Redbridge Local Safeguarding Children Board (LSCB)

ANNUAL REPORT

2017 – 2018

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Chair's Foreword

I am pleased to introduce the **Local Safeguarding Children Board's report for 2017/18**.

This is the fourth Annual Report for which I have been responsible since I began chairing the Board in August 2014. In introducing last year's report, I highlighted two issues in particular which I felt at that time had the potential to threaten the robustness of the safeguarding of children in Redbridge. One was the potential impact of the police restructuring into a single command covering Redbridge, Barking and Dagenham, and Havering. This was launched at the very end of 2016/17 with minimal consultation, or engagement, with the local authority children's services involved or with other partners. There were, and remained, a large number of unanswered questions about how it would or was supposed to work. The other issue of great concern was what the report described as the emerging crisis in mental health services for children and adolescents.

Both of these issues were standing items on Board agendas throughout 2017/18 for challenge and discussion. It is pleasing to be able to report the greater level of assurance and confidence that the Board now has in the delivery and future of these services, and this is described in more detail in Section 5 of this report. It is important to acknowledge however, as the report does, that both services continue to face major challenges, and impossible not to recognise the part that resourcing plays in this. The inadequacy of services for children and young people with mental health difficulties on a national scale is a frequently publicised and widely recognised issue. The implementation of bi-or tri-borough structures across the Metropolitan Police is part of the force's response to a 20% budget reduction since 2010. It is unlikely, in that context, that what has often been described as the 'gold standard' in joint working with the police, that Redbridge enjoyed under the borough-based command arrangements, can be fully regained. Nevertheless, I welcome the progress that has been made in stabilising the new arrangements, and very much appreciate the hard work and commitment on the part of both social care and police staff which has achieved that progress.

The body of the report contains substantial evidence that in the core areas of child protection work, performance remains overall good or excellent. One of the very positive aspects of the Redbridge culture, however, is that there is a determination to avoid complacency, and the multi-agency audit programme, described in Section 7 of this report, has focused attention on a range of areas where there is a need for improvement. In particular, all the audits undertaken identified a need for greater and more consistent professional curiosity - 'respectful uncertainty', the ability to explore and understand what is happening within a family rather than making assumptions or accepting things at face

value. There is an excellent Quick Learning Guide to Professional Curiosity on the LSCB website.

One of the challenges of safeguarding work is that it operates in a changing landscape. New issues emerge over time, demanding new and innovative responses. It became clearer during 2017/18, for example, that gang affiliation, the risks it poses to young people, the associated phenomenon of 'county lines' activity, and potential links with child sexual exploitation, are more significant issues in Redbridge than had previously been recognised. It is also increasingly recognised that these challenges demand new approaches to engaging with young people, and the planned developments of, for example, the Families Together Hub and the Families Intervention Team, briefly described in Section 5, demonstrate the kind of creative response that is needed. Falling numbers of children on child protection plans, and fewer children involved in care proceedings, may be early and encouraging signs of the potential impact.

In less than a year from the publication of this report, the LSCB as a statutory body will cease to exist. The onus now is on the newly defined statutory partners – the local authority, the police, and the Clinical Commissioning Group – to agree and publish new arrangements for working together to safeguard and promote the welfare of children in their area, and to identify and respond to their needs. Discussion of what these new arrangements should look like seems to be very slow in getting started in Redbridge. It is self-evident that one issue for discussion will be the extent to which a single set of arrangements might operate over Barking and Dagenham, Havering and Redbridge, given the footprint of a number of key partners. My personal view – and I stress that it is very much a personal view – is that it is essential, if the high standards of safeguarding activity and practice which Redbridge has achieved are to be sustained, that a central feature of the new arrangements should be a strong partnership body with a Redbridge-specific focus, able to provide the effective challenge and scrutiny across the local system that the LSCB delivers. Those issues to which I refer at the beginning of this foreword – the impact of police restructuring, and the deficits in child and adolescent mental health services – were issues specific to Redbridge. They did not, for a variety of reasons, impact in the same way on Barking and Dagenham or on Havering. I do not of course attribute the progress that has been made and described in this report in these areas to the LSCB: it is the hard work of managers and staff in those services that has delivered that progress. I am equally clear, however, that the continuing focus and scrutiny of the LSCB has made a significant contribution to supporting that progress. This would not have been achieved by any form of tri-borough 'Board'. Equally, though, I am clear that there is a real opportunity to streamline the infrastructure that supports the partnership at Board level – quality assurance, audit activity, training – across a wider footprint. The biggest gain from any changes will be if they succeed in making a reality of the principle which underpins the new legislative framework – that the three partners have a shared and equal responsibility for working together to protect children. Nationally, there must be a move away from seeing safeguarding as primarily the local authority's business, with supporting roles for other partners.

I would like to express my and I am sure the LSCB's appreciation to the LSCB Team – Lesley Perry, Andrea Barrell, Amanda Jones, and Andrew Reed – without whose commitment, enthusiasm, and creativity none of the Board's work recorded in this report would have been possible.

Finally, I want to highlight one of the most significant achievements of the year: the transformation in eighteen months of Brookside, an inpatient psychiatric unit for adolescents on the Goodmayes Hospital site, from an 'inadequate' to an 'outstanding' service. As we say in the body of the report, this is a remarkable achievement by NELFT and all the managers, clinicians, staff and others involved, and I am really pleased to be able to end this introduction to the LSCB Annual Report for 2017/18 on a note of well-deserved congratulation to everybody who contributed to it.

John Goldup

Independent Chair

Redbridge Local Safeguarding Children Board

1. Redbridge Local Safeguarding Children Board (LSCB): its purpose and future arrangements for multi-agency working to safeguard children

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. The Act requires every local authority in England 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.

Regulations and statutory guidance further expand on the role and responsibilities of LSCBs. In particular, an LSCB should:

- 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
- monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

Every LSCB is required to publish an Annual Report. The purpose of the Annual Report, as set out in statutory guidance, is to *"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 Children and Social Work Act 2017

The Children and Social Work Act 2017 received Royal Assent on 27 April 2017. It abolishes the requirement for Local Safeguarding Children Boards. In its place, it requires the 'safeguarding partners' for each area – the local authority, the Clinical Commissioning Group (CCG), and the police – to agree and publish arrangements for working together to safeguard and promote the welfare of children in their area, and to identify and respond to their needs. The arrangements should include other 'relevant agencies that [the safeguarding partners] consider appropriate'.

The Act also provides that two or more local authorities may combine in a single set of arrangements, and that the arrangements must include provision for scrutiny by an independent person of their effectiveness.

This new statutory framework for multi-agency work to safeguard children is much less prescriptive than that which is in place currently. Further statutory guidance was published in July 2018 – Working Together to Safeguard Children 2018, accompanied by Transitional Guidance. The safeguarding partners must publish the agreed arrangements by 29 June 2019 at the latest, and implement them at the latest by 29 September 2019. On implementation, the Local Safeguarding Children Board will cease to exist in its current statutory form. It is open to the safeguarding partners to agree a place for a similar multi-agency body, with similar functions, in the new arrangements, should they so choose, but there is no continuing statutory requirement for such a body. If a Serious Case Review is in progress at the point of implementation, the LSCB may continue to have an existence solely for the purpose of completing and publishing that review. This 'grace period' will run at the latest to 29 September 2020. However, until the new arrangements are implemented, LSCBs must continue to fulfil their current statutory responsibilities.

The Act also creates a new framework for what are currently 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 published local arrangements will specify how local reviews will be carried out.

Finally, the Act replaces the current requirement for Child Death Overview Panels (CDOPs) in each area with a 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.

Agreement has been reached that the new Child Death Review arrangements should operate across the three boroughs of Barking and Dagenham, Havering and Redbridge. However, at the time of writing, there has been little substantive discussion as yet about the form the new multi-agency safeguarding arrangements will take. 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. 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 currently provided by the Redbridge LSCB, both independently validated by Ofsted, are not compromised.

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

Membership: who are we?

The Children Act 2004 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. From 2009 to 2013 he was National Director of Social Care in Ofsted, and from 2012 Deputy Chief Inspector. In June 2017 he became Independent Chair of the Redbridge Safeguarding Adults Board.

