Redbridge Safeguarding Children Partnership

ANNUAL SCRUTINY REPORT

2019 –2020

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Independent Chair and Scrutineer

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Contents

Foreword

This is my first Annual Report as Independent Chair and Scrutineer of the Redbridge Safeguarding Children Partnership (RSCP). I attempt to explain the background to this role, the basis for the work of the Redbridge Safeguarding Children Partnership, and its relationship to the statutory BHR Safeguarding Partnership, in the Introduction that follows. The fundamental purpose of this report, though, is not to dwell on structural arrangements. It is, as it was for the Annual Reports of Redbridge Local Safeguarding Children Board for which under the previous arrangements I was responsible, to answer the question: how well are children and young people in Redbridge safeguarded?

This report covers the period from the end of September 2019, when the RSCP was established, to the end of September 2020. In the second half of this year, the world was turned upside down by the coronavirus pandemic. Part Two of the report explores the extraordinary impact of the pandemic and the measures taken to control it on the safeguarding of children, and some of the massively worrying and continuing risks to children, young people and families to which it has given rise. In particular, we are seeing signs of a steep increase in mental ill-health among young people which is unlikely to abate in the near future and which may have profound long-term consequences. Part Two also explores, though, the extraordinary ways in which staff and managers at all levels in all agencies have gone the extra mile to continue to provide essential services and maintain the best possible support and protection for the people they work with. It is fantastic to be able to report, for example, that over 90% of children and young people on child protection plans have had regular face to face meetings with their social worker every ten days or more often in cases where safeguarding concerns dictated that was necessary, through lockdown and beyond. Collaborative multi-agency working, which is long established as a real strength of the safeguarding system in Redbridge, has been strengthened even more at both strategic and operational levels as services have adapted and come together to face a wholly new set of demands and challenges.

Part One of the report is more concerned with the quality of safeguarding practice and outcomes for children in the period before the pandemic, and draws largely on data for the period April 2019 to March 2020. If the overall question is, how well are children and young people in Redbridge safeguarded, it is not complacent, from the evidence given, to say: very well. This is perhaps not surprising in a borough whose local authority children's services were assessed by Ofsted as recently as 2019 as outstanding. Demand, measured by the volume of referrals, is (or was, before the exceptional circumstances of the pandemic) at record levels; and the level of assessed

risk to children greater, indicated both by the increase in the number of children on child protection plans and the increase in the number of court care proceedings initiated. Performance on most measures remained exceptionally strong. Neither the local authority nor the partnership rest on their laurels, however, and the report does identify a number of areas which it suggests will benefit from continuing scrutiny: the low percentage of Section 47 inquiries which lead to a child protection case conference, raising the possibility that the threshold for initiating what may be a very difficult experience for families may be set too low; the year on year upward trend in repeat referrals, which could suggest some element of a "revolving door"; the importance of continuing to monitor very closely the rising number of cases diverted to early help services, to make sure that complex or high risk cases are responded to at the appropriate level; the need to ensure that a new and vital focus on the criminal exploitation of young people does not inadvertently lead to a reduced focus on child sexual exploitation, in the same way that the joint inspectorates have suggested that the focus on child sexual exploitation (CSE) over recent years may have led nationally to some losing sight of the issue of child sexual abuse in the family; and the critical difficulties in our national arrangements in ensuring that young people caught up in criminal exploitation are "reached out to" at moments of crisis such as arrest. The "rapid review" of the case of a young person who tragically committed suicide suggested that, even in a borough with a really embedded commitment to partnership working, it can be easy to slip into silo working: different agencies each working hard to support a young person but not talking to each other, and not creating a real sense of a "team around the child".

It is pleasing to be able to report continuing improvements in the two areas which were of the greatest concern to the LSCB in the last years of its work. One was the damage felt to be suffered in joint working with the police by what was experienced as a botched and rushed reorganisation away from a borough-based command to the tri-borough East Area Basic Command Unit (BCU). Joint working is now excellent. This has been further strengthened by a permanent appointment to the post of Detective Superintendent heading up the Safeguarding strand within the BCU after a year of extreme instability: there were five different incumbents in this role in twelve months. The other great area of concern over several years has been what the LSCB Annual Report for 2016/17 described as the "crisis' in mental health services for children and adolescents – a crisis which, without being melodramatic, could place some of our most vulnerable young people at substantially increased risk." In the intervening years, the service has changed substantially, and now, as the Emotional Wellbeing and Mental Health Service (EWMHS), can demonstrate that it is responding to an increasing number of referrals with improved triaging and more rapid initial assessment, and delivering a much more partnership-focused and accessible service. However, both funding and recruitment difficulties remain, and the service is still not reaching the expected proportion of its target population. The RSCP was very

concerned to hear of the long waits in A&E at BHRUT experienced by many young people presenting with mental health problems, due both to the lack of on-call psychiatric assessments services and the shortage of in-patient adolescent psychiatric beds. It was particularly shocking to hear of one young man who, during the coronavirus crisis, spent five days in A&E waiting for a suitable bed and was eventually sectioned and placed in a secure unit. We were assured that escalation processes at a senior level are being put in place to address such issues, and will continue to scrutinise this carefully, particularly given the explosion of mental distress we are seeing as the pandemic continues.

The quality and spread of multi-agency training are well-established strengths of the Partnership and continued to be so in the year under review. I was particularly struck by the creative way in which training adapted to the online world in response to the pandemic, and by the enthusiasm with which potential participants have, despite some anxiety about possible take up, been keen to sign up for this very new kind of training experience. This undoubtedly reflects the very high value which professionals place on the training offered by the multi-agency partnership. While many colleagues contribute to this continuing success, I do particularly want to pay tribute to the phenomenal amount of work put into it by Amanda Jones, RSCP Training Manager, and Andrew Reed, our Senior Administrator, along with Graeme Gail-McAndrew from NELFT, the sadly now outgoing Chair of the Training Sub Group. I am particularly pleased that 65% of RSCP training is now delivered by colleagues working within RSCP partner agencies: making use of, sharing and valuing the expertise that we have within our own workforce. Attendance at multi-agency training by NHS and police colleagues remains very limited, and I do express the hope in this report that one outcome of the equal responsibility of the police and the CCG for multi-agency safeguarding arrangements, defined within the Children and Social Work Act 2017, will be the increased participation of health and police staff in multi-agency training

At every meeting of the RSCP in the year under review we have heard, either directly or through survey reports, from young people themselves. The presentation described briefly later in this report from three young people attending Redbridge Alternative Provision, speaking from their own experience about what it's really like as a young person getting involved with the multi-agency safeguarding system, was especially powerful. I think that the commitment, inscribed in the RSCP's Terms of Reference (**Appendix A**), to the centrality of the experiences and voices of young people to all its work is fundamental to its success. I hope that those voices will continue to be heard in every aspect of the Partnership's work, and to feed into the independent scrutiny of its effectiveness.

Part Three of the report is an initial evaluation of the effectiveness of multi-agency safeguarding arrangements at the BHR level. It poses two questions: what difference has the BHR Partnership made to the quality of multi-agency working to safeguard

children across BHR and to outcomes for children; and what value has it added to partnership working, set against any costs and administrative burdens created? Given the immense impact of the coronavirus during the second half of the BHR Safeguarding Partnership's first year, I accept that it would be premature to attempt any definitive answer. The multi-agency safeguarding arrangements published in June 2019, which established the BHR Safeguarding Partnership, made a commitment to an independent review of the Partnership and the impact of the new arrangements, to be commissioned in May 2020. The demands of the coronavirus pandemic have of course led to the postponement of any such review. I do strongly recommend, however, that, as and when the world returns to some kind of normality, priority is given to commissioning that review.

Finally, I want to acknowledge the enormous commitment, creativity, and hard work of Lesley Perry and the RSCP Team, without whom none of the work of the Partnership would have been possible. Most of all, though, I want to end by paying the most heartfelt tribute to those hundreds of staff, in all agencies and at all levels, who have risen so heroically to the challenge of the coronavirus pandemic, and given such an amazing demonstration of the strength of public service values at a time of crisis.

John Goldup

Independent Chair and Scrutineer, Redbridge Safeguarding Children Partnership

Introduction

The Children and Social Work Act 2017 abolished what had previously been a statutory requirement for the establishment of Local Safeguarding Children Boards (LSCBs). Instead, it placed the responsibility for agreeing arrangements for multi-agency working to safeguard and promote the welfare of children, and to identify and respond to their needs, upon the local authority, the police, and the Clinical Commissioning Group (CCG) – defined in the Act as the three statutory "safeguarding partners". The arrangements should include other 'relevant agencies that [the safeguarding partners] consider appropriate'. In North East London, the three local authorities of Barking and Dagenham, Havering, and Redbridge (BHR), the BHR Clinical Commissioning Groups, and the Metropolitan Police East Area Basic Command Unit (BCU) which is responsible for policing the three boroughs, agreed to establish a single set of arrangements across the BHR area – the BHR Safeguarding Partnership. The core of this is a Safeguarding Partners Group – the three Directors of Children's Services, the East BCU Detective Superintendent with responsibility for safeguarding, and the CCG Director of Nursing. However, the BHR Partnership has clearly recognised the importance of a continuing focus on local needs and local accountability within the BHR arrangements. In Redbridge, a multi-agency Redbridge Safeguarding Children Partnership (RSCP) is responsible, within the framework of the statutory BHR Partnership, for identifying and progressing local safeguarding priorities, overseeing performance and the quality of safeguarding in Redbridge, coordinating the response to key local safeguarding risks, and ensuring the dissemination of learning both locally and contributing on a cross borough basis. I have been the independent chair of the Partnership since its inception in September 2019. I previously chaired the Redbridge LSCB, from August 2014 to September 2019. I was National Director of Social Care in Ofsted from 2009 to 2013, and from 2012 Deputy Chief Inspector. I have also chaired the Redbridge Safeguarding Adults Board since June 2017, having served as Director of Adult Services in Tower Hamlets from 2000 to 2009.

