers in every setting who may be worried about a child but are not quite sure what to do or where to go. A 'quick reference' guide to the document was published in November 2016 following consultation with the voluntary and community sector. Ofsted inspectors described the revised document as providing

> "comprehensive guidance to assist practitioners and managers in every agency to assess and identify a child's level of need."

This was described as providing a 'common language' for professionals, and the work seen by inspectors strongly demonstrated the usefulness and clarity provided by the threshold document."

Early help

If professionals and services are able to identify early signs of difficulties within families and mobilise effective, co-ordinated support at the right time, it is likely that in many cases the problems can be stopped from escalating. Effective early help is thus key to the effective safeguarding of children. Redbridge has an extensive range of well-developed early help services, and the LSCB receives regular reports on activity and outcomes. Early help can be provided by the Early Intervention and Family Support Service (EIFSS), which sits within the Council. Services offered by the EIFSS include:

- Direct family support work in the home.
- Direct work with children and young people.
- A parenting team which delivers evidence based parenting programs as well as courses on child development, parenting teenagers and parenting children with disabilities. Between April 2016 and March 2017, 28 courses were run attended by 455 parents (with between them 815 children), an 18% increase on 2015/16.

- The Freedom Programme is a domestic violence programme designed for women who are victims of domestic violence. Demand for the programme has continued to increase. Referrals from community social work teams rose by 340% in 2015/16, and by a further 69% in 2016/17.

Alternatively, it may be provided by partner organisations and universal services, through the use of the Common Assessment framework (CAF). This is a shared assessment and planning process which professionals in any agency can use to facilitate the early identification of children and young people's additional needs. The assessment supports relevant agencies coming together in a Team around the Child (TAC), with a named 'lead agency'.

The available data for 2016/17 suggests an increase in demand for the more intensive services provided by the EIFSS, but a fall in the volume of CAF and 'team around the child activity'. This may reflect an increase in the complexity of need and risk being identified. It may also reflect the increased pressures on, for example, schools and community health services, which are making it more difficult for them to take the lead in responding to the earliest signs of difficulties being experienced by families and children.

Families may be referred to the EIFSS from the Multi-Agency Safeguarding Hub (MASH) following initial consideration of a referral, from the social work assessment teams following a social work assessment which concludes that the family does not need social work intervention but could benefit from the EIFSS offer, or from the multi-agency Early Intervention Panel (EIP). The Panel meets weekly and considers requests for early help provision including individual work with children and young people, support to families and parenting programs. In 2016/17 there were 4787 referrals to the EIFSS, a 4% increase on 2015/16. The main reasons for referral included problems associated with parental mental ill health, parenting difficulties, housing issues, missing children, domestic violence and substance misuse. 12% of all incoming contacts to social care were passed directly to the EIFSS, offering families a more appropriate and less intrusive response and relieving some of the demand on statutory services. This is a similar percentage to 2015/16. 20% of social work assessments resulted in step down to the EIFSS, a slightly smaller proportion than in 2015/16 (24%).

However, in 2016/17 there was a 28% fall in the number of CAFs completed. CAFs were completed by the following agencies:

Agency completing CAF	2015/16	2016/17
Children's social care	938	570
Children's Centres	213	194
Early Intervention & Family Support Service (EI&FSS)	69	112
Education	71	60

Youth Service (inc. YOTPS)	0	4
Troubled Families (Families Together)	13	1
Health	1	2
Total	**1305**	**943**

The 'lead agency' role was distributed as follows:

Lead Agency	**2015/16**	**2016/17**
Early Intervention & Family Support Service	594	309
Children's Centres	332	352
Primary Schools	128	75
Secondary Schools	79	58
Troubled Families	27	13
Private, Voluntary & Independent (PVI) Sector	8	8
Special Schools	8	3
Health	7	3
Education Welfare Service	3	0
Total	**1186**	**821**

There does seem to be a shift in the balance of early help provided, with more intervention at the more intensive level delivered by EIFSS, and less at an earlier stage by other partners. It will be important to keep this under review, as the earlier difficulties are identified and support provided, the less likely problems are to escalate.

Troubled Families

The Troubled Families Programme, a national initiative, works with families at risk of developing multiple and complex problems. In Redbridge, following consultation with service users, the programme has been renamed as Families Together. Phase Two of the Programme began in April 2015, with a brief to work intensively with families experiencing or demonstrating combinations of the following characteristics:

- Involved in crime or antisocial behaviour on the part of parents and / or children and young people
- Children and young people who are not attending school regularly
- Children and young people who are identified as in need or are subject to a Child Protection Plan
- Adults out of work or at risk of financial exclusion or young people at risk of worklessness
- Families affected by domestic violence and abuse
- Parents and children with a range of health problems

To date Families Together have identified 1040 families in Redbridge who meet two or more of the criteria above. 301 families achieved 'significant and sustained progress' in 2016/17. 99 adults were successfully supported to move off out of work benefits and into 'continuous employment'.

In June 2016 the Department of Communities and Local Government (DCLG), who are responsible for the national programme, undertook a 'spot check' on the Redbridge programme. All claims under the 'Payment by Results' aspect of the programme were validated. In their feedback letter, the DCLG commented on their discussions with staff about their work:

> "Each worker was able to provide information about the family, the intervention they received and the outcomes achieved. All the families had a plan in place and had been worked with in accordance with the principles of the Troubled Families programme."

They commended the outcomes records used by the Families Together Team as a model of good practice, and noted the effective prioritisation of work with families affected by domestic violence.

Child Sexual Exploitation

Improving the protection and support of children who are sexually exploited, and strengthening our work in identifying, disrupting and prosecuting child sexual exploitation, have been priorities for the LSCB throughout 2016/17. At every meeting, the Board has received, scrutinised and challenged a report on progress against the CSE Action Plan, and a report on the developing profile of child sexual exploitation in the borough through the collation and analysis of data at the Multi Agency Sexual Exploitation Panel (MASE), which meets monthly.

The number of contacts raising concerns about possible child sexual exploitation received by the Multi-Agency Safeguarding Hub (MASH) fell in 2016/17, compared with 2015/16, from 156 to 128. From the high point of 64 contacts received in the last quarter of 2015/16, there was a downward trend in the number received throughout 2016/17 – 46 in Quarter 1, 27 in Quarter 2, 29 in Quarter 3, and 26 in Quarter 4. It may be that this reflects a growing confidence among professionals in recognising the potential signs of child sexual exploitation, reducing the number of 'false positives' reported. However, if it indicates a blunting of awareness, it would clearly be a matter of significant concern. This will need to be carefully tracked in 2017/18. Forty five (35%) of the concerns raised were referred to children's social care for a social work assessment.

55% of the contacts received concerned children aged between ten and fifteen, and 82% concerned girls. This is an important reminder that sexual exploitation does not only affect older adolescents, and that boys can be exposed to it as well as girls. The largest source of contacts was the police (42%), with 30% coming from schools. Very few concerns were

raised by health professionals. The Board was concerned to establish whether any misplaced understandings of patient confidentiality might be limiting the readiness of, in particular, sexual health clinics to make appropriate referrals. Members were reassured that at both Barts and BHRUT guidance was in place to ensure that information sharing necessary to ensure the protection of children was prioritised at all times and that compliance was regularly audited, with regular dialogue between safeguarding staff and sexual health practitioners.

Approximately 25% of the concerns raised related to young people whose ethnicity was recorded as White British, and 17% were of 'other white origin'. 11% were Pakistani (Asian/Asian British).

The data collated suggests that the majority of child sexual exploitation identified in Redbridge is carried out by single male abusers, exploiting young people on line. We have not seen evidence of organised networks of abusers. During the year the police issued seven child abduction warning notices. These can be issued against individuals who are suspected of grooming children by stating that they have no permission to associate with the named child and that if they do so they can be arrested. Four of these notices resulted in arrest. One Sexual Risk Order was granted following police application. This is an order which can impose restrictions on a perpetrator, such as limiting their internet use, preventing them from approaching or being alone with a named child, or restricting their travel abroad. The subject of the order was subsequently arrested. There were two convictions for child sexual exploitation notices in 2016/17. One was of a 27 year old man who received a four year custodial sentence and lifetime registration on the sex offenders register. The other was a 19 year old who received a 2 year suspended sentence and 10 year registration on the sex offenders register, and was required to complete a rehabilitation programme.