LSCB Membership (as at March 2018)
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, Director of Public Health (Interim) (Vice Chair)
Jackie Odunoye, Operational Director, Housing Services
Health Representatives
Bob Edwards, NELFT Integrated Care Director for Redbridge **NELFT**
Graeme Gail-McAndrew, Named Nurse Safeguarding Children **NELFT**
Jacqui Himbury, Nurse Director **Redbridge CCG**
Caroline Alexander, Chief Nurse **Bart's Health NHS Trust**
June Freed, 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)**
Stephanie Sollosi **Nurse Consultant Safeguarding Children Primary Care, Redbridge CCG**
Police
DS John Ross, Safeguarding **East Area Basic Command Unit (BCU), MPS**
Probation Representatives
Andrew Blight, Assistant Chief Officer **National Probation Service - London**
Lucy Satchell-Day, Area Manager (NE London) **London Community Rehabilitation Company (CRC)**
CAFCASS
Alice Smith, Service Manager **CAFCASS**
Schools Representatives
Aaron Balfourth, Safeguarding Lead **New City College (Redbridge Campus)**
Victoria Ballantyne, Deputy Head Teacher **Barley Lane Primary School**
Merherun Hamid, Head Teacher **Apex Primary School**
James Brownlie, Head Teacher **Little Heath School**
Rebecca Drysdale, Head Teacher **Ilford County High School**
Carley Smith, Associate Head **Oakdale Junior School**
Susan Johnson, Head Teacher **SS Peter and Paul's Primary School**
Terese Wilmott, Head Teacher **Beal Academy Trust**
Voluntary Sector Representatives
I'sha Hussain, Service Manager **Refuge**
Becky Fedia, 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
Rabiya Rehman
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. Despite extensive efforts, it has not proved possible to recruit to this role since the retirement of the previous incumbent in January 2015. However, the CCG made a successful appointment of a Nurse Consultant to link between the Board and primary health care services in January 2018.

During the year, the Board said farewell and thank you to a long standing Lay Member, Hilary Kundu, on her retirement from the role. Rabiya Rehman joined the Board as our third Lay Member.

A number of organisations with a London-wide or sub-regional brief have found it increasingly difficult to attend individual borough Boards on a regular basis. As reported in previous Annual Reports, NHS England has not attended the Redbridge Board for several years, although contact is maintained both by the LSCB Chair and the Business Manager through London Chairs and Business Manager meetings. Neither the National Probation Service - London nor the Community Rehabilitation Company (CRC) were able to attend any Board meetings in 2017/18. The Chair has agreed with the CRC that an expectation of regular attendance is unrealistic, but CRC have committed to an annual report to the Board from 2018/19 onwards. Cafcass were able to maintain the same level of engagement as in 2016/17, attending two out of four meetings during the year. However, generally the level of engagement and participation in the Board's work by partner agencies in 2017/18 has continued to be very high, with excellent attendance at all Board meetings.

Structure

The full **Board** meets four times a year. In 2017 – 2018, 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 experiencing or are 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.

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 five times during the year under review.

The **Child Death Overview Panel (CDOP)** continued to be chaired in 2017/18 by Gladys Xavier, Director of Public Health (Interim) and Vice Chair of the LSCB. In accordance with regulations and statutory guidance, 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 there were any 'modifiable factors' involved in the death, and makes recommendations to the LSCB or other relevant bodies so that action can be taken to prevent future such deaths where possible. Factors may be judged modifiable if actions (at a national or local level) could be taken to reduce the risk of future child deaths. The Panel has a particular responsibility for ensuring a rapid response to any unexpected death of a child. There were a number of personnel changes and other disruptions in 2017/18 to the work of the Panel, and a number of scheduled meetings were cancelled. However, the Panel met on six scheduled occasions during the year, and in addition held six Rapid Response meetings. The most recent CDOP Annual Report received by the Board, due to delays in validating more recent data, was for the year 2016-17. Out of 38 child deaths reviewed in that year, 7 were judged to have modifiable factors, primarily relating to parental consanguinity. However, 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 agreement already referred to in this report, that in future a single child death review process should operate

across the three boroughs of Barking and Dagenham, Havering and Redbridge, will produce more meaningful data across a larger population.

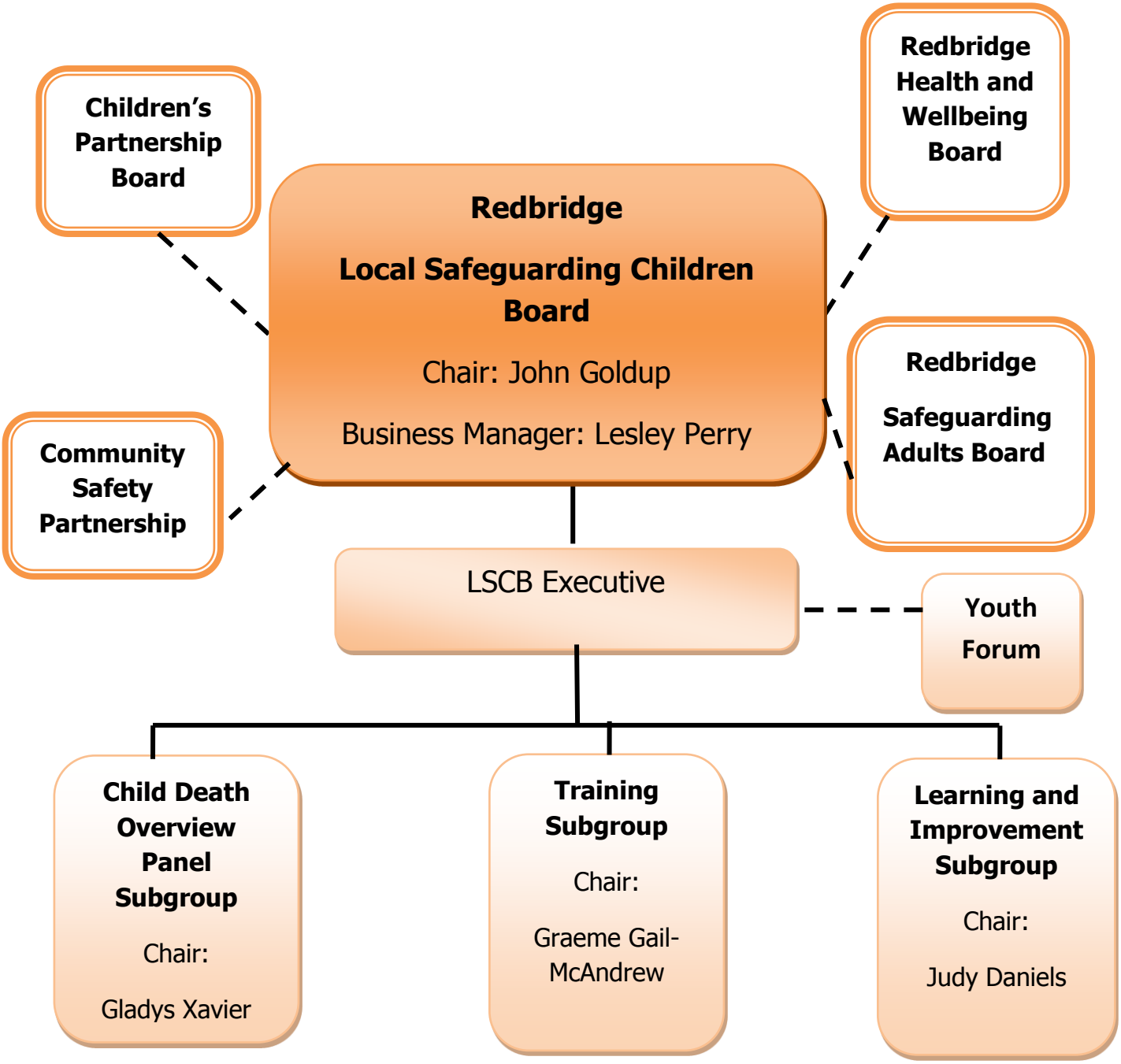
The **LSCB Youth Forum** is a group of young people, supported by the LB Redbridge Positive Activities (Youth) Service, who work to raise awareness of safeguarding issues among young people in the Borough and to make sure that young people's voices are heard and acted upon by the LSCB.

The **Training Subgroup** was chaired in 2017 – 2018 initially by Kate Byrne, Named Nurse Safeguarding Children, NELFT and then by her successor, Graeme Gail-McAndrew. 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** continued to be chaired in 2017 – 2018 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, reporting on both strengths and areas for improvement in front line multi-agency practice, and for identifying and disseminating the lessons to be learned. The findings of and learning from the multi-agency audit programme are discussed later in this report. The Group met five times during the year. Under the auspices of the Sub Group, the LSCB developed and published a number of different learning materials during the year, including the LSCB Quick Learning Guide to Neglect and LSCB Quick Learning Guide to Professional Curiosity .