Both the BHR Safeguarding Partnership and the Redbridge Safeguarding Children Partnership were formally established on 29 September 2019, when the relevant sections of the Children and Social Work Act 2017 came into force. This report covers the twelve-month period from that date, to the end of September 2020.

The RSCP terms of reference, which were agreed at its meeting of 14 January 2020, are attached as **Appendix A**.

RSCP Membership (as at September 2020)
Independent Chair
John Goldup
Local Authority Representatives
Adrian Loades, Corporate Director of People
Caroline Cutts, Operational Director, Children and Families
Judy Daniels, Head of Safeguarding and Principal Child and Family Social Worker (PCFSW)
Catherine Worboyes, Head of Child Protection, Early Intervention and Community Social Work Services
Kelsey Morris, Early Years and Childcare Improvement Team Manager, Education and Inclusion
John Richards, Crime Partnerships Service Manager
Chris Ma, Head of Positive Activities
Gladys Xavier, Director of Public Health (Vice Chair)
Jackie Odunoye, Operational Director, Housing Services
Health Representatives
Bob Edwards, NELFT Integrated Care Director for Redbridge **NELFT**
Graeme Gail-McAndrew, Named Professional Safeguarding Children **NELFT**
Jacqui Himbury, Nurse Director **Redbridge CCG**
Caroline Alexander, Chief Nurse **Bart's Health NHS Trust**
Gemma Shadbolt, 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 Nichols, Designated Nurse for Safeguarding Children & LAC **Redbridge CCG**
Doug Tanner, Children Maternity and CAMHS Commissioning Lead **Redbridge CCG**
Sue Elliott, Interim Director of Nursing and Clinical Governance **Partnership of East London Co-operatives (PELC)**
Ruth Rothman **Nurse Consultant Safeguarding Children Primary Care, Redbridge CCG**
Police
Detective Superintendent John Carroll **East Area Basic Command Unit (BCU), MPS**
Probation Representatives
Patsy Wollaston, Head of Service, Haringey, Redbridge & Waltham Forest **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, Senior Safeguarding and Enrichment Manager **New City College (Redbridge Campus)**
Victoria Ballantyne, Deputy Head Teacher **Barley Lane Primary School**
Meherun Hamid, Head Teacher **Apex Primary School**
James Brownlie, Head Teacher **Little Heath School**
Rebecca Drysdale, Head Teacher **Ilford County High School**
Carley Smith, Head of School **Oakdale Junior School**
Susan Johnson, Head Teacher **SS Peter and Paul's Primary School**
Yvonne Andrews, Co-Head Teacher **Beal Academy Trust**
Voluntary Sector Representatives
Edel Fitzgerald, Service Manager **Refuge**
Maria Love, Specialist CSE Project Manager **Safer London**
Suzanne Turner-Jones, Assistant Director **Barnardo's**
Jenny Ellis, Chief Executive Officer **Redbridge CVS**
Vinaya Sharma **Redbridge Faith Forum**
Lay Members
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, RSCP & RSAB Manager

The full Partnership met in October 2019, January and July 2020. The meeting scheduled for May 2020 was cancelled, to allow partners to concentrate resources on responding to the impact of the coronavirus pandemic.

The Partnership has two standing subgroups. The Training Subgroup continued to be chaired in 2019 – 2020 by Graeme Gail-McAndrew, Named Nurse Safeguarding Children, NELFT. The Subgroup was responsible for undertaking training needs analysis across partner agencies, commissioning the RSCP's own Training Programme and quality assuring safeguarding training, including an evaluation of its impact on frontline practice. The Subgroup met four times during this period.

The Learning and Improvement Subgroup continued to be chaired in 2019 – 2020 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. Its terms of reference include responsibility for the development and delivery of a 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. However, there has been no capacity to co-ordinate multi-agency audit during 2019/20, as the post of Quality Assurance Manager is currently held vacant due to budget restrictions. The Subgroup met four times during the period.

The table below shows the contributions to the LSCB/RSCP budget for the financial year 2019/20 from partner agencies, and the expenditure incurred.

Income		Expenditure	
Training attendance/non-attendance fees	37,365	Office Expenses	176
LB Redbridge *(comprising of contributions from Children's Services, Adult Services, Public Health & Housing)*	83,431	LSCB Training Programme	14,029
LB Redbridge, Corporate funding	0	LSCB Independent Chair	31,200
Metropolitan Police	5,000	LSCB Business Manager *(pro-rata with 30% re-charged to Redbridge SAB from June 2017)*	54,693
National Probation Service (NPS)	1,100	RSCP Training Manager (Part Time)	33,035
London Community Rehabilitation Company (CRC)	1000	RSCP Senior Admin Officer	41,774
Cafcass	550		

Redbridge Clinical Commissioning Group (CCG)	35,000		
Barking, Havering & Redbridge University Hospitals NHS Trust (BHRUT)	3,231		
Bart's Health NHS Trust	5,000		
NELFT	3,230		
London Fire Brigade (LFB)	0		
Total Income	174,907	**Total Expenditure**	174,907

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

The Metropolitan Police Service contribution is determined centrally by the Mayor's Office for Policing and Crime (MOPAC) at a flat rate of £5000 per borough. Given the absolutely central role of the police in the effective safeguarding of children, this was always 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. It continues to be a critical issue for the new multi-agency safeguarding arrangements under the Children and Social Work Act 2017, in which the police are one of 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".

For the first year of its work, the RSCP adopted the four priorities that had been agreed by its predecessor body, the Local Safeguarding Children Board, in May 2019:

- Safeguarding vulnerable adolescents
- Support to schools and other educational settings
- Learning from practice
- Learning from children, young people and families

The Children and Social Work Act 2017 requires that the arrangements agreed and published by the statutory safeguarding partners must include "arrangements for scrutiny by an independent person of the effectiveness of the arrangements". This provision was introduced in response to concern about the potential loss of independent scrutiny of multi-agency safeguarding performance as a consequence of the abolition of the statutory role of independent LSCB Chair. The "arrangements"

referred to are those published as the statutory arrangements at the BHR level. The development of these arrangements has been hugely impeded by the impact of the coronavirus pandemic, and the arrangements for independent scrutiny at the BHR level have not yet been clarified. However, I act as the independent scrutineer of the effectiveness of the multi-agency safeguarding arrangements as they operate in Redbridge. The statutory guidance, Working Together to Safeguard Children (2018), defines the role of independent scrutiny in the following terms:

> "The role of independent scrutiny is to provide assurance in judging the effectiveness of multi-agency arrangements to safeguard and promote the welfare of all children in a local area, including arrangements to identify and review serious child safeguarding cases…..Safeguarding partners should ensure that the scrutiny is objective, acts as a constructive critical friend and promotes reflection to drive continuous improvement. The independent scrutineer should consider how effectively the arrangements are working for children and families as well as for practitioners and how well the safeguarding partners are providing strong leadership, and agree with the safeguarding partners how this will be reported."

The BHR Safeguarding Partnership is required, under Section 18 of the Children and Social Work Act, to publish 'at least once in every 12-month period' a report on its work and the effectiveness of the multi-agency safeguarding arrangements in place. There is no statutory requirement for the publication of a report specific to Redbridge, as the statutory partnership is at the BHR level. However, the RSCP's terms of reference state:

> The Chair will publish an Annual Report on the effectiveness of the arrangements for safeguarding children in Redbridge. The report will seek to provide a rigorous and transparent assessment of the performance and effectiveness of local services. It will 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 will be submitted to the BHR Safeguarding Partnership for consideration as part of the Annual Report that they are required to publish under the Children and Social Work Act 2017 on the effectiveness of the BHR arrangements.

This is that report. As stated, it covers the first year of the Partnership's work, September 2019 to September 2020. The majority of activity, financial and training data, however, relate to the twelve-month period from 1 April 2019 to 31 March 2020. Published benchmarking data where quoted relates to 2018/19, as comparative data for 2019/20 has not yet been published. The report is structured in three parts.

Part One focuses on multi-agency safeguarding in Redbridge. It will consider the demands on the multi-agency safeguarding system, the response to those demands,

and the quality of that response. It will consider the themes, concerns and challenges that the Redbridge Partnership has focused on during its first year, and the progress made against the priorities is set itself for that year. It will set out the learning from a number of practice reviews undertaken and the action taken as a result, and include a review of the 2019/20 training programme.

Part Two focuses on the multi-agency response to the challenge of effective safeguarding in the unprecedented circumstances of the coronavirus pandemic, which have dominated all attention in the second half of the year under review.

Part Three is an evaluation of the effectiveness of the statutory arrangements at the BHR level, as they have impacted in Redbridge.

Part One

1. Safeguarding in Redbridge: demand, response and performance

Safeguarding in Redbridge: need, risk, and demand

The demand on children's social care in 2019/20 was at the highest level on record. 5212 referrals were received to the service, a 19% increase over the previous year.