The Safer London Foundation (SLF) was commissioned in September 2015 to provide a Young People's Advocate to support children at risk of or already a victim of child sexual exploitation. In 2016/17 the advocate provided intensive support in 12 cases and consultation on 30 others. Almost all the young people demonstrated that they have an increased understanding of healthy relationships and knowledge of safety strategies. An advocacy service is also provided by the Refuge – Redbridge Violence Against Women and Girls (VAWG) service for young people aged 14-17 year olds. Within the period support was provided to 15 young people concerning CSE.

The Community Safety Partnership, and the Council's Community Safety Services, are active partners in tackling child sexual exploitation in the Borough. In March 2017 a team of 29 enforcement and licensing officers and police officers visited 50 target settings such

as mini-cab offices and hotels to raise awareness of child sexual exploitation, preventive and disruptive measures, and how to raise concerns. National CSE Awareness Day in March was marked with a range of activity in and around Ilford High Road, involving the LSCB Team, Refuge, the Youth Service, and a number of volunteer parents, engaging almost 60 adults and over 30 young people in conversation and awareness raising. This event also prompted three disclosures of possible sexual exploitation.

Missing Children

Between April 2016 and March 2017, 218 children were recorded on Children's Social Care data systems as going missing from home on 409 separate occasions. 60 children went missing from care on 483 occasions.

	No. of children	No. of episodes	Average no. of episodes per child
Missing from home 2016/2017	218	409	1.88
Missing from home 2015/16	195	290	1.49
Missing from home 2014/15 (estimate based on six months data)	158	206	1.3
Missing from care 2016/2017	60	483	8.05
Missing from care 2015/16	55	521	9.47
Missing from care 2014/15 (estimate based on six months data)	74	524	7.08

Children who go missing from care are much more likely than children who go missing from home to go missing on multiple occasions. In 2016/17, 11 young people in care went missing on more than ten occasions. 85% of the children who went missing from home had no more than two missing episodes, and 74% only went missing once.

The position in Redbridge is made more complex to analyse by the very large number of children in the care of other local authorities who are placed in the Borough. Approximately two-thirds of young people in care placements are looked after by other local authorities. For young people who go missing from an address in Redbridge whose care is the responsibility of another local authority, the primary responsibility of Redbridge Children's Services is to ensure prompt notification to the placing authority in order that they can take the necessary steps to ensure the young person's safety, carry out a 'return

home' interview, and if necessary review the placement and care plan. However the local police in Redbridge are responsible for responding to all reports of children missing from a Redbridge address, and liaising with other police forces as necessary. For this and other reasons, it is not possible to compare police data with local authority data.

All children who go missing from home or care are offered an independent 'return home interview.' In 2016/17, 496 interviews were offered, a 35% increase on the previous year. However, the take up rate of the return home interview fell, from 87% (318 out of 366 offers accepted) in 2015/16 to 67% (330 accepted out of 496 offered) in 2016/17. Parents are also offered the opportunity to discuss the missing episode, and there is a 90% take up rate of this offer. Just over 11.5% of the young people interviewed were referred to the Early Intervention Panel for a package of support.

In the Annual Report for 2015/16 we described a range of initiatives and activities which had been established to seek to reduce the incidence of children going missing from home and care, and these activities have continued and developed throughout 2016/17. This has included the development of the Missing Children Panel, a strategic multi-agency group to plan and deliver activities to reduce the number of young people going missing and the risks to which they expose themselves. We concluded the discussion of the partnership's work with missing children in the 2015/16 Annual report by saying:

> "Considerable activity has taken place in 2015/16 to strengthen the partnership's response to the challenge. The test in 2016/17 will be to evaluate the impact."

Clearly, the data cited above shows that we have not yet been successful in achieving the impact we would want to see. There has been an overall increase in the number of children who go missing, either from home or from care, from 250 children in 2015/16 to 278 in 2016/17, although there has been a reduction in the number of missing from care episodes. There are indications that for those 'high risk' children who are discussed at the Missing Children Panel, the frequency of missing episodes reduces, although data is needed over a longer period to establish whether this is the case or not. Action to further develop and strengthen safeguarding arrangements for children and young people who go missing from home or from care remains one of the LSCB's core Business Plan priorities for 2017/18.

Housing

The shortage of affordable housing in the borough, and the impact of homelessness on vulnerable children, was a focus of the Board's concern throughout 2015/16, and continued to be so in 2016/17. Between 2015/16 and 2016/17 the number of households in temporary accommodation increased by just under 6%, from 2185 to 2308. However, the percentage placed outside the Borough, often at a considerable distance and with all the implications that has for continuity of education, friendships, and other networks of support, increased much more sharply, from 30% of all temporary accommodation arrangements to 45%. The number of households in bed and breakfast accommodation increased from 300 to 392. At the end of the reporting year there were 142 families with

children who had been in bed and breakfast for over six weeks, compared to 62 the year before. Until September 2014 the Council had no families with children in bed and breakfast for more than six weeks.

The Board received an update report on housing need in the Borough in July 2016. It welcomed the work in progress in the Council to develop a new Housing Strategy, but asked the chair to write to the Cabinet Member for Housing to set out the concerns that the Board would hope to see addressed in such a strategy, in particular:

- the overall rise in the number of homeless households, with 50% of those households headed by a single parent, the rise in the numbers in bed and breakfast, and the rise in the numbers in bed and breakfast for more than six weeks;
- the increasing number of families placed in temporary accommodation outside the Borough, with the potentially huge impact on, for example, the continuity and stability of children's education;
- the implication of the housing shortage for young people leaving care; and
- the low acceptance rate as homeless of applicants to whom a housing duty had been accepted (at 43.6% in 2015/16, the fifth lowest acceptance rate in London, and the concern this raised about the welfare of children in an unknown proportion of the 56.4% towards whom a duty is not accepted.

The Cabinet Member, Councillor Hussain, responded in detail to the concerns raised, and concluded:

> "I appreciate the concerns you have raised for children in Redbridge as a result of the housing pressures that exist. We have a legacy of a very small housing stock in the borough which leads to very few properties becoming available each year for letting. There has been a history of very modest levels of housing development. As part of our strategy we intend to escalate the levels of housing delivery in the borough and increase supply both of permanent social housing, decent temporary accommodation and sustainable private sector options for families. Some of the things we need to do will involve an adjustment in expectations, because increasing affordable housing supply takes time and addressing the significant level of under supply will be a massive task. We want to work with services to ensure that the options we develop support children and families. A key plank will be about prevention and early intervention and this will be something in which the support of other Council services and partners will be vital if we are to maximise the benefits for everyone."

A multi-agency audit of work with families with multiple needs carried out between November 2016 and March 2017 identified a number of concerns about the engagement of housing officers in the safeguarding of children, particularly in relation to their important role in identifying and recording safeguarding concerns while undertaking home

visits, and in understanding the potential risks to and impact on children of exposure to domestic violence. A number of actions were agreed between the LSCB Quality Assurance Manager and Housing Management to address these issues.

Neglect

One of the six priorities within the Board's Business Plan in 2015/16 was to strengthen our work in preventing, identifying and protecting children from neglect. A specific priority was to embed the use of the Neglect Toolkit, originally developed within the Council's early intervention and family Support Services as a tool for improving the identification of neglect and effective early intervention, assessment and care planning with children and young people affected, across all agencies working with children and young people. This objective was not achieved.