A **Serious Case Review Panel** is established when required to oversee the completion and publication of an independent review of a case which the Chair has determined meets the statutory criteria for an SCR – that either a child has died, or a child has been seriously harmed and there is cause for concern about the way agencies have worked together to safeguard the child, and in either case abuse or neglect is known or suspected. An SCR Panel to review a case meeting these criteria was convened in March 2018. The SCR is expected to be completed during 2018/19.

LSCB STRUCTURE CHART (as at March 2018)



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 2017 -18, and the expenditure incurred.

Income		Expenditure	
Balance brought forward	0	Office Expenses	1437
CDOP Grant	54,000	Publicity & Communications	295
Training attendance fees	9340	LSCB Training Programme	13523
Training non-attendance fees	2140	LSCB Independent Chair	28175
LB Redbridge *(comprising of contributions from Children's Services, Adult Services, Public Health & Housing)*	66,680	LSCB Business Manager *(pro-rata with 30% re-charged to Redbridge SAB from June 2017)*	57058
LB Redbridge, Corporate funding	50000	LSCB Quality Assurance Manager	65083
Metropolitan Police	5000	LSCB Training Manager *(Part Time)*	32351
National Probation Service (NPS)	1100	LSCB Senior Admin Officer	32815
London Community Rehabilitation Company (CRC)	1000	LSCB Apprentice	10462
Cafcass	550		
Redbridge Clinical Commissioning Group (CCG)	35000		
Barking, Havering & Redbridge University Hospitals NHS Trust (BHRUT)	3231		
Bart's Health NHS Trust	5000		
NELFT	3230		
London Fire Brigade (LFB)	500		
Total Income	**236771**	**Total Expenditure**	**241199**

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

There was an overspend in 2017/18 of around £4,500 which was met by the Local Authority. 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 have continued to pursue this actively with the Metropolitan Police Service and MOPAC and it will be a critical issue to resolve in agreeing the new multi-agency safeguarding arrangements under the Children and Social Work Act 2017, in which the police are one of only three statutory safeguarding partners and in relation to which the statutory guidance sets an expectation that the funding of the arrangements will be 'equitable and proportionate…..and sufficient to cover all elements of the arrangements, including the cost of local child safeguarding practice reviews'.

The LSCB Team

As of 31 March 2018, 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

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 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

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 2017 the Board agreed the following priorities for the Business Plan:

- 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 the quality and impact of the Independent Reviewing Officer / Child Protection Chair role, particularly with reference 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.

Progress against the Business Plan was reviewed at every Board meeting in 2017/18, with slippages identified and corrective actions agreed. At the final review in April 2018, of the 40 discrete actions in the Plan, 28 were assessed as 'Green' - fully completed; 9 as 'Amber' – generally meaning that progress has been made, but the action has not been fully delivered or completion has slipped into 2018/19; and 3 as 'Red' – not completed.

The actions which were graded 'Red' were:

- Work with Youth Council to 1) Deliver e-safety campaign targeted at secondary school pupils; and 2) Develop Support Guide for young people on sexual harassment

  A considerable amount of work took place but it was not possible to complete the planned video work or finalise design of the Support Guide by the end of the year. Resources are being sought to complete in 2018/19.

  Both these outstanding actions have been taken forward into the 2018/19 Business Plan.

- Establish social media communication channels for children who go missing.

A number of channels were explored but not taken forward because they were either assessed as unsuitable or could not be managed out of hours.

The Board agreed in April 2018 the following priorities for 2018/19:

- Improve services for young people experiencing mental ill-health.
- Strengthen the protection and support of children and young people exposed to any form of exploitation or at risk of going missing.
- Raise awareness of and develop services' response to peer on peer abuse, harmful sexual behaviours and violence.
- Develop engagement with children, young people and families to raise awareness of and inform development of safeguarding.
- Develop new multi-agency safeguarding arrangements and Child Death Review process as required by Children and Social Work Act 2017.
- Strengthen the protection and support of children and young people exposed to dangerous cultural practices

The full Business Plan 2018/19 is available on the LSCB website.

3. Safeguarding in Redbridge: need, risk and demand

The last two Annual Reports have reported a clear year on year trend: a continuing fall in the number of referrals received by children's social care, but a steady increase in the volume of 'high level intervention activity' (the number of Section 47 inquiries, children subject to child protection plans, and care proceedings). However, across all these areas of activity, the picture for 2017/18 is different. The number of referrals and the number of Section 47 inquiries completed stabilised; there were fewer children subject to child protection plans at the end of the year than there were at the beginning; and the number of children who were the subject of applications in care proceedings brought by the local authority fell slightly. At the same time, the number of early help assessments completed using the Common Assessment Framework CAF) increased, from 789 in 2016/17 to 867 in 2017/18, although this was still fewer than the 1211 CAF assessments completed in 2015/16.

Referrals to Children's Social Care							
2010/ 11	**2011/ 12**	**2012/ 13**	**2013/ 14**	**2014/ 15**	**2015/ 16**	**2016/ 17**	**2017/ 18**
4019	3691	3648	4718	5175	5086	4125	4161

'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.

Section 47 inquiries completed				
2013/ 14	**2014/ 15**	**2015/ 16**	**2016/ 17**	**2017/ 18**
482	676	1038	1173	1175

Historically, as the table shows, Redbridge had a very low rate of S47 inquiries, which gave rise to some concern that the bar for 'reasonable suspicion' might be being set too high. The rate of S47 inquiries relative to population, at 155.2 per 10,000 children, is now very similar to the rate for England as a whole (157.4 per 10,000 in 2016/17), although below that for statistical neighbour authorities (177.9 per 10,000).

On 31 March 2018, 298 children in Redbridge were subject to a child protection plan, compared to 380 a year earlier. The rate of children on plans per 10,000 children is similar to, but slightly below, that for England as a whole and for statistical neighbours (2016/17 data).

Children subject to child protection plans				
2013/ 14	**2014/ 15**	**2015/ 16**	**2016/ 17**	**2017/ 18**
188	268	349	380	298

However, although the number of children subject to a child protection plan at the end of the year fell significantly in 2017/18, the number of new plans made during the course of the year continued to increase as it has each year since at least 2010.

Number of children becoming subject to a child protection plan during the year							
2010/11	2011/ 12	2012/ 13	2013/ 14	2014/ 15	2015/ 16	2016/ 17	2017/18
184	189	153	228	309	409	459	477

With fewer children on a plan at the end of the year, but more new plans made during the year, this suggests that the average duration of plans is becoming shorter. This may indicate a sharper focus on ensuring that intervention is targeted and that children and families do not remain subject to a high degree of state oversight and intervention for longer than is necessary. However it is important also to bear in mind concerns that have been raised in previous years, as a result of audit activity, that children placed on child protection plans as a result of neglect may be 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.

There was little change in the percentage of child protection plans made under different categories of risk. 61% of plans were made under the category of emotional abuse, and 34% under neglect. Physical abuse accounted for 3% of the plans made, and sexual abuse for just over 1%. Nationally, in 2016/17, 48% of plans were made on the grounds of neglect, and 34% on the grounds of emotional abuse.

Nationally, for the first time for several years, the number of care proceeding applications fell in 2017/18, by 2.7%. Data for Redbridge reflects the national trend. The number of applications fell from 71 to 66 in the year, and the number of individual children involved fell from 126 to 114.

Care proceedings applications			
2014/ 15	**2015/ 16**	**2016/ 17**	**2017/ 18**
23	40	71	66

Number of children involved			
2014/ 15	**2015/ 16**	**2016/ 17**	**2017/ 18**
30	63	126	114

The number of children looked after has fallen slightly, from 231 to 229. At 30.7 per 10,000 children, this is a much lower rate than shown in the latest available (2016/17) data for statistical neighbours (46.2 per 10,000) or England as a whole (62 per 10,000).

While no firm conclusions can be drawn from a single year's figures, the picture is consistent across the data sets. The data may indicate that demand, which has grown, apparently inexorably, over several years, has now begun to stabilise. However, it must be emphasised that even if this is so, it has stabilised at a high level. The number of S47 inquiries has increased by 144% since 2013/14, and the number of children subject to child protection plans by 53%. Care proceedings have almost tripled, and the number of children involved almost quadrupled, since 2014/15. As one measure of the complexity of demand, the average social worker caseload increased in 2017/18 to 17 cases from 14.3 at the end of 2016/17.

The ethnic background of children subject to a child protection plan on 31 March 2018, 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.