Referrals to Children's Social Care						
2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
4718	5175	5086	4125	4161	4540	5212

However, fewer of these referrals came from BHRUT, the main hospital group serving the borough. BHRUT made 277 referrals to Redbridge in 2019/20, compared to 349 in 2018/19 and 448 in 2017/18. Across BHRUT as a whole, there was a 16% reduction in the number of referrals to local authority children's social care services. The Trust comment in their Annual Safeguarding Children Report that "The exact reasons for this decrease cannot be explained". However, across all local authorities, it is significant that 33% of referrals made to children's social care were made as a result of concerns identified from an adult attendance, which may be taken as encouraging evidence of a 'Think Family' approach.

'Section 47 enquiries' are enquiries 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 Enquiries Completed					
2014/15	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**
676	1038	1173	1175	1263	1575

More referrals are being received, and a higher proportion of those referrals are being assessed as meeting the threshold of "reasonable cause" for suspicion that a child may be suffering from significant harm: 30% of referrals proceeded to a Section 47 investigation in 2019/20, compared to 28% in 2018/19. It is not yet clear whether there has been a comparable increase in the number of referrals and the number of Section 47 investigations across London or in England as a whole, as the comparative data has not yet been published.

However, while more referrals led to Section 47 enquiries, only 22% of those enquiries led to an initial child protection case conference. This is a continuation of a downward trend: in 2018/19 33% of enquiries led to a child protection case conference, and in

2017/18 the figure was 41%. This may indicate, as suggested in the LSCB Annual Report for 2018/19, that an increasing number of concerns which suggest that a child is at risk of significant harm are found to have their roots in poverty rather than any form of parental neglect or lack of care, which cannot be addressed through a child protection plan. It could however suggest that the threshold for "reasonable suspicion" is being set too low, and that some families are being involved unnecessarily in what is inevitably an intrusive process and may be experienced as a stigmatising one. Prompted by the data, Children's Services have reviewed the thresholds applied in deciding whether or not to initiate a Section 47 enquiry, and are satisfied that this is not the case and that thresholds are appropriate. This assurance is welcome. If the number of Section 47 enquiries continues to rise and the percentage of those enquiries leading to a child protection case conference continues to fall, though, this may merit revisiting.

In the LSCB's Annual Report for 2018/19, we said:

> "What is striking overall is that while the number of referrals has increased significantly, the numbers of children assessed to need the protection of the most intensive forms of state oversight and intervention – protection within a child protection plan framework, or compulsory public care – have fallen even more significantly."

However, this trend was reversed in 2019/20. It is likely that this reflects increased levels of assessed risk, rather than any change in professional practice.

On 31 March 2020, 316 children in Redbridge were subject to a child protection plan, compared to 249 a year earlier.

Children Subject to Child Protection (CP) Plans on 31 March					
2014/15	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**
268	349	380	298	249	316

Nationally, the number of care proceedings brought by local authorities fell in 2019/20 by 3.6%, and the number of children involved by 4.5%. However, in Redbridge the number of proceedings brought increased by 39%, and the number of children involved by 14%. The number of applications rose sharply again in the first quarter of 2020/21. 18 care proceedings were initiated by Redbridge between April and June 2020, compared to 39 in the whole of 2019/20.

It must be noted, though, that these were increases from an extremely low base. The rate of care applications per 10,000 child population in Redbridge was 3.4 in 2018/19, compared to a London average of 8.9 per 10,000.

Although the number of children subject to a plan at year end increased by 27%, the number of new plans made increased by only 7%, from 348 to 371. This may indicate

that protection plans are needing to stay in place for longer, in order to ensure that children are effectively protected.

Number of children becoming subject to a Child Protection (CP) Plan during the year							
2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
153	228	309	409	459	477	348	371

Nationally, for several years, the main category of risk under which child protection plans have been made has been neglect: 48% in 2018/19, compared to 35% made on the grounds of emotional abuse. For several years, this pattern has been reversed in Redbridge, with emotional abuse consistently accounting for the majority of plans made. The gap has however been narrowing. In 2017/18 61% of plans in Redbridge were made on the grounds of emotional abuse, and 34% on the grounds of neglect. In 2018/19, emotional abuse accounted for only 50% of plans made, with neglect the main grounds for concern in 44% of cases. In 2019/20 almost equal numbers of plans were made under each category.

The ethnic background of children subject to a child protection plan on 31 March 2019, 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 2019/20**	**As a % of children subject to a CP Plan 2018/19**	**As a % of children subject to a CP Plan 2017/18**	**As a % of the 0-17 Redbridge Population (GLA projection 2017)**
White	20%	30%	20%	22%
Mixed	14%	13%	23%	10%
Asian or Asian British	42%	40%	40%	55%
Black or Black British	20%	14%	13%	10%
Other ethnic groups	3%	2%	3%	3%
Unknown	1%	1%	1%	0%

No clear conclusions should be drawn from year on year fluctuations in this data. The over-representation in this cohort of black/black British children is more marked in 2019/20 than in previous years. Children of Asian origin or heritage are consistently less likely to be made subject to a child protection plan than children from other ethnic groups, relative to their numbers in the overall child population.

Safeguarding in Redbridge: performance, quality and outcomes

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

Indicator	Redbridge 2019/20	Redbridge 2018/19	Redbridge 2017/18	National 2018/19	Statistical Neighbours 2018/19
% of repeat referrals within 12 months	21%	17.1%	15.3%	22.6%	20.2%
% of assessments completed within 45 days	94.9%	97.3%	91%	83.1%	84.9%
% of initial child protection case conferences held within 15 days of strategy meeting	96.2%	96.9%	89.2%	78.7%	75.4%
% of child protection plans reviewed within required timescales	96%	98.2%	99%	91.8%	92%
% of children becoming subject to a second or subsequent child protection plan	9.1%	10.6%	7.4%	20.8%	19.1%
% of children whose plan ended during the year who had been on a plan for two years or more	0.3%	2.5%	3.4%	2.1%	4.4%

Several points emerge from analysis of this data.

- 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 percentage of repeat referrals to children's social care has been on an upward trend for the last two years. Comparative data has not yet been published which would indicate whether repeat referrals have also increased nationally and regionally. A high figure 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. Over the same period there has been an equally slow but upward trend in the percentage of initial contacts referred directly to early intervention services rather than referred for social work assessment - 10.5% of contacts in 2017/18, 13.1% in 2018/19, and 14.5% in 2019/20. It may be worth examining whether there is any correlation between these two trends – whether potentially diversion at the point of contact to early intervention services may marginally increase the likelihood of re-referral at a later date, and if so, whether the criteria and threshold for diversion should be reviewed.
- The percentage of children becoming subject to a child protection plan for a second or subsequent time has reduced. It is consistently well below both statistical neighbour and national averages, but it is still higher than it was two years ago. 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 so great caution should be exercised in commenting on year by year data. However, it is important to be aware of the dangers of a 'revolving door', in and out and in again, in the child protection system. Previous work undertaken by the LSCB has highlighted that this is a particular risk for children who are made subject to child protection plans on the grounds of neglect.
- It is clear from data on the percentage of plans ended during the year which had been in place for two years or more that virtually no child protection plans last for more than two years – and indeed the great majority are in place for significantly less time than that. Plans will end either because the children are no longer judged to be at risk of significant harm, or because unresolved concerns are escalated into legal proceedings. The data appears to suggest that there is a strong focus on the effective review of plans and on ensuring that they do not last any longer than necessary.

Inspection evidence

No inspection of children's social care services in Redbridge took place in the period covered by this report. The services were judged by Ofsted to be outstanding in an inspection carried out in April and May 2019. There was no locally relevant inspection activity carried out by the Criminal Justice Inspectorates.

As part of a wider inspection of BHRUT, services for children and young people at King George Hospital were inspected by the Care Quality Commission (CQC) in September and October 2019. The overall judgement on the service, as of the Trust overall, remained as "Requires Improvement". Services for children and young were judged as "good" in the domains of "caring" and "well led", and as "requires improvement" in those relating to safety, effectiveness and responsiveness. However, inspectors commented that "Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it."

Maternity services at Whipps Cross Hospital, part of Barts NHS Health Trust, were inspected in October 2019. The service was judged to be "good" in all domains. Inspectors found that "The trust had clearly defined and embedded processes to keep people safe from abuse and staff demonstrated understanding of safeguarding processes and awareness on how to escalate and report safeguarding concerns." They also noted that in February 2019 the FGM Team had achieved the first court conviction in the UK for female genital mutilation, and had won a national award.

There were no other inspections of NHS providers with a relevant focus on children's safeguarding in the period covered by this report.

2. Learning and Improvement: learning from practice

Due to budget restrictions, the post of Partnership Quality Assurance Manager has remained vacant since February 2019. It has not therefore been possible to deliver the multi-agency audit programme which was one of the strengths of the predecessor LSCB. The BHR Safeguarding Partnership agreed in January 2020 an ambitious framework for a BHR-wide quality assurance programme, and the first multi-agency audit across the tri-borough footprint on the theme of domestic violence was due to take place in March. This was postponed due to the coronavirus pandemic and is expected to be rescheduled for autumn 2020.

Nevertheless, the Redbridge Partnership has conducted a number or reviews during the period covered by this report which have given important opportunities to learn from practice.

Serious Case Review – Baby T

The report of this review, which had been initiated by the LSCB, was published in January 2020.

Baby T died at the age of 11 months in October 2017 after sustaining a head injury. Her mother was a Vietnamese asylum seeker. She arrived in the UK in October 2015 and was initially staying in Hackney. She lodged a claim for asylum in June 2016 when she was four months pregnant. She was placed by the Home Office at four different temporary addresses in Croydon and in Cardiff while her asylum claim was considered before being allocated a longer-term placement in Redbridge in January 2017. On the day Baby T died, she became unwell while being illegally childminded by another Vietnamese woman, who had also applied for leave to remain in the UK and lived in Barking and Dagenham. The childminder was convicted of the manslaughter of Baby T in July 2019 and sentenced to six years imprisonment the following month.