The Board had been concerned in 2015/16 that children placed on child protection plans as a result of neglect are more likely than children subjected to other forms of abuse to have their plans ended early without evidence of real change having taken place and more likely to 'bounce back' into the child protection system on repeat plans – a child protection 'rolling door'. Children's Services undertook more work in 2016/17 to test this hypothesis in 2016/17. This work concluded that there was a clear correlation between neglect and the likelihood of a child becoming subject to one or more repeat plans. However, it also demonstrated that the numbers involved were small. Of 376 children subject to child protection plans at the point of the analysis, 36 were subject to a second or subsequent plan. However, only 17 (5%)of these had become subject to a second plan within two years of the initial plan ending, and only two within six months. Although in this very small number of cases there was cause for concern that the original plan might have been ended prematurely, overall only 4.1% of the plans made in 2016/17 were second or subsequent plans, compared to 14.7% in 2015/16 and national and statistical neighbour benchmarks (2015/16 data) of 17.9% and 15.8% respectively.

The effective identification of neglect, and successful engagement with parents to achieve real and sustainable change in their parenting in these cases, remains one of the most difficult and challenging areas of child protection practice. However, the Board welcomed the significant fall in repeat plans as some evidence of effective learning from audit and analysis translated into practice.

Children and young people with mental health needs

In July 2016, NELFT informed the Chair of the LSCB that the financial challenges anticipated for the financial year 2017/18 had led to numbers of staff opting to leave the service, resulting in "a significant shortfall in the staffing resources available". This had made it necessary to put in place a number of measures to manage demand:

- New referrals would not be accepted for the Hear and Now (early intervention) service. Subsequently the service ceased operating.
- Only the most urgent and vulnerable young people referred to specialist CAMHS services could be prioritised.
- New referrals could not be accepted for attention deficit hyperactivity disorder and autistic spectrum disorder.
- Young people referred to CAMHS who did not attend for appointment would not be offered a second appointment

These service restrictions remained substantially in force for the rest of the year. For those young people who were accepted for treatment ('the most urgent and vulnerable') the average waiting time from referral to treatment increased from 6.5 to 8.6 weeks.

CAMHS Services are commissioned by the Clinical Commissioning Group (CCG). In December 2016, the CCG reported that a 'new model' for CAMHS services in Redbridge had been agreed, and that the model was due to go live on 1 April 2017. Key elements of the model included an emphasis on equipping all professionals working with children and young people to promote resilience in young people and to respond effectively to early signs of mental ill health, a single point of access to all services and resources to address mental ill health in children and young people, including signposting to a range of preventive services and a new on-line counselling service to be commissioned, as well as more effective and streamlined access to specialist CAMHS services for those young people who needed this more specialist professional help. It was clear however by the end of the year that progress towards the implementation of the new model was much slower than planned, and none of the key elements were in place by April 2017.

The Board became increasingly concerned throughout 2016/17 about the very limited services available for children and young people in Redbridge experiencing mental ill–health, and the potentially drastic implications of this for safeguarding and for young people's mental health. Challenging and supporting improvement in this area is one of the LSCB's top priorities for 2016/17.

Domestic violence

The Board considered two reports in 2016-17 on the work of the Violence Against Women and Girls Integrated Support Service, delivered by Refuge, which had launched in mid-2015. This service provides:

- Four specialist independent gender-based violence advocates (IGVAs) to support women and men at risk of serious harm
- A young people's advocate and a children's outreach worker
- A group work and peer support scheme
- Volunteering opportunities

Around 25% of the women referred to the service are either pregnant or have dependent children.

The Board welcomed the reports and the examples given of young people being directly supported by the project to, for example, successfully give evidence against an abuser in court, or recognise and protect themselves against abusive situations. It was concerned that the funding for the project, from central Government and the Mayor of London, was time limited, and initially only guaranteed to March 2017. The Board was pleased to hear, by the end of the year, that funding had been extended, but remained concerned that funding remains time limited and not secure in the long term.

Private Fostering

Private fostering is the care of a child, via private arrangement, by somebody who is not a parent or close relative for 28 days or more. Such arrangements should be notified to the local authority, who have a duty to satisfy themselves of the welfare of the child. However, nationally, regionally and locally, the number of arrangements notified to the local authority are low. For many years, a range of other evidence has suggested that private fostering arrangements are much more widespread than the number of cases notified to local authorities would suggest.

The Board should receive an annual report on private fostering in Redbridge, but at the time of writing this has not been received. However, we do know that at 31 March 2017 there were 12 children in Redbridge notified as living in private fostering arrangements, compared to 6 a year earlier. This may be some limited evidence of the range of awareness-raising activity that was undertaken during the year. The Fostering Team delivered three specific awareness raising briefings, co-facilitated by the LSCB Training Manager, which will be repeated in 2017/18. Presentations were also made to a GP Protected Learning Event attended by 70 GPs, and to the Redbridge Early Years Providers' Forum. A Private Fostering Briefing was delivered as part of the LSCB Training Programme 2016 – 2017, although it should be acknowledged that a second planned briefing was cancelled due to poor take up. A private fostering stand, aiming to raise public awareness, was featured at the Redbridge Community Day in August 2016.

The report of the Ofsted inspection of children's services in Redbridge, published in November 2016, was positive about the 'far reaching service' and the 'high level of service' delivered by children's social care to those children in private fostering arrangements which had been notified to the Council, although it also recognised that the numbers notified were lower than would have been expected in a borough with Redbridge's profile. The LSCB has committed itself to a fully multi-agency action plan in 2017/18 to increase private fostering notifications.

Protecting young people from involvement with violent extremism

There is very close liaison between the Prevent programme, located within the Council's Community Safety Service, and the Multi Agency Safeguarding Hub (MASH) to ensure a common understanding of the dangers of involvement in violent extremism, including but by no means limited to radicalisation, as a core child protection issue. Vulnerable individuals who are identified are managed through the multi-agency Channel Panel which include representatives from children's services, adult social care and mental health services, child and adolescent mental health services, Community Safety, education and the police.

Ofsted's inspection of children's services, published in November 2106, described 'robust strategic and operational 'Prevent' arrangements which ensure an effective, and continually evolving, professional response to radicalisation'.

Police restructuring

During 2016, it was announced that the three boroughs of Barking and Dagenham, Havering and Redbridge would be one of two 'pathfinder' sites for the One Met model – a pan-borough configuration which would create a Basic Command Unit (BCU) bringing all policing activity in the three Boroughs together under the control of a single BCU Commander, rather than three separate Borough Commanders, and all safeguarding work across the BCU under a single command at Superintendent level. The Board welcomed the principle of integrating what had previously been a structure for child protection work fragmented across different Borough, sub-regional, and Met wide responsibilities under a single command; but stressed the importance of very detailed consultation with the individual boroughs over implementation. In the event however this consultation was very limited up to the launch of the new structure on 27 March 2016. It proved to be extremely difficult to access clear and detailed information about the proposed structure and how it would work in advance of implementation. The Chair felt very strongly that it was clear that, at the most senior levels in the Metropolitan Police Service, there had not been a sufficient recognition of the need to engage and consult with the three separate and different local authorities about the detailed implementation of the model in child protection work, and he and others raised a number of very significant concerns about the operational implications of the changes which had not been resolved by the end of the year. In its initial discussions in January 2017, the Board emphasised that Ofsted inspectors had described joint work with the police in Redbridge under the previous arrangements as 'the best we've seen anywhere'; and that it was absolutely critical to ensure that this gold standard was sustained through any police reorganisation. This must and will be a primary focus for scrutiny and assurance for the LSCB throughout 2016/17.

Allegations against staff

The Designated Officer (DO) within the local authority is responsible for managing the arrangements in place for responding to allegations that a person who works with children has behaved in a way that has 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 that they may pose a risk of harm to children.

Following the departure of the previous long serving and highly respected DO in early 2016, there were a number of changes and interim arrangements in place for the DO function through the remainder of the year.