Ethnicity	**As a % of children subject to a CP Plan 2017/18**	**As a % of children subject to a CP Plan 2016/17**	**As a % of children subject to a CP Plan 2015/16**	**As a % of the 0-17 population in Redbridge (GLA projection 2017)**
White	20%	25%	26%	22%
Mixed	23%	10%	21%	10%
Asian or Asian British	40%	49%	35%	55%
Black or Black British	13%	14%	15%	10%
Other ethnic groups	3%	1%	1%	3%
Unknown (unborn)	1%	1%	1%	0%

The rise in the number of older young people made subject to plans, which has been commented on in the last two Annual Reports, has continued. 32 young people aged 16+ were made subject to child protection plans in 2017/18, compared to 25 in 2016/17 and

15 in 2015/16. This may reflect an increased awareness of the risks to young people arising from gang affiliations and 'county lines' drug trafficking. It should also be noted that a third of these plans were made in relation to concerns about domestic violence incidents within the home.

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 2017/18	Redbridge 2016/17	Redbridge 2015/16	National 2016/17*	Statistical Neighbours 2016/17*
% of repeat referrals within 12 months	15.3%	17.9%	19.5%	21.9%	19.2%
% of assessments completed within 45 days	91%	93.5%	95.3%	82.9%	84.8%
% of initial child protection case conferences held within 15 days of strategy meeting	89.2%	86.0%	91.4%	77.2%	75.8%
% of child protection plans reviewed within required timescales	99%	96.3%	99.6%	92.2%	86.6%
% of children becoming subject to a second or subsequent child protection plan	7.4%	4.1%	14.7%	14.8%	17.3%
% of children whose plan ended during the year who had been on a plan for two years or more	3.4%	1.7%	1.5%	2.1%	2.2%

*Data for 2017/18 will not be available until November 2018.

A number of points emerge from analysis of this data.

- The percentage of repeat referrals to children's social care has continued to fall. This is positive, as 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.
- On the key indicators relating to timeliness (assessments completed within 45 days, case conferences when required taking place within 15 days of the initial strategy meeting, and timely review of child protection plans), children's social care in Redbridge continues to perform well above the level of comparator authorities.
- The numbers of children becoming subject to repeat child protection plans has increased slightly. This indicator is subject to fluctuation as one or two large family groups in the cohort in a given year will significantly affect reported performance. However, it may also be another reminder that while there is a positive drive

towards not maintaining child protection plans for any longer than is necessary, it is equally important that plans are not ended prematurely.

- Of those plans which were ended during the year, noticeably more than in previous years, or in comparator authorities, had been in place for two years or more. Again the data is subject to fluctuation due to the make-up of the cohort. Reported performance may though indicate again a sharpening focus on the effective review of plans and on ensuring that they do not last any longer than necessary.

Inspection evidence

The Annual Report for 2016/17 reported a range of inspection evidence that had been published during that year. The Ofsted inspection of the Council's children's social care services, published in November 2016, was positive, rating the overall service as good in nearly all areas, with room for improvement in services and outcomes for care leavers. However, the assessment of child protection work in the Metropolitan Police, published in November 2016 by HMIC (now HMICFRS – HM Inspectorate of Constabulary, Fire and Rescue Services) was extremely critical, as was the HMI Probation report on Community Rehabilitation Services in eight North London boroughs including Redbridge, also published in December 2016, and to a lesser extent the HMIP assessment of National Probation Services in the same area.

There was no further social care inspection activity in Redbridge by Ofsted in 2017/18. However, follow up inspection reports were published during the year on the work of the London Community Rehabilitation Company and the work in London of the National Probation Service, and on child protection in the Metropolitan Police.

Quality and impact inspection: the effectiveness of probation work by the London Community Rehabilitation Company – HMIP March 2018

The 2016 inspection was of work in eight London boroughs including Redbridge. This inspection however covered the whole of London. It found that in most aspects of its work the CRC "does now have the basics in place" and that, while overall still unsatisfactory, "the quality of work is improving from a very low base, and is still improving." However, in relation to child protection, the inspection reported:

> "The operating model allows Probation Service Officers to hold medium-risk cases featuring potential child safeguarding concerns. Many PSOs have had insufficient training to manage these cases."

Inspectors also reported that there were 'significant gaps' in information sharing in relation to child protection, and commented that:

> "The CRC's engagement at the multi-agency level on safeguarding children is under-developed and does not adequately support effective practice.'

As part of their ongoing work in response to inspectors' findings, the CRC have committed to an annual report to the Redbridge Board from 2018/19 onwards.

Quality and impact inspection: the effectiveness of probation work by the National Probation Service in London – HMIP January 2018

This was also a pan-London inspection. It found an improved service from 2016, particularly in the area of public protection.

> "Overall, the quality of NPS public protection work was good. Assessments focused on the right issues and informed good planning. Risk of serious harm had been assessed correctly in most cases."

However:

> "Timely information on child and adult safeguarding was often not available, and some staff lacked relevant training…we remain concerned about the quality of work to assess risks to children and vulnerable adults."

HMICFRS inspection of child protection work in the Metropolitan Police Service

Following the extremely critical report published in November 2016, HMICFRS published four quarterly assessments of progress in 2017/18. The last of these was published in February 2018. Inspectors described their overall findings as 'disappointing'. Despite significant changes in structure, strategic leadership and training, there had been little improvement in practice on the ground or in outcomes for children. In 89% of the 214 child protection cases reviews by inspectors during the quarterly assessments of progress, police practice was found to be either in need of improvement or inadequate.

It is not possible to draw specific conclusions about local performance from these quarterly assessments, or either of the two HMIP reports discussed. It might be noted that the view of HMICFRS inspectors is that the Basic Command Unit (BCU) police structures implemented in Barking and Dagenham, Havering and Redbridge at the end of March 2017 demonstrate 'a recognition and firm commitment by the force to provide a more co-ordinated approach to child protection and wider safeguarding [although] at this stage it is too early to assess their effectiveness and potential to improve outcomes." The MPS did undertake audits of 18 child protection cases across the East BCU area in January 2018. Practice was assessed as good in three cases, as requiring improvement in ten, and as inadequate in five. Supervision was assessed as below the standard expected or inadequate in 9 of the 18 cases. The category of case in which performance was poorest was the response to missing young people, where practice was judged to be inadequate in both cases reviewed and supervision inadequate in one and below the expected standard in the other.

The LSCB supported improvement activity throughout 2017/18 in the Metropolitan Police, not just locally but on a force-wide basis. The LSCB Business Manager represents London Business Managers on the MPS Audit Scrutiny Panel which meets bi-monthly, reviewing cases on a themed basis. The LSCB Chair represented London Chairs on a multi-agency advisory panel, reviewing and challenging progress against the force's improvement and action plan, and chaired the panel for much of 2017/18. He also met with the Deputy

Mayor of London, responsible for policing, to discuss the roll out of the BCU model across London and the lessons to be learned from the East Area 'pathfinder'.

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

An inspection took place in January 2018. The overall assessment of the Trust, which is that it requires improvement in order to be good, did not change from the last inspection in 2016. Prior to that, the Trust had been judged to be inadequate. As in previous inspections, inspectors commented that both children's and adults' safeguarding were well managed, with staff having a good understanding of roles, responsibilities and referral pathways. The Trust made substantial investment in additional safeguarding posts both for children and for adults in 2017/18. These included, in addition to adult-related posts, a Safeguarding Advisor, Harmful Practices; two Safeguarding Advisors in the Emergency Department; and a Safeguarding Children Advisor for Learning Disability and Autism.

The Trust commissioned an independent external review of its safeguarding function which took place in May 2017, with a report published in June. While it made sixteen recommendations for improvement, primarily relating to strategy development and alignment, supervision, and training, it concluded overall that the Trust had demonstrated a clear commitment to encourage, embed and maintain the best safeguarding practices for the local population and had made significant progress, with equally significant investment, in recent years. A combined Children and Adults Safeguarding Strategy 2018-20, including an easy read version, was published in September 2017.

Care Quality Commission inspection of Whipps Cross Hospital (Bart's Health)

An unannounced focused inspection took place in May 2017. The hospital, which had been judged to be inadequate in both 2015 and 2016, received an updated rating as 'requires improvement'. The 2017 inspection did not cover any services specifically for children or maternity services. However, it should be remembered that these services were judged to be good in the 2016 inspection, even though the overall judgement on the hospital at that time was that services were inadequate. That inspection reported that 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)

The Trust had been judged to require improvement in 2016. Following further inspection in November 2017, NELFT is now judged to be good. Of particular relevance to the LSCB was inspectors' finding that "robust safeguarding procedures were in place across all core services and staff understood their safeguarding responsibilities".