The review focused on the experiences of mother and child through the UK asylum system, and the degree to which practitioners and agencies appreciated and sought to mitigate the potential risks to the baby as the infant child of an asylum seeker who had mental health issues, who was isolated, had limited access to resources, and was liable to be moved at short notice from one part of the country to another. It painted a graphic and detailed picture of those experiences. It found that the Home Office lost sight of Baby T and her mother for ten out of the eleven months of the baby's life, and was not able to fully meet its statutory obligation to carry out its functions in a way that takes into account the need to safeguard and promote the welfare of children in the UK. The review detailed many examples where agencies that came into contact with mother and baby made considerable efforts to help and support her, in ways that were, in the words used by the independent reviewer to describe one particular incident, "resourceful, caring and kind". It also however identified a pattern in which agencies would touch their lives for a brief period but were unable to sustain ongoing

involvement in a way that fully met mother's needs for support and fully took account of Baby T's potential vulnerability. In Redbridge, the Early Intervention and Family Support Service (now restructured as the Families Together Hub) were engaged with Baby T and her mother between February and May 2017. However, the review found that the case was closed prematurely, with several tasks identified in the initial assessment still outstanding and without considering the concerns about mother's mental health that had arisen by the time the case was closed. The plan was for the case to remain open to the Children's Centre who had been providing mother with some support. However, the case was then "inexplicably", in the words of the review, closed by the Children's Centre shortly afterwards. In her contribution to the review, mother described this as the "disappearance" of support. She said that when she arrived in Redbridge, she and her baby received support for a time but then it had ended without notice of explanation.

The review recommended that the Families Together service should review its arrangements for case closure, to ensure that cases are not closed without confirmation that all planned actions have been carried out and wherever possible planned outcomes have been achieved. This recommendation has been effectively implemented. Many of the review's recommendations, however, were directed at the Home Office. These included recommendations that:

- the Home Office should take proactive steps to ensure that pregnant asylum seekers and asylum seekers with young children are referred to local primary care services at the point of first contact;
- that they provide assurance that new guidance which the review had been assured been put in place had had the desired effect in preventing the absence of oversight in cases such as that of mother and Baby T;
- that asylum-seeking mothers and their baby should not be moved before the child is eight weeks old or the relevant clinician confirms that essential core postnatal care has been completed, whichever is the longer;
- that the Home Office should consider ruling out the temporary 'dispersals' of asylum-seeking mothers and very young children;
- that they should ensure that they have robust mechanisms in place to ensure that providers of asylum support accommodation fulfil their contractual obligations to ensure pregnant asylum seekers and asylum seekers with young children access primary care without delay, accompanying them where this is stipulated in the contract;
- and that the Home Office publicise information about their safeguarding role and arrangements and how local health and social care practitioners can best engage with those Home Office safeguarding services.

As former Chair of the LSCB, which had published the Serious Case review, I wrote to the relevant Director General in the Home Office to ask for a response to these

recommendations on 11 February. Disappointingly, I have not received a reply. This has been escalated to the statutory partners in the BHR Safeguarding Partnership.

The review also recommended that the Government should introduce legislation which would require the Home Office to inform a local authority of the details of any child placed or dispersed to their area with an asylum seeker parent or parents. Currently, highly vulnerable children can be placed by a state agency in a particular area and there is no guarantee that the agency with the lead responsibility for safeguarding and promoting the welfare of children – local authority children's social care services – will even know of their existence. I wrote to the responsible Minister on this recommendation, also on 11 February. The Minister replied on 2 March.

> "While there are no plans to legislate in this area, I understand that officials in the Home Office have been engaging with local authorities on how to ensure they are better informed about asylum seekers in their areas. As a result, the Home Office is currently developing a data sharing pilot which will provide local authorities with details of asylum seeker arrivals."

The remainder of the review's recommendations were directed at the statutory safeguarding partners in the BHR Partnership, concerning issues which were felt to require attention across the area of all three boroughs represented in the Partnership: in particular, the need for an urgent strategy for improving the availability of effective interpreting services across the BHR footprint – the lack of which was a significant limiting factor in making an accurate assessment of the family's support needs, and in meeting those needs; and the need to consult with local housing providers about ways to reduce the risks associated with the placing of asylum seekers with dependent children in the area. These recommendations are currently being considered.

Adolescent suicides

During the year the Partnership completed two reviews of the cases of young people who tragically committed suicide, seeking to identify what could be learned from these sad events to improve practice and multi-agency working in the future. One was a Learning Review, originally commissioned by the LSCB, which concerned the unrelated deaths of two young people, one aged 15 and one aged 17, from an Eastern European community within the borough. Neither case was judged to meet the statutory criteria in force at that time for a Serious Case Review, but the Board agreed that it would be very helpful for agencies to come together to review these cases to identify any lessons that might be learned from it to improve future practice. The other case, of a young man aged 15 of Pakistani heritage, was reviewed under the Rapid Review process prescribed in Working Together to Safeguard Children 2018, following the notification to the national Child Safeguarding Practice Review Panel by the local authority of an incident involving the death of or serious harm to a child where there is any suspicion of abuse or neglect.

In none of the cases reviewed was there any evidence that the deaths of the young people could have been foreseen or prevented. The young people concerned were expressing positive feelings about their situations and their futures in the days before their deaths, However, there were significant lessons to be learned. Both young people whose deaths were considered in the Internal Learning Review had spent the first years of their lives in Eastern Europe, and had come to the UK later to join a parent who was already in this country. The review did not feel that the agencies involved in the lives of these young people had always fully explored the impact of disruption, attachment difficulties, and trauma on the lived experience of these young people, their emotional difficulties, and their behaviour. The need for sustained professional curiosity and increased cultural competence in such situations is consistently reinforced through a number of courses in the RSCP Training Programme, including Safeguarding Refugee and Vulnerable Migrant Children and Working with Race, Culture and Belief Systems in the Context of Professional Curiosity. There were also issues raised in both cases about the appropriate sharing of information between professionals, either because of questions of clinical confidentiality or because of lack of "join up" between different services working with the same young person. Some of these issues are being addressed through joint training. However, there was also some significant good practice in both cases. In both cases there were support services involved with the young people and they were engaging with the support offered.

Working Together requires that, once a serious incident has been notified to the Child Safeguarding Practice Review Panel, the "safeguarding partners" (the local authority, the police, and the Clinical Commissioning Group) must complete a rapid review of the case and report the outcome to the Panel. The target is to report to the Panel within fifteen working days of the incident notification, although the Panel have acknowledged to all partnerships that they accept that the demands of the coronavirus pandemic mean that this target is unlikely to be met. The purpose of the rapid review is "to enable the safeguarding partners to:

- gather the facts about the case, as far as they can be readily established at the time
- discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately
- consider the potential for identifying improvements to safeguard and promote the welfare of children
- decide what steps they should take next, including whether or not to undertake a child safeguarding practice review"

The review undertaken during the period covered by this report was the first one carried out by Redbridge under these provisions. All the agencies who had been involved with the young person or his family at any point responded promptly and fully to the request for information and, following a multi-agency meeting to review

and analyse all the information received, a report was submitted to the National Panel, 20 working days after the incident notification.

The review did not recommend that a full Child Safeguarding Practice Review should be undertaken. It did not consider that a further review would add value, or be of benefit to a grieving family. The Panel agreed with this conclusion. The review did however identify learning points for local agencies. Most centrally, it found that while in the weeks before the young person's death four different services had been involved in supporting him – his school, children's social care, child and adolescent mental health services, and the GP - they had worked in isolation from each other. Apart from sending and receiving referrals, they did not appear to have spoken to each other at any point. The sense of a "team around the child" was lacking. In particular, the role and contribution of the school, who knew the young person and his family best and were a vital part of his support network, even during lockdown, seemed to have been undervalued. However, the review was clear that the young person's death was neither predictable or preventable, and that no different action by any agency involved would have led to a different outcome. In their report to the Panel, the safeguarding partners committed to a range of actions to address the learning that had arisen from the review, and reported a number of steps that had already been taken, in particular to strengthen the joint working between children's social care and specialist mental health services. The partners also committed to establishing a task and finish group, reporting to them as the statutory partners, to ensure that all actions were followed through.

The case also highlighted an issue of national relevance. At the point that the school was closed for most children, the young person concerned did not meet the definition in national guidance of a "vulnerable child", as he did not have a social worker (a referral to social care was in process) or an Education Health and Care Plan as a child with special needs. He was not therefore eligible for the opportunity to continue to attend school during the lockdown. There were however at this point compelling reasons to regard him as vulnerable in any commonly accepted sense of the word. The review recommended that Government should review the guidance in the event of any further period of school closures with a view to a more flexible definition of "vulnerability". The Panel agreed to raise this with the Department of Education.

The rapid review process does not include involvement with the family, to engage with their views and experiences, as would a Child Safeguarding Practice Review, and this may be considered a significant weakness. The review report has however been shared with the family.

The review of cases under Working Together to Safeguard Children 2018

The provisions in legislation and statutory guidance concerning the notification of serious incidents, rapid reviews, and Child Safeguarding Practice Reviews have been

in force since July 2018. In their first Annual Report, covering the period July 2018 to July 2019, the Child Safeguarding Practice Review Panel noted that, while they received 473 serious incident notifications during that period, 15 out of 152 local authority areas had made no notifications. They commented:

> "In those 15 local areas there are over 30,000 Children in Need and over 5,000 Looked After Children. From this cohort it is unlikely there were no incidents which would meet the criteria for notification. Safeguarding partners should regularly refresh their understanding of the criteria for notification."