Data on the LADO service is currently available on a calendar basis and was last reported to the LSCB in January 2017. The LADO received 282 notifications in 2016, continuing the year on year upward trend in the number of notifications received - 269 in 2015, 223 in 2014, and 146 in 2013. However, there was a significant change in the pattern of response to notifications. Between 2013 and 2015 the percentage of notifications which were assessed as meeting the threshold, as described above, and were subject to a formal evaluation, fell each year - 55% in 2013, 30% in 2014, and 18% in 2015. By contrast, in 2016, 107 (38%) were assessed as meeting the threshold. The reasons for this increase are not clear. It may in part reflect changes in September 2016 to the statutory guidance, Keeping Children Safe in Education, which emphasised for schools the importance of regular safeguarding training, clear lines of responsibility in respect to designated safeguarding leads and the need to refer when appropriate to the Designated Officer. Schools were the source of 16% of the referrals assessed as meeting the threshold in 2015. In 2016 that figure was 30%. Social care services accounted for 22% of referrals, and early years services for 21%. As in previous years, there were very few referrals from health services (3 out of 107). The number of direct referrals from parents increased from 4 in 2015 to 10 in 2016.

In terms of outcomes, of those notifications subject to formal evaluation, one resulted in a criminal conviction; 14 led to a criminal investigation, compared to 4 in 2015; six resulted in dismissal – none in 2015 – and six in other forms of disciplinary action, compared to two in 2015. There were seven referrals to a regulatory body (one in 2015), and six referrals to the Disclosure and Barring Service, one more than in 2015.

Joint working between children's and adults' services

Analysis of findings from Serious Case Reviews (SCRs) indicates that where children are being cared for by adults with significant needs of their own, particularly those with substance misuse or mental ill health problems, or are witnessing repeated domestic violence, they are more likely to be at risk of being harmed within their families. Inquiries into child deaths have shown that close joint working between professionals involved with the whole family can impact positively on child protection planning and is vital for a full understanding and assessment of risk. The LSCB and the Safeguarding Adults Board

agreed in March 2016 a joint working protocol which sets out clearly the responsibilities of professionals who work primarily with vulnerable adults or adults at risk in relation to the protection of children within those households. A complementary piece of work, setting out the equivalent responsibilities for professionals who work primarily with children have in relation to the protection of vulnerable adults, will be completed in 2017/18.

Resolving professional disagreements

The LSCB recognises that it is inevitable and healthy that from time there will be disagreements between professionals about the safeguarding needs of a child, and how to make sure they are effectively met. It also recognises that it is crucial for the welfare of children that opportunities exist to resolve such differences in a constructive and non-adversarial way. In May 2016 the LSCB published its Escalation and Resolution Policy which aims to provide streamlined but effective channels for the resolution of professional differences, ensuring that the child's safety and welfare are the paramount considerations at all times.

Communication, publicity, and engagement

The LSCB has continued to give priority in 2016/17 to communication and engagement – with front line staff across the partnership, with parents and carers, with children and young people, and with the general public. It continued to publish a quarterly newsletter, widely distributed to agencies and individuals working with children, young people and their families or carers in Redbridge and available to the public via the LSCB website. The website itself has continued to develop, including the embedding of a translation facility and accessibility page, an on-line Contact Form, and a direct 'feed' from Twitter. In their assessment of the effectiveness of the LSCB, published in November 2016, Ofsted described the website as "excellent… interactive and informative, with up to date information for professionals, children and young people and parents… Information is particularly well presented in a range of age-specific categories, providing information in visual and audio format."

The LSCB has also continued to expand its social media presence via Twitter and Facebook. On 31 March 2017 the LSCB had over 650 followers on Twitter, with 74 new followers, 191 'tweets', 1,622 profile visits, 36 mentions and 75.2K 'tweet' impressions in March alone.

The LSCB also had an active presence at a number of public and community events, including both generic community engagement days and specific events linked to National CSE Day and Internet Safety Day.

6. Safeguarding Training

In 2016/17, the LSCB continued to commission and deliver a substantial training programme for multi-agency staff working in Redbridge. The Annual Report for 2015/16 reported a worrying fall in attendance at training events compared to the previous year. It is pleasing to be able to report that the numbers attending LSCB training in 2015/16 recovered significantly in 2016/17, from a total of 397 attendances to 649.

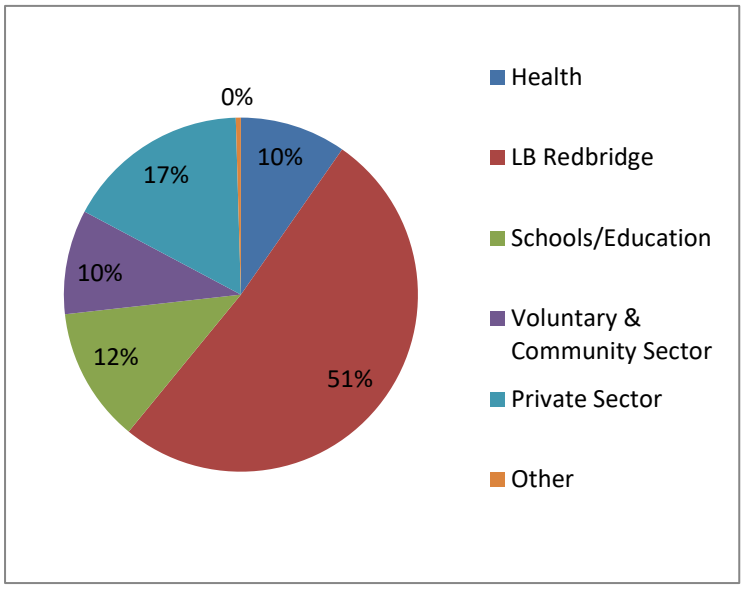
A total of 56 events (including training courses, briefings and workshops) ran as part of the LSCB Programme in 2016/17. Programmes delivered were as follows:

- Safeguarding Children Level 2 - 4 courses
- Abuse in Teenage Relationships - 2 courses
- Common Assessment Framework Workshop - 7 workshops
- Child sexual exploitation - 3 courses
- CSE Briefing - 2 briefings
- Cousin Marriage Awareness - 1 course
- Female Genital Mutilation - 2 courses
- Learning from Child Deaths - 1 course
- Learning from Multi-Agency Audits - 2 workshops
- Private Fostering Briefing - 1 briefing
- Safeguarding Children Who Go Missing - 3 courses
- Understanding Thresholds - 2 courses
- Trafficking Across Borders - 1 courses
- Voice of the Child Briefing - 1 course
- WRAP – Prevent Training - 4 courses
- Working with Families with Multiple Needs - 3 courses
- Safeguarding Children from Neglect - 4 courses
- R U Ready - 1 course
- Safeguarding Children in a Digital World - 1 course
- Safeguarding Children with Disabilities - 2 courses
- Working with Young People in relation to Gangs - 2 courses

A small number of sessions were commissioned but then cancelled due to poor take up:

- CAF Workshops – 2 workshops
- CSE Briefings – 2 briefings
- Private Fostering Briefing – 1 briefing

Participant satisfaction continued to be high with 95.69% of attendees rating courses as 4 or 5 (satisfied / very satisfied).



Attendance by agency in 2016 – 2017 is represented in the chart to the left. It is interesting that the private sector accounted for 17% of attendances compared to 5% in 2015/16. Total expenditure from the LSCB budget on training was £14,621, compared to £15,037 in 2015/16 and £17,254 in 2014/15. £8680 was received in attendance fees and £3360 was received in charges for non-attendance. Significant progress was thus made towards the LSCB's strategic aim of a self-funding training programme.

Individual partner agencies and commissioned providers have delivered a wide range of safeguarding training for their own staff and the organisations they support.

The Education Welfare Service trained 1309 school staff at Level 1 across 25 school settings, 216 Designated Safeguarding Leads and Senior Leadership Teams at level 2 across 37 school settings and 252 staff in additional briefing sessions on topics such as FGM, CSE and reporting skills. The service also reached the wider workforce supporting vulnerable children to specialist schools, by training 61 Redbridge Transport passenger assistants at Level 1.