Previous Annual Reports have referred to the significant concerns that the LSCB had over some time about a number of safeguarding issues at Brookside, an inpatient psychiatric unit for adolescents run by NELFT on the Goodmayes Hospital site in Redbridge, and the action it took. 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. At this inspection, the service had improved sufficiently to lead to a judgement of 'good'. It is a remarkable achievement that, following further inspection in November 2017, the service is now judged by CQC to be outstanding. Young people and their families who spoke to inspectors were hugely positive about the care, treatment and support on offer – words like 'amazing' 'excellent', and 'supportive' featured heavily in their testimonies. The LSCB congratulates all the managers, clinicians, staff and others involved for this extraordinary transformation in a very challenging service – from inadequate to outstanding in eighteen months.

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.

The LSCB Annual Report for 2016/17 identified two major concerns about the robustness of safeguarding activity in Redbridge. One was the potential impact of the police restructuring into a new tri-borough Basic Command Unit (BCU), which was implemented at the end of March 2017 with minimal consultation or engagement with the local authority children's services involved or with other partners. The other was what the Report described as the emerging crisis in mental health services for children and adolescents. The Chair's Foreword to the 2016/17 Annual Report was clear:

> "If young people in Redbridge are to be adequately safeguarded, we have to see dramatic and rapid improvement in a system that promotes resilience in all young people and provide appropriately intensive and timely help for those young people in most need."

Both of these issues were standing items on Board agendas throughout 2017/18 for challenge and discussion. Although significant – and possibly, given the continuing massive financial pressures on all public services, intractable – challenges remain, it is pleasing to be able to report positive developments in both areas of concern.

The impact of police restructuring on safeguarding of children and young people

The first few months of 2017/18 were a period of considerable churn in the BCU, with frequent changes of personnel and little continuity or consistency of engagement by the police in a range of partnership activity. However, there was greater stability in the second half of the year. From May 2018, regular meetings were instituted, led by the Council's Director of People, between senior staff in children's social care, the BCU, and the LSCB Chair. These have been helpful both in terms of developing relationships and progressing the resolution of a number of operational issues.

The Board received an update report in January 2018 on the impact of police restructuring on multi-agency safeguarding work. The CAIT (Child Abuse Investigation Team) Referrals Desk had been relocated into the Multi-Agency Safeguarding Hub (MASH), where all child protection referrals are received and screened on a multi-agency basis, and working relationships were described as excellent. However, there continued to be major difficulties in securing police engagement when joint child protection enquiry visits were agreed to be required; and significant problems in communication beyond the CAIT with other police teams such as the Community Safety Unit (CSU) dealing with domestic violence, the CSE Team and the Missing Persons Team. On many occasions telephones simply went unanswered. There were also lengthy delays in securing police involvement in strategy meetings from these non-CAIT teams, delaying planning of effective investigations without which children may be in situations of unassessed risk. The Board

welcomed the progress made in embedding effective working relationships at the front line, but remained concerned about the continuing gaps in the system.

By the end of the year further improvements had taken place. The joint working arrangements between social care and the CAIT, and the police contribution to those arrangements, continued to be excellent and effective. Joint working on domestic violence issues was greatly enhanced by the introduction of an officer from the CSU into the MASH. The timeliness and quality of the police response to requests for strategy meetings had improved, although greater consistency was still required.

The Board agreed in April 2018 that, while challenges remained and ongoing scrutiny and joint work to resolve issues would be essential, this could now be regarded as 'business as usual'. It must be recognised that, whatever other ambitions for improvement might be, the implementation of the BCU model across London has in part been driven by the need to adapt to the significant cuts in resources that the Metropolitan Police Service has experienced since 2010 - 20% of its annual budget, a third of support staff, and 10% of police officers[1]. Sadly, in this context, it is unlikely that the police contribution to effective safeguarding can return to the 'gold standard' level that Ofsted commented on in its 2016 inspection of children's services in Redbridge.

Services for children and young people with mental health needs

At the request of the CCG, NELFT undertook a Fundamental Service Review of Child and Adolescent Mental Health Services (CAMHS) to seek to identify the gap between the resources available and those required both to deliver the agreed model for service transformation and to achieve national targets for the percentage of young people in the population estimated to experience mental health difficulties who are reached by CAMHS services. The review was completed in July 2017. It concluded that the service in Redbridge was underfunded by £1.1m a year. NELFT wrote to the LSCB Chair in September 2017 to highlight their concerns about the 'perilous position' of the service, the restrictions in service they had had to impose, and the 'fears for the safety of young people in mental health crisis within Redbridge that the service deficit creates'. Following presentation of the LSCB Annual Report for 2016/17 at the Health and Wellbeing Board in November 2017, the Chair of that Board wrote to the CCG to express members' 'significant concerns' about the position, and seeking assurance that "the current and stark gaps in the service are addressed as a matter of urgency".

The LSCB was pleased to receive a report in January 2018 which confirmed that the CCG had agreed to increase funding for CAMHS in Redbridge by £700k.; that NELFT were in the process of recruiting to the additional posts required; and that restrictions on referrals had been lifted. NELFT assured the Board that all referrals received during the period of restriction had been thoroughly risk assessed to ensure that a safe service was provided. The Board also learned that in January 2018 the CAMHS service (which has now been renamed the Emotional Wellbeing and Mental Health Service - EWMHS) had been relocated from the poor premises it had occupied for many years to the Grove in Chadwell

[1] Financial Times, 16th June 2018

Heath. The service is now co-located with the Child Development Centre. The intention is that this will enable the physical and mental health needs of children and young people to be treated more holistically on one site, although there is some concern that a single referral form may be difficult to negotiate for non-health professionals who are keen to refer young people for whom they have mental health concerns but are puzzled by questions about a range of very detailed medical issues – continence, spinal abnormalities, and much else besides.

A key element of the Transformation Model which was agreed in December 2017 is the concept of the Wellbeing Hub – a single point of access to all services and resources to address mental ill health among children and young people, including signposting to a range of preventive services. The Hub was originally due to be established in April 2017. It was not in place by the end of 2017/18, but preparations were well advanced and it was due to be launched in June 2018.

Another key element of the model is an emphasis on equipping all professionals working with children and young people, particularly schools, to promote resilience in young people and to respond effectively to early signs of mental ill health. The Board was made aware on a number of occasions during 2017/18 of some considerable confusion about the training planned for this, who was responsible for it, and how it was being co-ordinated. This was a source of great frustration for schools but the board has been assured that these issues are now resolved.

In terms of the service available and delivered on the ground, 2017/18 was another very difficult year for children's mental health services. For much of the year access to the service was significantly restricted, as it had been since mid- 2016. For those young people whose referral was accepted there was an increase in the average waiting time for treatment from 8.6 weeks in 2016/17 to 9.7 weeks in 2017/18 (it was 6.5 weeks in 2015/16). However, the increase in funding, the recruitment of additional staff, the improvement in facilities, and the imminent launch of the Wellbeing Hub by the end of the year, gave some confidence that the prospects of improvement are real. It will remain a priority for the LSCB in 2018/19 to monitor, challenge, and support this improvement.

In addition to these two high priority areas of concern, the LSCB focused on a number of other themes and challenges in 2017/18.

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.

Early help can be provided by the Early Intervention and Family Support Service (EIFSS), which sits within the Council. 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'. According to the data submitted to the LSCB, there was a shift in the volume of early help activity in 2017/18. The number of referrals to EIFSS fell from 4787 to 4491 (6%); but the number of completed CAFs increased by 10%, from 789 to 867. There was a slight reduction in the number of parenting courses run by the EIFSS, from 25 courses involving 455 parents in 2016/17 to 23 courses with 355 participants in 2017/18.

During 2017/18, work was done on reconfiguration of early help services, to expand and co-ordinate a wider menu of services available to families experiencing difficulties. This will create a 'Families Together Hub' offering family support, parenting work, and links with employment and other community services; and a Family Intervention Team, focusing on families with children on the edge of care. It will include a range of commissioned services from voluntary sector organisations working with drug misuse, gang affiliated young people, child sexual exploitation, and harmful sexual behaviour, as well as directly provided youth and social care services. The new and reconfigured services will be launched early in 2018/19.

Child Sexual Exploitation (CSE)

Improving the protection and support of children who are sexually exploited, and strengthening our work in identifying, disrupting and prosecuting child sexual exploitation, have continued to be priorities for the LSCB throughout 2018/19. The Board receives a comprehensive annual report on the identification, management and disruption of CSE in the Borough.