During that first year, Redbridge was one of those 15 areas. However, the local authority submitted its first notification, of the death of the young person which is discussed above, in mid-June 2020, almost two years after the provisions came into force. The responsibility for notifying a serious incident sits with the local authority, rather than the three safeguarding partners jointly. It should not be deduced from the foregoing comments that there is any reason to suppose that there were between July 2018 and the time of writing any incidents in Redbridge that should have been notified and were not. However, it would be useful to review the systems and processes in place to identify serious incidents that should be notified, to give assurance that none are being missed.

There is clearly variation in practice across local authorities. The Panel's first Annual Report highlights, for example, that in the twelve month most authorities made between three and six notifications, whereas there were four local authorities which between them made 42. There is particular variation on the question of whether incidents should be notified if there has been no history of agency involvement with the family. In April 2020 two small children were murdered in Redbridge, with the prime suspect being their father who then apparently tried to kill himself. The family were not known to social care and there appeared to be no record of any concerns on the part of health or any other services. As independent scrutineer, my view was that this should be notified as a serious incident, on the basis that if the children had been murdered within the family this appeared to me by definition to constitute abuse. The local authority, however, took the view that the murder did not constitute 'abuse' in the sense intended by statutory guidance, and the logical outcome of treating it as such would mean that all murders of children or occasions of criminal harm to children would require a rapid review. A rapid review would add no value as the family were either unknown or not of concern to any relevant agency. Ofsted queried why a serious incident had not been notified but after discussion accepted this position. I felt that a rapid review would ensure that all information known about the family was fully considered, and would give formal assurance if it were indeed the case that there was no previous knowledge or any way of anticipating an episode of such violence in the family. This example highlights ambiguity in current statutory guidance.

The children's father has subsequently pleaded guilty to the manslaughter of the children by reason of diminished responsibility. He has not at the time of writing been sentenced.

3. Learning and Improvement: learning from children, young people and families

Finding effective ways of hearing and acting on the voice of children and young people has been a preoccupation of the RSCP since its inception, as it was for the LSCB.

At the RSCP's first meeting, in October 2019, young people from the Redbridge Youth Council presented and led a discussion on the Youth Council's priorities, work, and action plan for the year. In 2019, almost 10000 young people in Redbridge voted on their "top priorities for action" in the annual Make Your Mark ballot organised by the British Youth Council. Their top three priorities were protecting the environment, tackling hate crime, and ending street harassment. Ending knife crime and promoting young people's mental health, which had been top of the list in 2018, had a lower profile as issues for young people in Redbridge. (It is perhaps though likely that concern about mental health will have risen again in 2020 during the coronavirus pandemic.) However, ending knife crime featured again in the top three priorities for young people in London as a whole, and across the UK. Youth Council members described vividly some of the complexities involved in tackling knife crime. They emphasised that what young people most fear is the sense of unpredictability – anybody could be carrying a knife, knife attacks can happen at random, it is increasingly difficult for teachers to know who is carrying a knife as they can easily be made, for example, to look like pens. Installation of knife arches or metal detectors in schools can simply lead to students throwing knives into the bushes on the way into school and picking them up again when they come out. The young people felt that what they saw as the zero tolerance of knife carrying in schools, with automatic expulsion if found to be carrying a knife, had unintended consequences. It could make it harder to reach out to those young people who carried knives out of fear rather than violent intent. They felt strongly that a long-term strategy for ending knife crime must concentrate intensively on the education of younger children.

Redbridge young people elect two members to the UK Youth Parliament, who pursue specific campaigns based on their election manifestos. The MYPs in 2019 campaigned on body image issues for young people and on period poverty. The Government had committed to providing funding for free sanitary products in all English secondary schools and colleges; but delivery remained patchy. Meanwhile, research suggested that one in ten young women aged between 14 and 21 have been unable to afford sanitary wear. Following the meeting, the Partnership wrote to all secondary schools and colleges in Redbridge to highlight this issue and to encourage them to do everything they could to help tackle period poverty.

The RSCP devoted half of its meeting in January 2020 to a special session, "Telling it like it is – young people's experience of the system". This was an opportunity to hear from three young people who attend Redbridge Alternative Provision – the borough's

pupil referral unit – who spoke from their experience about what it's really like as a young person getting involved with the multi-agency safeguarding system. They spoke warmly about some of the positive experiences and relationships they have had, but they were also very challenging. They spoke about how frustrating it is when professionals seem to think they know all about them before they've even met – 'people just make assumptions about you because they've read the file'. They spoke about how 'assessment' can feel like it's just working through the boxes that need to be ticked. Over and over again they emphasised the importance of building up trust – 'the more time you spend with someone, the more you trust them'. And they were very straight about how clumsy professionals can occasionally be when they're trying to develop a relationship. Perhaps most direct was the answer one young person gave to the question, 'Where do you feel safe?' – 'We don't feel safe anywhere.' While it was clear that professionals need to do more to help young people to understand the system, the real challenge that came out of the session was asking us to think about ways in which we might need to change the system. Senior managers from both children's social care and EWMHS (emotional wellbeing and mental health services for young people) committed to following up the issues raised through further discussion with the young people at RAP. This has been difficult to progress due to the disruption caused by the coronavirus pandemic, but the Partnership reaffirmed at its July meeting its determination to pick up those discussions in 2020/21, and not to lose sight of the learning from an immensely valuable and powerful session.

The July 2020 meeting of the Partnership received a report of a survey of young people's experiences and concerns during lockdown, led by the Youth Council and supported by the CCG. 915 children and young people, aged from 8 to 18, responded to the survey. Some of the key messages and findings were:

- Lockdown had a significant impact on the mental health of young people. A quarter of young people stated that they are feeling down and a slightly higher number said that mental health is something that they have been worried about during lockdown. Those suffering with anxiety, depression and stress commented that lockdown had compounded their issues further, particularly young people who have been unable to speak to or see their therapists and counsellors
- More and more young people began to experience mental health issues for the first time, as a result of being in lockdown. Being unable to see their friends and family, do things they enjoy, worrying about becoming infected and struggling to study on their own all had an effect and contributed to issues around stress, feeling depressed and unmotivated.
- The long-term impact of the prolonged time out of school was a huge concern for young people, in particular those in Year 10 and above. They worried that there will be too much to catch up on in too little time. Education was one of the biggest concerns for young people both during and after lockdown

- Too much schoolwork was also a factor causing young people to have a difficult time during lockdown. Many young people felt that their schools were giving them too much schoolwork and that the support was not always in place to help them understand and complete the work assigned to them. Furthermore, many young people did not have the resources to do schoolwork, with textbooks and other learning material left at school with no way to access them

There were however also some positive findings.

- Young people appreciated the time they had been able to spend with their families. They had found themselves becoming closer with their parents and, in particular, their siblings.
- They were also appreciative that lockdown had allowed them to work at their own pace, which many felt had helped them with their schoolwork, and to spend time on bettering themselves, including developing new skills, meditation and reconnecting with their faith.

The clear message was that there needed to be support in place to help young people cope as they began to transition back into school, with careful attention to individual needs and experiences. Respondents were keen for reassurance that schools should be safe to return to, and that they would be rushed back without the necessary safety precautions in place.

The RSCP has had less input during the year on the views and experiences of families engaged with the multi-agency safeguarding system. Complaints can be an important source of this feedback. However, very few complaints were received during the period covered by this report. Learning from complaints can also lead to important changes in practice. One complainant objected to the involvement in decision making at an initial child protection case conference of a social worker from the Community Social Work Team, which had had no direct involvement with the family but which would be responsible for implementing a child protection plan if one were to be agreed. As a result of this complaint, it was agreed that in future the Case Conference Chair would invite contributions from the Community Social Work Team representative at the protection planning stage, given that they would be responsible for its implementation. However, the CSW Team representative would not be asked for their views on decision making and recommendations on the need for a child protection plan, as they did not know the children or the family. This is a positive example of a system being open to change as a result of a complaint.

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

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

Early Help

If professionals and services can identify early signs of difficulties within families and mobilise effective, co-ordinated support at the right time, it is likely that in many cases the problems can be stopped from escalating. Effective early help is thus key to the effective safeguarding of children. Redbridge has invested substantially in early help services over a number of years. In their report on the inspection of children's services that took place in April/May 2019, Ofsted described the Council's early help service as "a flexible, multi-skilled service that is highly successful in providing a preventative service for children with the highest levels of need…. a highly successful service [which] prevents children from becoming looked after unnecessarily and protects children from some of the highest risks" and "offers a proactive and empowering model for families".

The local authority early help offer is delivered through the Families Together Hub (formerly the Early Intervention and Family Support Service - EIFSS). Early help is also delivered by partner organisations and universal services, in particular through the use of the Common Assessment Framework (CAF). This is a shared assessment and planning process which professionals in any agency can use to facilitate the early identification of children and young people's additional needs. The assessment supports relevant agencies coming together in a Team around the Child (TAC), with a named 'lead agency'. The number of completed CAF assessments increased by 39% in 2019/20, from 1234 to 1771. This continues a year on year trend: in 2017/18 867 completed CAF assessments were recorded.

Redbridge Children's Centres are another important element of the partnership early help offer. The number of families and children accessing the service however fell in 2019/20. The service was required to make substantial savings as an outcome of the Council's budget process, and implementation of service changes to deliver the savings required began in September 2019. Take up of Children's Centre services was also affected by the outbreak of the Covid 19 pandemic towards the end of the financial year. There was a 21% reduction in the number of families accessing targeted Children Centre support in 2019/20 compared to the previous year. The number of families using "open access" Children's Centre services fell by over 25%.