There were 73 attendances by school governors on safeguarding training on a range of topics from safer recruitment, safeguarding responsibilities to WRAP (Workshop to Raise Awareness of Prevent) across the year.

The Redbridge Foster Carer Training Programme 2016 – 2017 featured a number of courses related to safeguarding for foster carers. These included Safeguarding Children and Young People, Internet Safety, and Introduction to Sexual Abuse.

The CCG requires 85% of all health staff to be trained at the required level. In 2016/17, this target was met by all our major health providers.

Health Providers Safeguarding Children Training Compliance				
Agency	**Year End 2016 – 2017**		**Year End 2015 - 2016**	
	Level 2	**Level 3**	**Level 2**	**Level 3**
NELFT	94.2%	95.6%	87.5%	90%
BHRUT	92.3%	89.3%	80%	85%

PELC	90.0%	98.0%	62%	83%
Bart's Health	89%	87%	62%	83%

In the Annual Report for 2015/16, we said that:

> "The LSCB has a responsibility, not only for the quality of its own training programmes, but also for evaluating the effectiveness of the training provided by partner agencies, and the impact of training on practice and outcomes for children. However, as a result of delays in recruiting to the new post of LSCB Training Manager, there was very limited capacity during 2015/16 to develop this function. It is a priority in the 2016/17 Business Plan."

The Ofsted report on the effectiveness of the LSCB in November 2016 also commented that while training was comprehensive and of high quality, "evaluation of training courses is underdeveloped". There was significant progress on this in 2016/17. A Framework and Principles for Safeguarding Children Training was agreed in 2016. It set out the mechanisms for both quality assuring the safeguarding training provided by individual partners, and for evaluating the impact of training. In the second half of the year, under the Framework, ten observations of LSCB training were undertaken and two observations of partner agency training were undertaken with findings shared back with both the provider, commissioner and agency to ensure ongoing improvement and development.

As part of the new Framework, on-line evaluation of training and learning, completion of which is mandatory in order to achieve an attendance certificate, has replaced the previous paper response form, and this has significantly enriched the feedback, not purely on the participant's evaluation of the training itself, but on their learning and their intentions on putting the learning into practice. Effectively following up the impact of training three months later has continued to be a challenge, but a combination of email questionnaires and telephone interviewing has, on the courses on which it was piloted, delivered a 40% response, which is a very significant improvement on past return rates. The Training Sub Group will continue to develop their work in quality assuring and evaluating the impact of training in 2017/18.

7. Learning and Improvement

Learning and Improvement Framework

Working Together to Safeguard Children 2015 requires every Local Safeguarding Children Board to publish a Learning and Improvement Framework, setting out how it will create, maintain, review and measure a framework of continuous learning across the partnership. Redbridge LSCB published a revised Learning and Improvement Framework in October 2015. The framework was described by Ofsted in November 2016 as 'clear, succinct and [covering] all matters expected by statutory guidance'. It sets out a range of mechanisms which the LSCB will use to promote continuous learning and improvement, including:

- Training and Development supported by the Redbridge LSCB Training Programme
- The evaluation of training and its impact
- Serious Case Reviews (SCRs) and Independent Management Reviews (IMRs) and learning from SCRs carried out by other LSCBs
- Multi-agency reviews carried out by the Learning and Improvement sub group on individual cases
- Multi-agency and single agency audits
- Section 11 Audits
- Learning from Inspection
- Consideration of cases at the Child Death Overview Panel (CDOP)
- Scrutiny of performance data
- Consultation with young people

Serious Case Reviews

The Chair of the LSCB must commission a serious case review in relation to any incident in which the abuse or neglect of a child is known or suspected, and either a child has died, or a child has suffered serious harm and there is cause for concern about the way agencies have worked together to safeguard that child. The Government has established a statutory National Panel of Independent Experts on Serious Case Reviews, to whom all decisions either to commission or not to commission a serious case review must be reported. If the Chair decides not to commission a serious case review, the Panel can challenge that decision.

During 2016/17, the Chair considered in depth one child death against the criteria for a serious case review. He decided that it was not appropriate to initiate a serious case review. The national panel concurred with this view.

Multi-Agency Audit

The multi-agency audit of practice is a key ingredient for learning and improvement - ensuring that the LSCB has a clear grip on quality at the front line. It is also difficult and challenging to get right – balancing the necessary rigour and creating the necessary opportunities for shared reflection, and engaging the expertise of front line practitioners in

evaluating the quality of each other's practice, while not making unrealistic demands on very pressurised staff in all partner agencies. For much of 2016/17 the LSCB continued to struggle with this challenge. Ofsted commented in November 2016:

> "The multi-agency audit programme needs to be further embedded for the board to have further assurance of frontline safeguarding practice. The chair is aware of this and acknowledges that they are on a journey to make this more effective."

The Board was however able to make a significant step forward on that journey with the appointment of a permanent Quality Assurance Manager in December 2016, and the agreement of a much more robust, deliverable, and multi-dimensional approach to multi-agency audit in March 2017. The impact of this should be clearly demonstrated in 2017/18.

Four multi-agency audits were completed in 2016/17, each of which, in spite of the challenges described above, contained some important learning:

- An audit of safeguarding practice in Early Years provision was completed in August 2016. In all the cases audited, effective information sharing and multi-agency working were found to have demonstrated a positive impact on outcomes for children and for families

- An audit of work with children with disabilities was completed in September 2016. Again, multi-working was assessed as effective in all the cases audited. However, there were some significant areas for improvement. The quality of social care assessments, and the quality of child protection plans, were found to be highly variable. However, it should also be noted that Ofsted found that work in the Council's children with disabilities service was effective:

  > "Social work practice is sensitive to the needs of children with disabilities, with good awareness demonstrated of child protection issues when they affect this service user group…The safety of children with disabilities is assured."

- A multi-agency audit of a number of identified cases of child sexual exploitation was completed in October 2016. It was significant that in 50% of the cases audited, the young people were not of the view that they were at risk or being exploited, although in a number of cases intervention helped them to recognise more clearly their exploitation. Generally, multi-agency working in the cases audited was strong.

However:

- Information sharing was not always timely, and there were particular problems with timely information sharing across local authority borough boundaries.
- An important factor in successful outcomes was appropriate access to appropriate services at the right time. In one case a delay in access to CAMHS services led to missed opportunities with services not being available to young people, when they were ready to engage.
- A consistent relationship with a caring professional was a key factor in helping young people to engage with services and to accept help. Changes in social worker, for example, had a significant impact in setting back engagement. Young people often found it easier to engage with 'non state' agencies such as Safer London or the NSPCC than with statutory services.
- Some plans did not fully reflect the areas of concern – for example, sexual activity, exposure to risk, or poor school attendance – and did not sufficiently address action to address those risks.
- In one case, agencies seemed to be working together in a more co-ordinated way whilst a young person was subject to a child protection plan. Once the plan was 'stepped down' to a Child in Need plan, the level of co-ordinated activity reduced

- An audit of work with families with multiple needs – children living with combinations of parental domestic violence, substance abuse and mental ill-health – was completed In February 2017. Although much strong multi-agency practice was identified, this audit demonstrated the impact of more rigour in identifying areas for improvement. These included:

  - intervention or support offered to families was not always targeted or timely and often did not result in sustainable change, or consistently improve outcomes.
  - There was sometimes a lack of focus on the child and a focus on parental needs.
  - There was a need for greater professional curiosity – there were numerous occasions when professionals accepted a general statement without enquiring deeper.
  - Men who played a significant role in a family were not always adequately involved in assessments.

A summary report of key findings and learning from the Multi-Agency Audit Programme 2016 – 2017 has been published on the LSCB website. Learning was also disseminated though multi-agency briefings as part of the LCB training programme, and through dedicated sessions with, for example, child protection case conference chairs.

Single agency audit

Since July 2106, each Board agenda has included a summary report from an individual partner agency of the audit activity in that agency, and the learning and areas for improvement identified. In 2016/17 reports were considered from children's social care, NELFT and BHRUT.