The publication of a revised edition of the London CSE Operating Protocol in June 2017 required the partnership to review its multi-agency arrangements for the management of CSE, to develop a more strategic and evidence based response to the issue through a reshaped MASE (Multi Agency Sexual Exploitation) Panel. This was successfully achieved with the new MASE arrangements launched in January 2018, and those arrangements have bedded in well. However, one aspect of this is that, from the final quarter of the year, a wider range of data has been collected on a wider range of cases. This means that it is not possible to generate comparable data for the whole year, or data that can be meaningfully compared with previous years. However, some key points can be made:

- The number of contacts received by social care raising concerns about sexual exploitation for young people aged between 10 and 18 has remained constant – 127 in 2017/18 compared to 128 in 2016/17. However, data is now also collated on contacts with a CSE concern relating to children under 10. There were 20 such contacts in 2017/18.

- 80% of the contacts concerning young people aged between 10 and 18 were for girls. However, for younger children, there were slightly more for boys than for girls.
- 37% of contacts were for white children ('White British' or 'other white background'). 33% were for children from different Asian backgrounds, the biggest group of whom of whom were recorded as 'other Asian background', with smaller numbers recorded as being of Pakistani, Indian, or Bangladeshi heritage
- The majority of referrals came from the police (42%) or from schools, colleges, and early years provision (33%)
- 39% of contacts received were referred for social work assessment
- During 2017/18 78 cases of potential child sexual exploitation were referred to the police CSE team. 57% of the victims were aged 14 or 15 years.

In January 2018 a CSE 'workspace' within the Children's Social Care Integrated Children's System (Protocol) was launched, enhancing recording and reporting capabilities. This, combined with improved data gathering through the refocused MASE Panel which collates data from all strategy meetings about young people for whom there is concern about potential exploitation in relation to the victim(s), the offender(s), location, and emerging themes, has begun to deliver a significantly deeper understanding of the nature of child sexual exploitation within Redbridge. More detailed information about where exploitation is believed to be taking place has led both to a number of police operations and to the development of multiagency action plans to tackle the issue in specific contexts. The range of services available to support young people at risk of exploitation and their families, and to provide specialist support and advice to professionals, has continued to expand. Safer London and the Refuge – Violence Against Women and Girls advocacy service between them undertook direct work in 2017/18 with 26 young people affected by sexual exploitation. In addition to these established services, a therapeutic and family support service (Tiger) was commissioned from Barnardos in November 2017, and between then and March 2018 worked with 14 young people and seven families. During the year, a joint funding bid with Barnardos and 8 other London boroughs was successfully made to the Mayor's Office for Policing and Crime (MOPAC) for a service which will provide a therapeutic advocate to support young people displaying unhealthy sexual behaviour. It is becoming increasingly clear that relationship based engagement with one trusted adult is key to the effective support and protection of young people who are subject to exploitation but will often not see themselves as victims. Supporting the wider development of more creative approaches to working with young people in such circumstances is a priority for the LSCB in 2018/19.

It remains the case that the majority of child sexual exploitation in Redbridge is carried out by single male abusers, often exploiting young people online. There is also some evidence of more organised activity. It is also notable that many of the suspected abusers themselves are young people – 75% of suspected abusers identified in in the last quarter of 2017/18, when this data began to be systematically collected, were aged 25 or under.

The majority of young people experiencing exploitation are at school. In June 2017 the LSCB co-ordinated a survey of schools in the borough, seeking views on how they might be better supported in working with young people in their school who were exposed to exploitation. There were two specific outcomes to this initiative. One was the development and circulation of a presentation on CSE which could be adapted for use with parents, students, or staff. The other was the development, with the Redbridge Drama Centre, of a play for pupils in years 5, 6 and 7 called 'Playing with Fire'. The play highlighted the dangers of the abuse of mobile phones and social media, including peer on peer abuse. Each showing of the play was followed by a short workshop in which pupils explored the key issues from the play and reinforced safeguarding messages. Forty schools showed the production reaching in excess of 1000 pupils. The feedback was overwhelmingly positive.

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. One of these notices resulted in arrest.

Missing Children

Previous Annual Reports have described a range of initiatives and activities which have been established in Redbridge to seek to reduce the incidence of children going missing from home and care. These initiatives have included the development of a dedicated Missing Children's Team in children's social care; a comprehensive Return Home Interview service offered by the Early Intervention and Family Support Service, the development of a multi-agency Missing Children's Panel, which in 2017/18 considered and progressed plans for 45 persistently missing young people with the most complex needs; and increased engagement with children's home providers by the police and children's social are. It is very pleasing that in 2017/18 we began to see clear evidence of the impact these developments have had. The number of children who went missing from care in the year fell, from 60 to 55, and the average number of times those children went missing also fell, from 8.05 to 7.8. (Some caution should however be exercised in analysing this data as it may be influenced by under-reporting: children's homes and other care providers have reported that the long delays which they experience in getting through to the 101 number on which they report missing young people to the police have led on some occasions to them giving up attempting to make the report). The fall in the numbers who go missing from home is more marked: from 218 in 2016/17 to 182 in 2017/18 – a 16% reduction.

However, this generally encouraging picture of some progress in reducing the number of children who go missing from home or care also includes some issues of concern. The number of 14 year olds who went missing at least once during the year increased, from 27 in 2016/17 to 33 in 2017/18. This appears to reflect the growing involvement of younger children in 'county lines' drug trafficking activity. Similarly, the average number of times young people have gone missing home has increased slightly, from 1.88 to 1.95. More

significantly, the number of young people who were missing from home for more than ten days doubled in the period, from 16 in 2016/17 to 32 in 2017/18. For the first time in 2017/18, the Missing Children's Team were able to begin to systematically map the involvement of missing children in county Ines activity. Although this mapping is still at an early stage, the involvement of Redbridge young people in county lines is clearly significant, with connections established to South London, Southampton, Colchester and Ipswich, among other places.

All children who go missing from home or care are offered an independent 'return home interview' (RHI). The aim is to build positive relationships with all missing children, to gain trust and enable them to speak freely about their experiences of running away. A telephone number is provided at interview to call or text for children considering going missing again with a named worker to contact. They also pass on the out of hours Emergency Duty Team contact details. The MPS East Area Basic Command Unit (BCU) receive a full un-redacted copy of the RHI and this provides them with background information and intelligence on CSE, gang involvement, drug running and other issues. Young people and their parents can decline the offer of a return home interview. In 2017/18, however, 81% of interviews offered were accepted, a significant improvement on the take up rate in 2016/17 of 67%.

Modern Slavery and Child Trafficking

Under Section 52 of the Modern Slavery Act 2015, local authorities and the police have a duty to identify and refer to the National Referral Mechanism (NRM) if they have reasonable grounds to believe that a person may be a victim of modern slavery or human trafficking. Home Office guidance clearly states that 'child trafficking' is child abuse and that it is not possible for a child to give informed consent.

Multi-agency work within Redbridge to tackle modern slavery and human trafficking is led by the Community Safety Partnership, but the LSCB maintains close contact with it. The LSCB Business Manager is a member of the task and finish group established by the CSP to make recommendations to the Council and the wider partnership on improving its response to the issue, and made a presentation to local GPs on the topic in September 2017.

Safeguarding children in sport

Following substantial national media coverage about the abuse of young people in professional football and other sporting contexts, the LSCB Chair wrote to all sports clubs and coaches in the Borough in April 2017 highlighting the issue, reminding all organisations of their safeguarding responsibilities and what should be in place to deliver them, and providing links to a wide range of information and resources to assist organisations in ensuring that all young people involved in their activities were safe from abuse.

The Healthy Child Programme

In July 2017 the Board considered a report on the new integrated Healthy Child Programme 0-19, led by health visiting and school nursing services, which went live in April 2017. The service will be delivered through a new 'skill mix' model, utilising a wider range of staff than qualified health visitors and school nurses. While recognising the benefits that such a model might deliver, the Board was concerned to have assurance that it would deliver high quality and safe services in practice. A full report evaluating the impact of the new model will be considered by the Board in 2018/19.

Housing

The shortage of affordable housing in the borough, and the impact of homelessness on vulnerable children, has been a focus of the Board's concern for some years, and continued to be so in 2017/18. While the underlying issue, the shortage of supply, inevitably remains unresolved, the Board was pleased to learn of a number of improvements in the position for families in need. There was a small reduction in the number of households in temporary accommodation, from 2,308 at the end of 2016/17 to 2,270 in March 2018. During the course of the year there was an increase in procurement of temporary accommodation in or close to the Borough. This resulted in a reduction in placements at long distances from the borough, especially of those in emergency accommodation. Most bed and breakfast placements, where the impact of a placement further away is most acute for families and children, especially in relation to school attendance, were in or near the Borough by year end. The number of households overall in bed and breakfast accommodation decreased from 392 to 189. Most significantly, by the end of the year there were no families with children in bed and breakfast accommodation who had been there for more than six weeks, compared to 142 at the end of 2016/17.