The Families Together Hub brings together a range of social care and family support services with commissioned services from voluntary sector organisations supporting children and young people living with domestic violence and other issues. It has strong links with employment and other community services. The service includes specialist

workers supporting families with children with disabilities, and staff working with families with no recourse to public funds facing homelessness. The aim is to deliver co-ordinated, targeted, and where necessary intensive early intervention, based wherever possible on the principle of "one family, one worker, one plan". A Parenting Team delivers a broad range of accredited and non-accredited evidence-based parenting programmes, with additional bespoke support provided to families where required. In 2019/20 424 parents took part in these programmes, between them responsible for over 800 children – a 37% increase on 2018/19.

The service continued to innovate, expand and evolve during 2019/20. The Junior Family Intervention Team was launched in April 2019. The team works with younger children to reduce the risk of their becoming drawn into gang and serious youth crime. Interventions are tailored to meet the specific needs of the child with the emphasis on encouraging them to engage in a diversionary activity. There were 200 referrals to the team in 2019/20. The team has also partnered with Box Up Crime, which uses boxing as a medium to engage young people and deter them from crime and gang affiliation. The model is innovative, making use of pop up gyms in community facilities such as schools and halls rather than relying on traditional boxing gyms.

Another innovation launched during the year was the Phoenix Project, a partnership with Barnardos aimed at creating systemic changes within families experiencing domestic abuse, addressing the impact on the mental health and wellbeing of children in the family. The project worked with 15 families between September 2019 and March 2020. The service also began work with EWMHS to develop a collaborative early intervention approach to meeting the emotional and wellbeing needs of young people in Redbridge. Four Family Support Workers will be trained to an appropriate level in cognitive behavioural therapy to work with depression and anxiety in adolescents.

The range of early intervention services in Redbridge is impressive, and the emphasis in many areas of the service on evidence-based practice equally so. The service has continued to successfully prioritise increasing the access of families and children to early intervention. It is important in pursuing this aim to ensure that the threshold for diversion to early intervention services, rather than a contact proceeding as a referral for a full social work assessment, is clear and consistently applied. According to the service database, the number of cases diverted from the Child Protection and Assessment Service to the Families Together Hub increased in 2019/20 by almost 60%. The two services work very closely together to agree appropriate diversion, through, for example, a daily triage meeting. It will be very important, however, to continue to monitor very closely the level of diversion, to make sure that complex or high-risk cases are responded to at the appropriate level.

Help for young people experiencing mental health difficulties

After several years of extreme concern about serious deficiencies in the services available for young people experiencing mental health difficulties, the LSCB Annual

Report for 2018/19 was able to report significant improvements in the service, relaunched in June 2018 as the Emotional Health and Wellbeing Service; and, importantly, that the reported improvements were validated by the experience of partners, particularly schools. The RSCP received an update report at its first meeting, in January 2020, which confirmed that in many respects those improvements had been sustained. The number of referrals had steadily increased throughout the year – up by 27% between April 2019 and January 2020 – with a particular increase in the number of self-referrals, ascribed to the enhancement of the service's online offer. All referrals were triaged within 24 hours of receipt, with an initial telephone assessment by a clinician within two weeks. There had been significant developments in partnership working: the service was providing regular supervision and consultation to parenting workers in the Families Together Hub and the local authority Family Intervention Team, supporting the pathway from parenting support to specialist interventions. All 74 Redbridge schools were offered a monthly consultation with their allocated STAR (Support Time and Recovery) worker. Overall, the RSCP welcomed assurance that the EWMHS had developed to the point where it was delivering a partnership focused and accessible service in a very different way to the previous CAMHS arrangements.

However, the service continued to struggle to achieve the national target of reaching 35% of the estimated number of young people in the community experiencing mental health difficulties. In January 2020, services were achieving 28% penetration. Funding for the service was still not at the level recommended in the 2017 Fundamental Service Review, and recruitment remained difficult in the face of national skill shortages in child and adolescent mental health services. In January 2020, the EWMHS had 9.6 whole time equivalent staff vacancies against an establishment of 19.3 WTE, of which 5 WTE were covered by agency staff. Although agreement to additional funding had by September 2020 led to an increase in the number established posts, vacancy levels remained high. There were 10.2 vacancies against 25.8 clinical posts, with 5.9 of them covered by locums. In 2019/20, the average waiting time from referral to treatment increased from 11.6 to 12.6 weeks.

The length of time many children and young people presenting with mental health problems wait in A&E at BHRUT is a major concern. An audit presented to the RSCP in July 2020 reported that children presenting out of hours almost invariably wait for 12 hours or more for CAMHS assessment, as there is no on-call service. Children who need admission to a paediatric psychiatric unit also experience long delays and long waits in A&E for a bed to be available. The audit found that these children stay in A&E for up to 72 hours. These young people are often extremely distressed and behave in very challenging ways. Admission to a children's ward would be inappropriate, but small paediatric A&E Department is a grossly unsuitable environment for them to wait in.

Improving the quality of referrals to children's social care

The RSCP has supported ongoing work to improve the quality and timeliness of referrals to children's social care. Following a report to the then LSCB in May 2019, the RSCP considered an update on progress in October. There had been some improvements following the activity and action taken prompted by the May report, but the improvement had not been consistently sustained. The RSCP Business Manager has continued to work with the MASH Manager, Designated Safeguarding Leads in schools, named professionals in health settings, and others, to emphasise the importance of timely referrals with clear information about the concerns being raised, and to support feedback to and quality assurance in partner agencies.

In January 2020 I wrote to the Home Office to raise a concern about the timeliness and quality of safeguarding referrals received from asylum and immigration officials. Redbridge had received a referral in late December about an injury that had been noted three months earlier. The referral contained no information about, for example, family composition. I suggested that it would be helpful if the Home Office could develop a simple referral form which would ensure all essential information was captured. A follow up conversation was scheduled, but did not take place due to the disruption caused by the coronavirus pandemic. This issue is currently being pursued again.

Exploitation

Improving the protection and support of children who are sexually exploited, and strengthening our work in identifying, disrupting and prosecuting child sexual exploitation, has been a priority for the multi-agency partnership in Redbridge for several years. Building on this work, the RSCP has had a strong focus in 2019/20 on tackling the exploitation of children and young people in all its forms. Different patterns of exploitation are often interrelated and often affect the same young people. The coercion or enticement of young people into criminal activity, and involvement in the hugely lucrative county lines business, is a clear form of exploitation. Pulling young people into involvement with gangs, very frequently associated with both sexual and criminal exploitation and the risk of involvement in violence, is highly exploitative. Modern slavery and trafficking – increasingly seen as the framework within which for example the control of young people in county lines should be understood and prosecuted – has been increasingly highlighted since the passing of the Modern Slavery Act in 2015.

In October 2019 a number of what had previously been different groups and panels dealing with different forms of exploitation were brought together into a single Multi-Agency Sexual and Criminal Exploitation Panel (MASCE). At both operational and strategic meetings information is shared to ensure co-ordinated action in relation to individual cases of concern, networks, hotspot locations, and emerging patterns of exploitation. A Mapping Exploitation Tool is being developed which when complete will

make available a dynamic and "real time" problem profile of child exploitation in the borough: who are the young people, who is connected to who, where they live and where they go to school, where are they being recruited and exploited. The project has been considerably delayed by staffing changes and other factors, and most recently by the impact of the coronavirus pandemic, but its completion remains a high priority for the partnership.

170 contacts about individual young people, raising concerns about possible sexual exploitation, were received by children's social care in 2019/20 – virtually the same number as the previous year. 36% of contacts (62) led to a referral to children's social care; and of those, 42 resulted in a child and family social work assessment. 25 multi-agency strategy meetings were held on young people believed to be experiencing sexual exploitation. The Pan-London Child Protection Procedures are clear that "Child sexual exploitation is sexual abuse and child protection procedures should be followed when there are concerns that a child is at risk of CSE or is already the victim of CSE". On the face of it, one might expect 170 contacts concerning child sexual exploitation to have resulted in rather more than 42 social work assessments and 25 strategy meetings. The RSCP has been assured however that having examined a large sample of cases that did not proceed beyond initial contact, managers are satisfied that all cases are rigorously examined and have been appropriately responded to. A number of the contacts related to children looked after placed in Redbridge by other local authorities, who would have undertaken any social work assessment required.

The characteristics of the young people concerned in contacts received by social care, and the form of sexual exploitation suspected, were very similar to those seen in previous years – the great majority were girls, mainly aged between 10 and 15, and believed to be at risk of exploitation through inappropriate relationships with an older person or through online exploitation. Younger children are also at risk. One nine year old, one eleven year old, and four thirteen year olds were the subject of CSE strategy meetings. Parental drug use, family conflict, and domestic abuse, singly or in combination, were characteristics of about half of the cases which were the subject of a strategy meeting. A third of the young people were known to be associated with gangs, and about a quarter were associated with other young people vulnerable to or experiencing sexual exploitation. The majority of the young people concerned lived at home. Overall, however, the recording of information from strategy meetings is not yet consistent or systematic enough to enable a full picture of child sexual exploitation to be developed applying the VOLT (victim – offender – location – themes) framework recommended in the 2017 London Child Sexual Exploitation Operating Protocol.