Qualitative case audit – how good was our practice in this case? – is currently underdeveloped in the Metropolitan Police. In November 2016 the first recommendation of the HMIC report on child protection work within the force was that the Service should immediately take action to put arrangements in place to monitor child protection practice:

> "The force should then provide officers and staff with a clear understanding of what good service looks like and the standards it expects, and begin to develop a performance management framework that will operate to achieve consistent standards of service across London."

Progress against this recommendation would significantly support the LSCB in understanding and assuring the quality of practice at both a single agency and a multi-agency level.

Section 11 Audit

Section 11 (s.11) of the Children Act (2004) requires every LSCB partner to have arrangements in place to ensure that "their functions are discharged having regard to the need to safeguard and promote the welfare of children". Every partner is required by the LSCB to conduct a self-assessment or "Section 11 audit" on a regular basis to ensure compliance with this requirement. In Redbridge, Section 11 audits are completed every two years.

A comprehensive programme of Section 11 audits was completed in 2016/17. In its Business Plan for the year, the LSCB recognised the need or a more robust and transparent process than had been in place in the past, and committed itself to ensuring that:

- Section 11 audits are subject to peer and lay challenge, including input from young people
- Section 11 audits are transparent and rigorous in their assessment of weaknesses and planned action to address
- The LSCB monitors and challenges required improvements

To deliver on these commitments, each statutory partner was asked to complete a self-assessment. All agencies participated, with the exception of the Community Rehabilitation

Company (CRC). The CRC submitted a self-assessment completed on a pan-London basis, but did not make themselves available to attend the Challenge Panel described below.

In their self-assessment, agencies were asked to rate themselves against eight standards, and whether these standards were wholly met, partially met, or unmet. Critically, they were also asked to present the evidence for that judgement. Each agency was then invited to attend a two hour 'Challenge Panel', at which their self-assessment was scrutinised and challenged. The panels were all chaired by the LSCB Chair or the Board's Quality Assurance Manager, and included both a senior representative of another statutory partner agency and either a representative from the voluntary sector or one of the Board's lay members. This proved to be an exceptionally challenging, constructive and productive process. No standard was judged to be 'wholly unmet' by any agency. For every agency, however, one or more standards were agreed as only 'partially met'. Where appropriate, agencies revised and resubmitted their self-assessments following panel challenge.

All agencies will present their action plans to address those areas of weakness to the Board in July 2018, and progress against those action plans will be reviewed at every Board meeting for the remainder of the year. We will be able to report on this in detail in the Annual Report for 2017/18.

In view of the significant organisational changes within the Metropolitan Police, the Panel agreed that the new Safeguarding Command in the tri-borough Basic Command Unit should be asked to repeat the S11 self-assessment six months after implementation and embedding of the new structure.

The Board did not succeed this year in securing the direct engagement of young people in the Section 11 programme. Should an equivalent programme be continued into 2018/19, following implementation of the Children and Social Work Act 2017, renewed efforts should be made to achieve this.

Other learning events and reviews

In the Annual Report for 2015/16, we reported that a multi-agency learning review had been initiated of one case which had initially been considered against the criteria for a Serious Case Review. The Chair took the view that, although a SCR was not required, there were potentially important lessons to be learned about the complexities of multi-agency working in relation to a child with a severe disability and a high level of parental conflict with professionals. The review was completed during 2016/17.

The LSCB also commissioned a multi-agency learning event, which was facilitated by a senior partner at the Tavistock Institute, to explore some of the tensions that had arisen between professionals working with another child with a severe disability. The event was attended by both practitioners and managers from social care, education, and health agencies involved in the care of the child.

Both the internal learning review and the multi-agency learning event generated a richness of learning which had a significant impact on the professionals involved in working with the children concerned. While there were of course differences which reflected the different complexities of each case, some strong common themes also emerged, including:

- The challenges, and the indispensable centrality, of ensuring that the voice and lived experience of the child is the central concern and focus of everybody involved, whatever the specific communication difficulties of the child or the needs, demands or behaviours of parents or carers may be
- The importance of professional curiosity about all aspects of the child's experience, and the danger of agencies making assumptions about each other's involvement
- The need to be alert to the signs of frustrations and difficulties in working with parental non-engagement or non-cooperation translating themselves into conflict and 'blaming' between professionals
- As always, the crucial importance of full information sharing and constructive challenge between professionals

Action		Lead Officer	Timescale and milestones	How we will measure success and impact	RAG Rating/ Commentary
PRIORITY 1: To improve services for young people experiencing mental ill-health.					
1.1	Development of early recognition and early intervention across the children and young people's workforce for children and young people with mental health needs.	Deputy Director, Safe-guarding, Redbridge CCG	Com-missioned by 01 05 17 Rolled out of training by 01 06 17 Training completed by identified target groups by 31 12 17	• Provision of a 'resilience' training programme commissioned as part of the CAMHs review to enable school staff and other professionals to support children and young people with mental health issues. • Enhanced confidence of school staff to manage and support children with mental health issues, with early intervention, thus reducing the need for higher level intervention.	**Grade: White**
			Publication of new referral pathways by 30 07 17	• Increase of 5% of CAF or early intervention referrals relating to mental health. • Consistent and effective use of referral pathways ensuring that children and young people get the right service at their point of need.	
			Com-missioning of training course and publication of Training Programme by 01 04 17	• Inclusion of young people's mental health awareness raising training as part of the LSCB Training Programme 2017 - 2018 to aid improved awareness and recognition of mental health needs of young people across the workforce.	
1.2	Oversight and monitoring of the agreed CAMHs Local Strategy Plan (LSP) to ensure that this adequately addresses local mental health needs of children and young people.	Deputy Director, Safe-guarding, Redbridge CCG	Multi-Agency Audit Report of findings and learning to the Executive in March 2018	• Multi-Agency Audit of cases open to Early Intervention and Family Support Service (EI&FSS) and Children's Social Care in relation to mental health to identify gaps, good practice and impact of early intervention.	**Grade: White**
			Report on CAMHs Local Strategy Plan (LSP) evaluation of progress to LSCB by 30 10 17	• Exploration and identification of opportunities to fast track identified vulnerable groups into mental health services or appropriate supporting including community based activities.	

Action		Lead Officer	Timeline and Milestones	How we will measure success and impact	RAG Rating/ Commentary
			31 12 17	• Publication of Improvement Plan following consultation.	
			31 01 18	• Clarity across the workforce and with service users of service provision through a communications programme.	
			31 10 17	• Use of the iThrive Outcomes Framework to identify improvements in services available to children and young people.	
1.3	Oversight and involvement with the development of the response to children and young people's self-harm. Redbridge Suicide Prevention Strategy and its implementation to ensure that children and young people are a key priority.	LSCB Business Manager	Publication of the Strategy by 30 09 17	• Contribution to the development of the new Redbridge Suicide Prevention Strategy to ensure a strong emphasis on safeguarding children and young people and early help. • Engagement with partners in delivery and challenge in relation to implementation.	**Grade: White**
			Inclusion of training on self-harm in the LSCB Training Programme 2017 – 2018 published by 01 04 17	• Understanding across the workforce of the indicators and risks relating to young people and self-harm and suicide. • Sharing of the Suicide Prevention Strategy via the mental health training courses run as part of the LSCB Training Programme.	**Grade: White**
			Resources published on the LSCB website by 30 10 17	• Development of mental health resources and specifically support relating to suicide on the LSCB website.	
		Head of Child Protection and Early Inter-vention Service, LBR	December 2017	• Completion of gathering of intelligence and analysis to identify self-harm trends or particular schools or colleges, then used to inform targeted learning and development activities.	**Grade: White**
1.4	Strengthen peri-natal mental health pathways linking to Children's Centres, health visiting service and midwifery, to support early attachment and reduce the risk of children requiring support later in life.	Inte-grated Care Director, NELFT	Workshop held by 31 10 17	• Workshop to bring together appropriate professionals to support development of relationships, embedding of pathways and sharing of good practice.	**Grade: White**
			Materials published by 31 10 17	• Availability of resources, including guidance and learning materials on attachment.	