A new Housing Strategy was approved by Cabinet in July 2017. Within the 5-year Strategy (2017 – 2022) there is a commitment to deliver 1,000 new affordable homes.

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 the report for 2017/18 has not been received. One of the Board's Business Plan priorities for 2017/18 was to develop and implement a robust multi-agency plan to substantially increase private fostering notifications. Significant promotional work was

undertaken across a range of agencies. However, success in increasing the number of notifications was limited. As of 31 March 2017 there were only seven arrangements in place known to the local authority, compared to 13 at the end of 2016/17. However, there were 16 notified arrangements in place at some point during the year, compared to 15 in the course of 2016/17. It should also be noted that the Ofsted inspection of children's services in Redbridge, published in November 2016, was very positive about the 'far reaching service' and the 'high level of service' delivered by children's social care to those few children in private fostering arrangements which had been notified to the Council.

Protecting young people from involvement with violent extremism

The early part of 2017/18 was dominated by the aftermath of the London Bridge and Borough Market terrorist attacks in June 2017. One of the perpetrators was known to have had access to young people in Redbridge. There was extremely close liaison between the Prevent Team, the police and children's social care on these matters, and a great deal of work undertaken to address any potential risk to the welfare of the young people potentially affected. This work was able to build on the existing very close liaison between the Prevent Programme and the Multi Agency Safeguarding Hub (MASH) to safeguard and support those most at risk of radicalisation through early intervention and appropriate support.

In April 2018 the Board received a comprehensive report on the activities and outcomes delivered by the Prevent Programme in Redbridge in 2016/17. This included feedback from a Home Office Prevent Peer Review undertaken in January 2018. The overall conclusion of the review was:

> The peer review team agreed that Redbridge is generally delivering Prevent to a high standard. Peers observed a range of innovative practice, strong partnership working and demonstrable leadership. The statutory obligations on Redbridge are being met well and processes are well embedded with good partnership working, especially between the local authority, borough police, and SO15 (Counter Terrorism unit).

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 throughout 2016 and the first half of 2017. However, a newly appointed permanent DO took up post in October 2017, and the service is now on a secure footing, working proactively to promote and develop the role, offering support, advice, and guidance to statutory and voluntary agencies within Redbridge.

Data on the DO service is currently available on a calendar basis. The DO received 240 notifications in 2017, 15% fewer than in 2016 and reversing what had been a year on year upward trend since 2013 – 282 in 2016, 269 in 2015, 223 in 2014, and 146 in 2013. The percentage of notifications which were assessed as meeting the threshold, as described above, and which were subject to a formal evaluation, was little changed: 35% of referrals were subject to formal evaluation in 2017, compared to 38% in 2016.

In terms of outcomes for the referrals which were the subject of formal evaluation, the table below demonstrates the rigour with which the DO's inquiries are followed through by the relevant agencies.

Of those referrals subject to formal evaluation:			
	2017	2016	2015
Number resulting in criminal investigation	14	14	4
Number resulting in criminal conviction	1	1	0
Number resulting in dismissal	9	6	0
Number resulting in other forms of disciplinary action	8	6	2
Number resulting in referral to a regulatory body	3	7	1
Number resulting in referral to the Disclosure and Barring Service	3	6	5

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 protocol, setting out the

equivalent responsibilities for professionals who work primarily with children have in relation to the protection of vulnerable adults, was agreed by both Boards in 2017/18.

In June 2017 the independent chair of the LSCB also became independent chair of the Safeguarding Adults Board. The LSCB Business Manager now serves as Business Manager for both Boards. It is hoped that these developments will support more joint working between the Boards. In December 2017 the Safeguarding Adults Board agreed the final version for publication of a Multi-Agency Self-Neglect and Hoarding Protocol, developed to provide detailed and practical guidance to staff in all agencies on recognising, assessing the risks involved in, and acting on adult self-neglect, including hoarding behaviour. The protocol has been circulated through children's social care, to heighten awareness of the potential risks to children in a household where hoarding is a feature of the environment and adult behaviour, and the referral routes through which those concerns can be raised.

In its Annual Report for 2017/18, published at the same time as this report, the Safeguarding Adults Board reflects on its concern about vulnerable young people becoming vulnerable adults and potentially falling through the gaps between two safeguarding systems – the concept of 'transitional safeguarding'. This is a potential focus for some joint work between the Boards in the future.

Resolving professional disagreements

The LSCB recognises that it is inevitable and healthy that from time to 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 2017, the LSCB reviewed and updated 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

Throughout 2017/18 the LSCB continued to expand its work on communication, publicity, and engagement. The LSCB newsletter, published on-line after every Board meeting, has a circulation of several hundred professionals working across all sectors. As well as information about a whole range of LSCB activities, the newsletter includes full briefing on the issues and outcomes discussed at the Board, and a 'service highlight' page publicising the work of an individual service. In 2017/18 the work of the Safer London Foundation with young people experiencing sexual exploitation, of Refuge with women and girls suffering violent abuse, the NSPCC Schools Service, and the Council's Fostering Service, have all been featured in the newsletter. The LSCB also contributes regularly to RedPEN, which goes to all Redbridge schools, to the Clinical Commissioning Group newsletter which is distributed to all GPs in the borough, and to RedbridgeCVS eNews, widely circulated throughout the voluntary sector. The LSCB's Twitter feed now has over a thousand followers, and its Facebook and Instagram presence are growing. The LSCB had just under 500 followers on Instagram by 31 March 2018. This is targeted at young people,

and has been used to raise awareness of road safety, mental health, understanding consent, eating disorders and knife crime, and to send out positive messages about body image, relationships, and most importantly seeking help.

Community-based activity has been led by Lesley Perry, Business Manager, and the LSCB Team, with a huge contribution made by the Lay Members of the Board. It included participation in a number of outreach events in Central Ilford during the course of the year, as part of which the team engaged with around 300 children, young people, families and other professionals. There was an active programme of presentation to a range of forums including the Designated Safeguarding Leads in Redbridge schools, Chairs of School Governors, the GP Forum, and the local pharmacists' consortium. The views of young people have been sought in all the LSCB's multi-agency audit work, working with, among others, the Youth Council and groups of children in care and care leavers.

All of this work and more is presented and reflected in the ever-expanding and changing LSCB website, already described by Ofsted in November 2016 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 news page is updated on an almost daily basis, disseminating information on national developments and research as well as local content.

6. Safeguarding Training

In 2017/18, the LSCB continued to commission and deliver a substantial training programme for multi-agency staff working in Redbridge. In spite of clear workload and caseload pressures, the number of professionals attending LSCB training events has continued to increase, from 649 attendances in 2016/17 (itself a significant recovery from the year before, with a 63% increase from a low of 397 in 2015/16) to 715 in 2017/18 – a further increase of 10%. The great bulk of attendances were by children's social care staff (34%), schools and colleges (19%), private sector providers (18%), staff from the Council's Education and Inclusion Division (15%), and the voluntary sector (10%). One of the priorities for 2017/18 was to facilitate and increase participation by schools in the multi-agency training programme. Participation by school-based staff increased by 71%, with 133 attendances in 2017/18 compared to 78 in 2016/17.

It is disappointing that there is so little attendance at multi-agency training by health staff, and virtually none by the police. However, it should be noted that all health providers have extensive training programmes and requirements for their own staff, and achieve a high level of compliance with mandatory training targets. These require 85% of all health staff to be trained at the required level. In 2017/18, this target was met by all our major health providers.

Health Providers Safeguarding Children Training Compliance		
Agency	**Year End 2017 – 2018**	
	Level 2	**Level 3**
NELFT	95.7%	89.4%
BHRUT	96.3%	91.8%
PELC	93%	95%
Bart's Health	94%	84%

The LSCB Training Sub Group undertakes an ongoing training needs assessment, and a number of new topics were included in the training programme for 2017/18 as a result of this. These included sessions on safer recruiting (an accredited course), harmful sexual behaviours, peer on peer abuse, forced marriage and honour based abuse, understanding the Roma community, safeguarding children from refugee families, and modern slavery awareness.