In contrast with the stable numbers of contacts received by children's social care raising concerns about child sexual exploitation, the number of contacts concerning gang affiliation has more than doubled: 304 contacts in 2019/20, compared with 131 in 2018/19. (Although the great majority of these contacts concerned young men, it

must be remembered, of course, that for young women gang affiliation and sexual exploitation are often highly correlated.) Again in contrast with the data on outcomes for contacts concerning child sexual exploitation, over 50% of contacts concerning gang affiliation led to a social care referral, and 100% of referrals led to a social care assessment. In relation to criminal exploitation, no data was recorded in 2018/19 to allow comparison with 2019/20. 315 contacts were received in 2019/20 concerning the criminal exploitation of children. 45% of those contacts led to a referral to children's social care, and 92% of those referrals led to a social care assessment.

The police were the main source of referrals for exploitation of all kinds, followed by schools. It is clear that awareness of the risks associated with criminal exploitation and with gang affiliation has increased very significantly over the past year in these agencies, overwhelmingly in relation to young men. Other agencies, including hospitals and community NHS services, made few referrals. Although services are confident that the focus on sexual exploitation has not diminished, it will be important to continue to ensure that this form of exploitation continues to be in the forefront of professional awareness. The Joint Targeted Area Inspection report on the multi-agency response to child sexual abuse in the family environment, published in February 2020, suggested that the concentration over the last few years on understanding and responding to child sexual exploitation may have led to some loss of focus on and confidence in responding to intra-familial sexual abuse. As, for example, the criminal exploitation of young people and in particular of young men has a vastly higher profile than it did some years ago, we must make sure that we do not have a similar loss of focus on the sexual exploitation of young people, and overwhelmingly of young women.

The Rescue and Response Project, funded by the London Crime Prevention Fund for three years from 2018, has three functions: direct casework with young people engaged with county lines, including an out of hours services to collect young people who have been arrested outside London for drug dealing offences; intelligence development to use available data to develop an accurate picture of county lines activity emanating from London; and a training offer. In 2019/20 their data analysis identified 109 individuals from Redbridge with links to county lines activity, and a further 9 with suspected links. This is an increase from the 99 with identified or suspected links identified between January 2018 and March 2019. 27 (26%) of the 118 individuals identified in 2019/20 were referred to the Rescue and Response Service. If young people are not linked up with intervention services at the point of arrest which may also be a point of crisis, then what the Serious Case Review published by Waltham Forest LSCB in May 2020 on Child C (a 14 year old murdered in January 2019 by being deliberately knocked off his moped and repeatedly stabbed), and others, have described as "reachable moments" may be missed. Individuals from Redbridge county lines cohorts have been linked to 18 counties, with the top ten being Avon and Somerset, Hampshire, Cambridgeshire, Essex, Norfolk, Kent,

Northamptonshire, Wiltshire, Devon and Cornwall and Dorset. The top 10 towns affected by county lines activity (based on available intelligence) are Weston-Super-Mare, Cambridge, Northampton, Southampton, Southend on Sea, Aylesbury, Basingstoke, Bedford, Benfleet and Castle Point.

The Junior FIT team within the Families Together Hub, launched in April 2019, works with younger children at risk of being drawn into gangs or criminal exploitation. A team of one senior practitioner, 4 Junior FIT workers and 2 sessional workers provide support to young people and their families. Interventions are tailored to meet the specific needs of a child with the emphasis on encouraging them to engage in a diversionary activity. There is a strong partnership with Box Up Crime.

The Family Intervention Team within the community social work service includes social workers, youth workers, family support workers, and staff from voluntary sector agencies. The team work with young people aged between 11 and 17 affected by sexual exploitation, drug misuse, criminal exploitation or gang membership. While other social work teams will also be working with exploited children, the FIT has developed as a centre of expertise, and a range of other specialist services are co-ordinated through the team, including a recently recommissioned voluntary sector for young people involved with gangs and two Barnardos services, one working with young people exhibiting harmful sexual behaviour and one with young people who have been sexually abused. Redbridge is working with Family Psychology Mutual to deliver a Functional Family Therapy approach to working with young people at risk of gang exploitation. FFT is a licensed, evidence-based intervention developed in the USA and now being piloted in Redbridge and one other site in the UK. Delivery and evaluation of the project is funded by the Youth Endowment Fund: the project employs three practitioners and a manager, co-located with the FIT.

In March 2020 the national Child safeguarding Practice Review Panel published a thematic review of work with children at risk from criminal exploitation – "it was hard to escape". The report concluded by identifying "a series of questions and challenges in four key areas that we believe every partnership should be working on and be able to answer." The four key areas, under which those twenty-one questions are set out, are: problem identification; supporting your staff; service design and practice development; and quality assurance. As one of its priorities for 2020/21, the RSCP has committed to a multi-agency self-assessment which will answer those questions and meet those challenges.

Transitional safeguarding

Addressing the challenge what has become known as 'transitional safeguarding' – a concern about vulnerable young people who become vulnerable adults and potentially fall through the gaps between two safeguarding systems – is a priority for both the RSCP and the Safeguarding Adults Board. A joint project has been established to develop proposals for an effective response to the needs of young adults at risk of

exploitation or with other vulnerabilities, recognising that adolescence as a developmental phase does not suddenly end on the eighteenth birthday. This work is being co-led by two Heads of Service, one from Children's Services and one from Adult Social Services. Following a workshop for practitioners across children's and adult social care, terms of reference were drawn up for the project, and a multi-agency task and finish group established to take the project forward. However, demands of the coronavirus crisis which erupted in March 2020 have prevented this work from going forward. It remains a priority for both the SAB and the RSCP for 2020/21.

Children going missing from home and care

Previous LSCB 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; the development of a multi-agency Missing Children's Panel, which considers and progresses plans for persistently missing young people with the most complex needs; the offer of time-limited bespoke packages of 1:1 work with children with a pattern of repeated missing episodes.

There has been a steady reduction in the numbers of young people in Redbridge's care who go missing since 2016/17, when 60 young people had at least one missing episode. In 2019/20 43 young people in Redbridge's care were reported as missing at least once, down from 54 in 2018/19. However, the average number of times each young person was reported missing went up, again continuing a year on year trend, from 8.2 to 9.7. This average, however, conceals very wide variation. 70% of missing from care episodes were for one day or less. Conversely, 11% were for five days or more. One young person went missing 69 times during the year – accounting for over 15% of the total number of missing episodes. 75% of young people who go missing from care are aged 15 or over. 60% of young people recorded missing are boys. However, the Missing Children's Team have identified an increase in the number of young women involved with gangs and county lines activity. As in previous years, young people who go missing repeatedly appear to fall into two broad categories. The first are children who are going missing to return to their homes or other relatives. The second are children who are being exposed to gangs and groomed for sexual or criminal exploitation.

168 young people were reported to the police as missing from home at least once in 2019/20, a slight increase from 163 the year before. Again, the numbers of young people going missing from home have been on a downward trend since 2016/17, when 218 were reported missing at least once. The profile of young people who go missing from home is very different from those who go missing from care:

- The average number of times young people went missing was 1.74, up from 1.63 in 2018/19
- Younger children are more likely to go missing from home than they are from care. Only 61% of the young people who went missing from home were 15 or over. 35% were aged 13 or 14.
- 55% of the young people who went missing from home were girls

Generally, most children who go missing from home are running away, albeit temporarily, from arguments or difficulties at home. For most children who go missing from care, they are running to something – generally family or friends – rather than away from something. However, it is very clear that going missing from home or care is also highly correlated with risk of all forms of exploitation. The strengthened links between the Missing Children's Panel and the Multi-Agency Sexual and Criminal Exploitation Panel are key to addressing this.

Less information is available about young people in care placed in Redbridge by other local authorities who go missing, as all follow up work with the young person is undertaken by the local authority with care responsibility. Responding to reports of missing young people in this group does however fall to the local police service. The BCU receive more notifications of missing persons in Redbridge than they do for Barking and Dagenham and Havering put together – 3060 in 2019/20, compared to 2403 for the other two boroughs combined. There are more young people placed in Redbridge by other authorities, particularly in unregulated semi-independent settings, than there are in the care of Redbridge Council, wherever they are placed, and the numbers are rising. The total number of children in Redbridge's care on 31.3.20 was 245. There were 623 young people placed in Redbridge by other local authorities in 2019/20, compared to 529 in 2018/19 and 404 in 2017/18. 405 of these young people were reported as missing at some point in 2019/20, on a total of 1476 occasions. On average, each young person went missing on just under four occasions.

Female Genital Mutilation

The RSCP has adopted the Female Genital Mutilation (FGM) Strategy – Working Towards Ending FGM in Redbridge which was agreed by the LSCB in January 2019. The strategy identifies four priorities, and makes a series of commitments under each priority:

- Improving prevention and support
- Improving practice and multi-agency working
- Developing an informed, confident, and culturally competent workforce
- Strengthening leadership

An action plan to deliver the strategy was agreed by the LSCB in May 2019. The RSCP received an update of progress against the action plan in January 2020. The

partnership was encouraged to note that all but two of the multiple actions agreed in the action plan had been completed. However, while actions have been completed, the outcomes and impact of those actions have not yet been evidenced. The partnership asked to receive a future report evaluating those outcomes and impact.

In November 2018 the Council entered into a partnership with the National FGM Centre as part of which a specialist FGM social worker was recruited. Although the individual worked hard and effectively to raise awareness and support practice, the partnership did not achieve its primary objective, which was to increase the number of referrals to social care in which FGM was identified as a risk factor. The contract was ended in March 2020. 48 referrals were received in 2019/20, compared to 49 in 2018/19. Female genital mutilation was disclosed by or identified in 209 women attending BHRUT in 2019/20, compared to 199 in 2018/19. All these cases related to adult women. There were no cases identified of, or disclosures by, children under the age of 18 years. Overall the number of cases identified in hospital has declined over the past few years - 215 cases identified in BHRUT in 2017/18, and 243 in 2016/17.