Action		Lead Officer	Timescale and milestones	How we will measure success and impact	RAG Rating/ Commentary
PRIORITY 2: To strengthen the protection and support of children and young people exposed to exploitation and harmful practices.					
2.1	Provide a co-ordinated robust response to FGM through the use of the pan London FGM strategy and data resource.	LSCB Inde-pendent Chair	July 2017	• Review of effectiveness of the cross-borough FGM Strategy and progress on the Action Plan.	**Grade: White**
			October 2017	• Review of the effectiveness of mandatory reporting.	
			March 2018	• Increased referral rate monitored via the LSCB data scorecard.	
			December 2017	• Availability and promotion of learning and development activities for the workforce to increase awareness and promote response.	
			December 2017	• Updated database of FGM resources available to women and girls affected.	
2.2	To continue to embed and further develop a response to CSE both on an individual case basis and strategically.	Head of Child Protection and Early Inter-vention Service, LBR Children's Services	July 2017	• Publication of a revised LSCB CSE Prevention and Intervention Strategy reflecting the new Government definition of CSE, Government Practice Guidance and the new pan London CSE Operating Protocol.	**Grade: White**
			September 2017	• Effective implementation of new structure for MASE and the operational group to ensure continued sharing of multi-agency intelligence to inform service response to CSE.	
			Quarterly Reports - April, July, October 2017 and January 2018. Annual Report July 2017	• Effective Monitoring through the receipt of quarterly activity reports and an annual report to the Board.	
			March 2018	• Increase of 10% in the number of contacts and referrals relating to CSE through raising awareness with partner agencies, including specific activities with schools.	
			December 2017	• Increase of 10% the number of cases referred to the operational group.	

Action		Lead Officer	Timescale and milestones	How we will measure success and impact	RAG Rating/ Commentary
			17 March 2018	• Participation in National CSE Awareness Day 2018 to raise the profile of CSE with the public.	
2.3	Learning and development activities on various topics relating to exploitation and harmful practices included in the LSCB Training Programme.	Chair, LSCB Training Sub Group	Commissioning of the training courses and briefings and publication of the LSCB Training Programme by 01 04 17	• Topics covered to include CSE, Trafficking, Gangs and Harmful Practices including FGM. • Knowledge and awareness of CSE and other harmful practices embedded in general safeguarding training to optimise learning opportunities. • Incorporation of the new HM Government Guidance on CSE for Practitioners and Local Leaders to be incorporated into CSE briefings and training.	**Grade: White**
			May 2017	• Publication of 'quick' guides on the LSCB website on a range of exploitation and harmful practices for use by professionals.	
2.4	Implementation of a multi-agency response to trafficking through the implementation of a local policy, procedures and pathways leading to greater awareness, early intervention and robust reporting arrangements.	Community Safety, Transformation and Enforcement Lead, LBR	31 October 2017	• Development of local policy and pathways based on statutory reporting requirements. • Identification of Single Point of Contacts (SPOCs) in 'responder' agencies. • Identification of resources and support to enable signposting for victims.	**Grade: White**
			31 March 2018	• Mapping of incidence and themes in Borough. • Awareness raising activities across partner agencies leading to increase of reporting by 10% for 2017 – 2018.	**Grade: White**

Action		Lead Officer	Timescale and milestones	How we will measure success and impact	RAG Rating/ Commentary
PRIORITY 3: To strengthen quality and impact of the Independent Reviewing Officer (IRO)/Child Protection (CP) Chair role, particularly with reference to cases of neglect.					
3.1	Delivery of the post-Ofsted Inspection Action Plan section relating to the role of IROs/CP Chairs to ensure improvement in the service delivery and impact.	Oper-ational Director, Children and Families, LBR	All actions completed and evidenced by December 2017	• SMART CP and LAC Review plans. • Evidence of the voice of the child in reports. • Evidence of increased engagement of children and young people in CP Conferences and LAC Reviews. • Reduction in the number of complaints received by the LSCB which relate to reports provided to Conferences. • Evidence of the use of the dispute resolution process.	**Grade: White**
3.2	Multi-Agency Audit on cases of children and young people on Child Protection Plans subject to Neglect.	LSCB Quality Assurance Manager	April – September 2017	• Evidence of robust Care Plans with identified outcomes.	**Grade: White**
3.3	Audit of records of CP Conferences and LAC Reviews to identify good practice and areas for development.	LSCB Quality Assurance Manager	April 2017 – October 2017	• Positive findings of audit. • Identification and implementation of learning.	**Grade: White**
3.4	Development of multi-agency recruitment panels and children and young people's involvement in recruitment of IROs/CP Chairs.	Chair, LSCB Learning and Improve-ment Sub Group/ PCFSW	July 2017 – March 2018	• Effective engagement of children and young people in recruitment.	**Grade: White**

Action		Lead Officer	Timescale and milestones	How we will measure success and impact	RAG Rating/ Commentary
PRIORITY 4: To develop and implement a robust multi-agency action plan to substantially increase private fostering notifications.					
4.1	Development and delivery of a multi-agency Private Fostering Communications Plan to raise awareness across agencies working with children, young people and families of private fostering to improve notification and safeguarding.	LSCB Business Manager	Agreement and launch of the Communication Plan by 01 05 17	• Creative and comprehensive Plan that engages all partner agencies, to include LSCB themed Newsletter on Private Fostering.	**Grade: White**
			Completion of Communication Plan by 31 03 18	• Increase in Private Fostering notifications from 2016 – 2017 of 20%.	
			Spring Edition of the LSCB Newsletter published by 01 05 17	• Evidence that partner agencies have undertaken communication activities within their agency included in the LSCB Annual Private Fostering Report.	
4.2	Provision of an Information Pack, including PowerPoint presentation on Private Fostering for internal use by partner agencies.	LSCB Business Manager	Publication of the Information Pack by 01 05 17	• Promotion of the pack via different channels with follow up activities to ensure receipt and to embed.	**Grade: White**
			Distribution of pack and letter by 30 06 17	• Specific targeting of agencies with increased likelihood of contact with privately fostered children and young people including international language schools.	
4.3	Oversight, monitoring and challenge by the LSCB of private fostering.	LSCB Independent Chair	Report provided to January 2018 Board	• Annual Private Fostering Report to be presented to the LSCB for scrutiny, challenge and feedback.	**Grade: White**
4.4	Participation in community events to promote awareness of private fostering with the public.	LSCB Business Manager	June – September 2017	• Publicity stand at community events	**Grade: White**
			National Private Fostering Week – 3 – 7 July 17	• Delivery of a high profile activity relating to Private Fostering Week 2017 and associated social media drive.	
4.5	Provision of learning and development activities relating to Private Fostering to raise awareness and improve notification rate from the children and young people's workforce particularly with hard to reach groups.	LSCB Training Manager	2017 - 2018	• Delivery of a minimum of 4 presentations at forums including GP Protected Learning Events, provider forums, head teachers, early year's forums etc.	**Grade: White**
			Briefings to be commissioned and included in Training Programme published by 01 04 17	• Inclusion of Private Fostering Briefing in the LSCB Training Programme 2017 -2018.	