The following courses were delivered in the 2017/18 Training Programme:

LSCB Priorities 2017/18

- 2x Introduction to Child and Adolescent Mental Health
- 1x Abuse in Teenage Relationships
- 2x Child Sexual Exploitation Briefing
- 2x Child Sexual Exploitation for Practitioners
- 2x Safeguarding Children in a Digital World and Cyberbullying
- 2x Female Genital Mutilation
- 2x Working with Young People in Relation to Gangs & Crime
- 2x Child Sexual Exploitation Briefing
- 3x Child Sexual Exploitation for Practitioners
- 2x Safeguarding Children in a Digital World and Cyberbullying
- 3x Safeguarding Children who go Missing
- 2x Modern Slavery Awareness
- 1x Multi Agency Neglect Toolkit Workshop
- 1x Peer on Peer Abuse
- 1x Private Fostering
- 1x R U Ready
- 1x Child Trafficking Across Borders
- 4x Workshop to Raise Awareness of Prevent

Working with Diversity

- 1x Cousin Marriage Awareness
- 1x Safeguarding Children with Disabilities
- 2x Female Genital Mutilation
- 2x Honour Based Abuse
- 2x Working with Race, Culture & Belief in the Context of Professional Curiosity
- 2x Safeguarding Children from Refugee Families
- 1x Understanding the Roma Community in the Context of Professional Curiosity

Safe-guarding Theory and Practice

- 3x CAF: An Introduction
- 5x CAF: Assessment & Planning for Practitioners
- 1x Harmful Sexual Behaviours
- 5x Multi Agency Audit Briefings
- 1x Neglect
- 3x Safer Recruitment
- 2x See the Adult, See the Child
- 9x Safeguarding Level 2
- 2x Understanding Thresholds in Safeguarding
- 1x Voice of the Child

A number of planned sessions were cancelled due to low take up or other unforeseen reasons. Participant satisfaction continued to be high with 98% of attendees saying they were satisfied or very satisfied with the programme attended, and 96% of trainees reporting that they would recommend it to a colleague.

Total expenditure on LSCB training was £13,253, compared to £14,621 in 2016/17, £15,037 in 2015/16 and £17,254 in 2014/15. Income was £11,400 - £9,340 in attendance fees and £2,140 received in charges for non-attendance. From a deficit on the training budget of almost £12000 four years ago, the LSCB training programme is now very close to being self-financing.

Individual partner agencies and commissioned providers have delivered a wide range of single agency safeguarding training for their own staff. 39 Foster Carers have received Safeguarding Training with another 10 completing an on-line eLearning module. The Early Years Service continues to provide an extensive training programme. The Education Welfare Service provide a traded service to schools. In 2017/18 the service trained:

- 1132 school staff at Standard Level across 25 school settings
- 114 Designated Safeguarding Leads and Senior Leadership Team staff at Advanced level across 23 school settings
- 20 Staff at Extended level across 5 schools.

The service delivered additional briefing sessions on topics such as female genital mutilation, child sexual exploitation, and reporting skills, and supported foster carer, school governor and newly qualified teachers' training. For the first time in 2017/18, the service offered safeguarding supervision support to schools as part of Traded Services; with 10 primary schools and 5 secondary schools taking up the offer.

In 2016 the LSCB agreed a Framework and Principles for Safeguarding Children Training which set out the mechanisms for both quality assuring the safeguarding training provided by individual partners, and for evaluating the impact of training. The post training online evaluation introduced as part of this framework, completion of which is mandatory in order to achieve an attendance certificate, has been fully applied to all LSCB courses in 2017/18. It gathers 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 - 'training transfer'. The overall completion rate in 2017/18 was 65%. Effectively following up the impact of training three months later has continued to be a challenge. A sample of five LSCB courses were chosen for this impact evaluation, but a response rate of 11% to the online inquiry used for this evaluation and limited capacity for follow up and telephone interviews meant that a full evaluation was not possible. Nevertheless, responses were generally very positive, with much evidence of efforts to share learning and resources within teams. Respondents reported a greater understanding of safeguarding theory and practice. The LSCB website which has been utilised to offer paper-free access to training materials such as PowerPoint presentations and videos from training was much valued.

A recurring theme among respondents was the benefit for training transfer of pertinent information on local policies and procedures, resources and services, delivered by local practitioners currently working in the Borough.

Supported by the LSCB Training Manager, Amanda Jones, the LSCB Training Programme has benefitted from the time and commitment of a range of professionals from Children's Services and Community Safety and plans are in place to extend these partnerships.

7. Learning and Improvement: learning from practice

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 the quality of practice 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.

In March 2017 the LSCB agreed a robust multi-dimensional framework for its audit work (see the MA Audit Programme) which included, in addition to individual agency case file audits of practice in the sample of cases chosen:

- a 'round table' event bringing all involved agencies together to integrate and challenge the findings of individual agency audits
- auditing a wider sample of key documents such as child protection child in need plans
- direct observation of multi-agency practice in for example child protection case conferences or multi-agency panel meetings
- engaging with young people directly on their views and experiences of the issue which the audit is focusing on.

Five multi-agency audits were completed in 2017/18. The topics were:

- Children subject to child protection plans on the grounds of neglect;
- Children who go missing
- Peer on peer sexual abuse and harassment
- Mental health and social issues
- Female genital mutilation (FGM)

All the audit activity found evidence of high quality professional practice and good multi-agency working. However, it is inevitable that in terms of learning the focus of the reports which the Board considered was on areas for improvement. Each audit report was rich in detail, findings, and learning, and it is not possible to do them justice in this report. It is only possible to give a selection of the themes that emerged:

- Greater consistency is needed in the sharing by children's social care with other agencies of key documents such as the minutes of core group meetings when a child is subject to a child protection plan.
- Reports for child protection case conferences are not consistently available for parents and professionals within the timeframes required. This limits the capacity of

the conference to integrate information from different sources, and for parents to absorb and challenge that information.

- The potential contribution of school nurses and health visitors to the safeguarding of children is not always recognised or their contribution invited.
- A need for greater and more consistent professional curiosity was identified in all the audits. Professional curiosity is defined as the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value. The LSCB published a Quick Learning Guide to Professional Curiosity in April 2018.
- Much greater use could be made of independent and non-statutory services with particular skills in engaging with young people.
- Professionals need support to feel confident in engaging with difficult or unfamiliar issues – for example, the audit of work in situations where children are believed to be at risk of female genital mutilation found professionals often relapsing into procedural issues or limiting engagement to simply conveying information about the legal position.
- Professional differences are inevitable but can prevent effective work if they are not addressed and resolved. More use should be made of the LSCB's Escalation and Resolution Policy.
- Poor school attendance is not always identified as an early risk indicator, and opportunities to intervene early can be missed.
- A culture of reflective self-audit of practice is not consistent between agencies. It was not possible, for example, in the audit of work with children who go missing to get a clear picture of the quality of the police involvement with and response to young people who go missing.

While there is a need for continuing improvement in the methodology of audit, the effectiveness with which learning is identified, and the consistency of engagement across all agencies, the audit programme delivered in 2017/18, led by Andrea Barrell, LSCB Quality Assurance Manager, has laid a really strong foundation for ongoing learning and improvement. The key question is how that learning from audit gets translated into practice. The learning from audit is disseminated through multi-briefings offered to staff from all agencies after each audit has been completed. It informs all training activity – for example, the theme of professional curiosity has a high profile throughout the LSCB's Training Programme. It informs strategy – the learning from the audit of work with families where there is a risk of female genital mutilation will be a key driver for the development of a Female Genital Mutilation Strategy to which the Board is committed in 2018/19. It informs changes in policy and procedure: the audit of the response to peer on peer abuse highlighted the value of the Brook Sexual Behaviours Traffic Light Tool in assessing risk and helping to determine the appropriate response. As a result, the tool has been promoted through the LSCB website, and is referenced as a valuable resource in the LSCB's Threshold Document, "Are you worried about a child?" One of the findings of this audit was that the risks associated with some of the social media apps which young people use – which are of course developing all the time – are little known about or

understood by adults. One outcome of the audit was a joint piece of work between the Multi-Agency Audit Working Group and the Youth Council to develop a Social Media App Guide, designed both to help young people protect themselves and to support adults in working with them on keeping safe. This project will be completed and go live on the LSCB website in 2018/19.

Strengthening the impact of audit activity on practice remains a key theme for the LCSB, and a number of areas for improvement identified in audit in 2017/18 are scheduled for 'deep dive' follow up work in the Board's programme for 2018/19.

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 have been completed every two years. The Annual Report for 2016/17 described the comprehensive programme of Section 11 audits which was completed that year.

An integrated Section 11 action plan, drawing together the actions to which agencies had committed themselves to address those areas of weakness identified in their Section 11 audits, was presented to the Board in July 2017. Progress against those action plans was reviewed at every Board meeting for the remainder of the year. In April 2018 the Board considered a final report on progress against the actions agreed as an outcome of the Section 11 audits carried out in 2016/17. It was content that good or satisfactory progress had been made against the 75 individual actions that had been recorded in the integrated plan, and formally signed it off as closed.

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