Action		Lead Officer	Timescale and milestones	How we will measure success and impact	RAG Rating/ Commentary
PRIORITY 5: To strengthen and improve support to children and young people on e-safety and peer on peer sexual harassment.					
5.1	Refresh of the e-safety campaign targeting secondary school pupils as a Youth Council project.	Head of Positive Activities, Children's Services, LBR	April – October 2017	• Consultation with children and young people on their safeguarding concerns relating to e-Safety and peer-on-peer sexual harassment to inform the campaign.	**Grade: White**
			October – December 2017	• E-safety material being refreshed and published through workshops with representatives from Youth Conferences, youth centres and Youth Council members.	
			June – December 2017	• A video clip on e-safety awareness raising published on LBR 'YouTube'.	
5.2	Development of a "Support Guide" for young people to deal with sexual harassment in schools. The "Support Guide" will be produced by the Youth Council through research and consultation with other young people.	Head of Positive Activities, Children's Services, LBR	October 2017 - January 2018	Support Guide developed, published and widely circulated.	**Grade: White**
			January 2018	• Secondary schools fully endorse and promote the support guide.	
			March 2018	• Evidence of use of the Support Guide by young people.	
5.3	Inclusion of eSafety Training for professionals in the LSCB Training Programme 2017 – 2018.	Chair, LSCB Training Sub Group	Commissioning of course and publication of Training Programme by 01 04 17	• Commissioning of the training course. • 95% take up and attendance. • Publication of course materials on the LSCB website to support training transfer and cascade of learning.	**Grade: White**
5.4	Inclusion of peer-on-peer sexual harassment training in the LSCB Training Programme 2017 – 2018.	Chair, LSCB Training Sub Group	Commissioning of the training course and publication of Training Programme by 01 04 17	• Commissioning of the training course. • 95% take up and attendance. • Publication of course materials on the LSCB website to support training transfer and cascade of learning.	**Grade: White**
5.5	Awareness raising activities and provision of guidance and support to parents and carers on eSafety.	LSCB Business Manager	Safer Internet Day 06 02 18 CSE National Awareness Day 18 03 18 October 2017	• External campaign and activities for both national awareness raising days. • Evidence of reach exceeding that of the 2017 events by 10%. • Publication of additional guidance, support and signposting information for parents/carers on the LSCB website, inc. specific materials for primary aged children.	**Grade: White**

Action		Lead Officer	Timescale and milestones	How we will measure success and impact	RAG Rating/ Commentary
PRIORITY 6: Further develop and improve safeguarding arrangements for children and young people that go missing from home or care.					
6.1	Monitoring of the effectiveness of the multi-agency response to missing children.	Head of CPAT and EI&FSS, LBR	July 2017	• Publication of the revised LSCB Missing from Care or Home Policy.	**Grade: White**
			Annual Report on Missing from Home or Care to be presented to the Board in July 2017	• Evidence of effective use of intelligence gathered from return from missing interviews for both individual cases and identification and protection of other at risk young people. • Quarterly analysis report provided to LSCB on the Missing Children Panel (MCP) to support monitoring. • Analysis and comparison of data from 2016-17 and 2015-16 on missing included in the Annual Report. • Identification through Protocol reports of care homes, including foster placements, with high incidence of missing children and action taken to reduce frequency.	
			Delivery of the LAC Missing Project March 2018	• Reduction in the number of children going missing by 10% from previous year. • Reduction in the number of missing episodes by 10% from previous year. • Information sharing agreed in relation to sharing information on children and young people at risk of going missing with new placements.	
6.2	Provision of learning and development activities and resources on working with children and young people that go missing.	Chair, LSCB Training Sub Group	30 06 17	• Practice Lead for Missing Children to attend team meetings within the Children and Families Service.	**Grade: White**
			Commission-ing of workshops and publication of the Training Programme by 01 04 17	• Delivery of a series of three Workshops as part of the LSCB training Programme 2017 – 2018.	
			31 07 17	• Delivery of Workshop to Redbridge Foster Carers as part of Fostering Carers Training Programme 2017 – 2018.	
6.3	Re-establishment of the Missing Young People's Group as part of provision of support.	Head of CPAT and EIFSS, LBR	July 2017	• Development of a standard procedure for promoting the Group to children who have returned from missing episodes.	**Grade: White**

Action		Lead Officer	Timescale and milestones	How we will measure success and impact	RAG Rating/ Commentary
			March 2018	• Evaluation of feedback from young people on Group evidencing increased understanding and awareness of safeguarding issues related to missing.	
6.4	Establish a Social Media presence for Redbridge Missing children	Comms Manager LBR	October 2017	• Scope feasibility of setting up and managing social media facility for communicating with children and young people who go missing frequently to improve safeguarding.	**Grade: White**
			From May 2017	• Utilise existing LB Redbridge social media routes to share messages around staying safe.	

Action		Lead Officer	Timescale and milestones	How we will measure success and impact	RAG Rating/ Commentary
PRIORITY 7: Monitoring and ensuring the effectiveness of the arrangements for safeguarding children and young people in Redbridge in the new Metropolitan Police structure.					
7.1	Monitoring and evaluation of the impact of the new tri-borough Met Police arrangements in relation to safeguarding children.	Head of CP and Early Intervention Service, LBR	Paper to Board with initial evaluation – October 2017 and six month progress check in January 2018	• Effective establishment of the CAIT Referral Desk with no Negative impact on service delivery. • Continued high level of engagement of CAIT in CP Strategy Meetings. • Continued high level of attendance by CAIT at CP Conferences and Core Groups.	**Grade: White**
7.2	Effective engagement of the new Safeguarding division of the Met Police with the LSCB under the new tri-borough Borough Command Unit arrangements and in the context of the HMIC Inspection Report (November 2016).	DS, Safe-guard-ing, East Area BCU, Met Police	Ongoing	• Continued Co-Chairing by Met-Police of the MASE with Children's Social Care. • Regular attendance and participation of Met Police in the LSCB Executive and Board Meetings.	**Grade: White**
			30 04 17	• Agreement on implementation of the local operating model.	
			31 07 17	• Agreement on performance data to be available to the Board.	
			30 10 17	• Completion of new S11 Audit Self-Assessment to enable monitoring of the Safeguarding Command in the BCU arrangements.	**Grade: White**

Action		Lead Officer	Timescale and milestones	How we will measure success and impact	RAG Rating/ Commentary
PRIORITY 8: To further strengthen the LSCB's monitoring and oversight of practice.					
8.1	Deliver a multi -agency audit programme for 2017 – 2018, aligned to the Business Plan embedding the adopted audit methodology.	LSCB Quality Assurance Manager	Multi-Agency Audit Programme 2017 – 2018 agreed (minimum of six audits in line with the LSCB Business Plan) and published by 01 04 17 Completed by 31 03 18	• Audits make clear judgements on the quality of practice and areas for improvement. • Follow up demonstrates impact on outcomes for children and young people as a result of audit activity.	**Grade: White**
			Inclusion in LSCB Training Programme published by 01 04 17	• Inclusion of key learning from each audit through Learning from MA Audit Workshops and/or inclusion in other training courses commissioned as part of the LSCB Training Programme.	
8.2	Annual reporting from key statutory agencies on their single agency audit programme including key findings, learning and outcomes.	LSCB Business Manager	April 2017 – March 2018 on a rota basis.	• Published schedule in place for reports to come to LSCB Board meetings in 2017 – 2018 • Effective scrutiny leading to improvements in outcomes.	**Grade: White**
8.3	Monitoring of the S11 Audit Action Plans	LSCB QA Manager	July 2017 – March 2018	• Updated reports to be presented to LSCB Board as per S11 Programme.	**Grade: White**
8.4	Embedding of the LSCB Framework for Quality Assurance and Evaluation of safeguarding children training.	Chair – LSCB Training Sub Group	Report to Board in July 2017	• Evidence of the high quality provision of training. • Evidence of impact of training on improving outcomes for children families. • Development of the workforce in relation to skills and knowledge relating to safeguarding children and young people.	**Grade: White**
8.4	Review of LSCB Lay Members role, agreement and activities to ensure ongoing effectiveness.	LSCB Business Manager	Meeting with Lay Members by 01 06 17 Report back to LSCB Executive by 30 06 17	• Review of role and opportunities for increased engagement of Lay Members.	**Grade: White**
8.5	Development of the relationship and connectivity between the LSCB and the Safeguarding Adults Board (SAB).	Inde-pendent Chair	Workshop included in Training Programme published by 01 04 17	• Workshop on Joint Working Protocol – "See the adult, see the child". • Promotion of joint learning and development activities	**Grade: White**

Keeping Children & Young People Safe

Redbridge Local Safeguarding Children Board

CONTACT INFORMATION

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