Dealing with allegations against staff

The Local Authority Designated Officer (LADO) 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.

The LADO recorded 441 contacts on individual cases (including both referrals and consultations) in 2019 /20, compared to 362 in 2018/19 and 240 in 2017/18. The continued increase in contacts should not necessarily be taken as an indicator that more professionals are harming children and young people, but rather as an indicator of increased professional confidence and knowledge of when and how to raise concerns. This can also be linked to ongoing training and consultation offered by the LADO which continues to increase awareness and knowledge as to when a referral should be made. This includes the delivery of "Managing Allegations Training" twice a year, participating in training sessions for newly appointed headteachers, and attending Faith Forum Trustees meetings.

110 cases (25% of referred cases) were assessed as meeting the threshold, as described above, and were subject to a formal evaluation, compared to 122 in 2018/19 (35% of referred cases) and 79 in 2017/18.

The table below shows the outcomes for the referrals which were the subject of formal evaluation.

Of those referrals subject to formal evaluation:				
	2019/20	2018/19	2017/18	2016/15
Number of accepted referrals meeting the threshold for criminal investigation	33	21	14	14
Resulting in criminal conviction	0	0	1	1
Resulting in dismissal	5	5	9	6
Resulting in other forms of disciplinary action	12	13	8	6
Resulting in referral to a regulatory body	1	1	3	7
Resulting in referral to Disclosure and Barring Service (DBS)	7	7	3	6

The LADO has an ongoing concern about allegations made against professionals working in unregulated settings, such as private tutors. Unless the allegation meets the threshold for a police investigation, there is no agency which can complete an appropriate investigation or offer appropriate training and advice. She continues to liaise with colleagues in Education and Inclusion Services to ensure that out of school settings, such as private tutors and after school activities, are safe for young people. It is essential that parents are aware of the limitations in monitoring and regulating these settings and what they can do to assure themselves that their children will not be exposed to any risk. Information, including an updated leaflet for parents and carers, is available on the Redbridge Safeguarding Children Partnership website.

Safeguarding in schools

The RSCP recognises that schools are in the front line of safeguarding practice. In July 2020 we received a comprehensive report on the support to effective safeguarding in schools delivered over the past three years by staff within the Education and Inclusion Service within the People Directorate of the Council – the School Improvement Service, the Governor Support Service, and the Education Welfare Service. This includes

universal services available to all schools (the annual refresh of the Council's model safeguarding policy for schools, termly seminars for Designated Safeguarding Leads and for Safeguarding Governors, and the provision of regular safeguarding updates and briefings for headteachers, Chairs of Governors and Clerks); targeted services (safeguarding audits in primary and secondary schools, both to identify and share good practice and to target support on schools where safeguarding arrangements are ineffective, and leadership support through a seconded safeguarding consultant); and traded services (supervision for Designated Safeguarding Leads, and school based training). Safeguarding audits were carried out in 22 primary schools, including four and 9 of the borough's 11 secondary schools between September 2017 and November 2019. 20 schools bought in supervision training for their Designated Safeguarding Leads in 2019/20.

In April 2019, the Council agreed in principle to establish a private company, to be jointly owned by the Council and by Redbridge schools who choose to become shareholders, to deliver support services to schools on a traded basis. The company will be called SixFive Education. It will seek to sell services, not only to Redbridge schools, but also to schools and other customers in other local authority areas. The launch of SixFive Education, and the work to specify the services that the Council will require of the company, have however been suspended for the period of the coronavirus pandemic. At the appropriate time, the RSCP will wish to seek assurance on the impact of these developments on the safeguarding support to schools.

Child Friendly Redbridge

Throughout the period covered by this report the RSCP has strongly supported the bid by the London Borough of Redbridge for accreditation by UNICEF as a Child Friendly Borough, and the work underway to underpin the aspiration to make Redbridge a great place for children and young people to live and grow up in. Redbridge is only the second borough in London to partner with UNICEF in this programme. Lesley Perry, our RSCP Business Manager, is a member of the Steering Group.

The direct participation of young people is a key element of the programme. A Youth Panel, known as the Child Friendly Redbridge Ambassadors, was formed in March 2020. The group continued to meet weekly during the coronavirus lockdown, ensuring that young people were able to continue to shape the programme. The Ambassadors, as well as members of the Youth Council, helped design a Back to School leaflet, providing help, information and guidance for all secondary school students as they returned in September.

One component of the UNICEF definition of a "Child Friendly Community" is that "children feel safe and protected from discrimination and harm". One of the projects within the Redbridge programme is Safer Routes, led by the Metropolitan Police, which focuses on travelling safely to and from school. Beyond a specific focus on

safeguarding, though, is the rooting of the whole programme in a commitment to children's rights. The ambition of the programme is explicit:

"It is expected that by the end of the programme children in Redbridge will:

- Understand their rights
- Have the skills and support to constructively challenge when their rights ae being overlooked
- Are aware of and can access the support they need, when they need it
- Are satisfied with the services that they experience
- Feel they have the ability to influence and shape services which affect them"

This vision resonates strongly with the values and principles to which the RSCP has committed itself as part of its terms of reference, agreed in January 2020, and which open with the following statements:

- The Partnership 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 experiences and voice of children and young people are central to all the Partnership's work. The Partnership will work closely with the Redbridge Youth Council, and seek to ensure that the voices of children and young people are heard in everything it does.

Communication, publicity and engagement

Due to the coronavirus pandemic, there have been limited opportunities this year for outreach and community-based activity. However, led by Lesley Perry, RSCP Business Manager, and the RSCP Team, the RSCP has maintained an active programme of communication, publicity, and engagement. The RSCP newsletter, published online after every Partnership meeting, has a circulation of several hundred professionals working across all sectors. As well as information about a whole range of RSCP activities, the newsletter includes full briefing on the issues and outcomes discussed, and a 'service highlight' page publicising the work of an individual service. Featured services and developments have included the launch of the Families are Forever Functional Family Therapy project; publicising the Truth Project – part of the Independent Inquiry into Child Sexual Abuse, offering survivors of sexual abuse in childhood the opportunity to share their experience with the inquiry, "in a safe and confidential way, and to be listened to without judgement"; and the work of the Out of School Settings Team within the Council, supporting parents and providers in assuring the safety of children in a whole range of unregulated out of school activities.

The team work closely with Designated Safeguarding Leads in schools through their termly seminars. They contribute regularly to the RedPEN Newsletter, which goes to

all Redbridge schools, and to the Redbridge CVS eNews which is widely circulated throughout the voluntary sector. As Chair of the RSCP, I held an extremely lively online workshop with a range of front-line practitioners and managers across children's and adults' social care and health services, exploring their experience of working to safeguard vulnerable children and adults during the pandemic. The RSCP is represented on a range of local strategic groups, and the team were also actively involved in a number of consultations and stakeholder events. The RSCP Twitter feed has almost two thousand followers and was used extensively throughout the year to promote national and international safeguarding awareness days including Safer Internet Day, International Day for the Abolition of Slavery, National CSE Awareness Day, and Domestic Violence Day. The RSCP has nearly 700 followers on Instagram, and uses it to communicate positive messages to young people. This has been particularly important during the pandemic. The RSCP Facebook page has 160 followers.

All of this work and more continues to be presented and reflected in the ever-expanding and changing RSCP website, already described by Ofsted in 2016 in its previous incarnation as the LSCB website as "excellent… interactive and informative, with up to date information for professionals, children and young people and parents… Information is particularly well presented in a range of age-specific categories, providing information in visual and audio format." The news page is updated on an almost daily basis, disseminating information on national developments and research as well as local content.

5. Safeguarding Training

The RSCP commissioned and delivered a substantial training programme for multi-agency staff working in Redbridge in 2019/20. The number of total attendances at RSCP training events was slightly reduced by the cancellation of a number of courses in March, due to the impact of the coronavirus pandemic. Taking that into account, it can be seen that in spite of clear workload and caseload pressures, the number of professionals attending RSCP training events was sustained at the level achieved by the LSCB over the last few years, following a sudden drop in 2015/16.

Number of attendances at LSCB training events				
2015/16	2016/17	2017/18	2018/19	2019/20
397	649	715	760	705

There were 132 non-attendances (individuals who booked a place on a course but did not attend), up slightly from 127 in 2018/19. In total, 66 training courses and events were planned as part of the RSCP Training programme for 2019/20. In the event, eight events were cancelled due to low take up or other unforeseen circumstances. Topics covered in the programme, most of which ran more than once, were:

Abuse in Teenage Relationships	Safeguarding Children in a Digital Age and Online Bullying
Awareness of CSE	Safeguarding Children who go Missing
CSE for Practitioners	Safeguarding Children with Disabilities
CAF – Assessment and Planning for Practitioners	Safeguarding Refugee and Vulnerable Migrant Children
Child Protection Conferences and the Strengthening Needs Approach	Safeguarding through Relationship and Sex Education
Designated Safeguarding Lead Training	Supervising Safeguarding Practice
Domestic Abuse and Safeguarding Children	Understanding Drug Use and the Impact on Children
FGM and Breast Flattening	Understanding Loss, Grief and Bereavement
Getting Early – an Introduction to CAF	Understanding Thresholds and Making Referrals
Harmful Practices and Safeguarding	Voice of the Child and Safeguarding
Harmful Sexual Behaviours	Working with Race, Culture and Belief in a Context of Professional Curiosity
Introduction to Child and Adolescent Mental Health	Working with Young People in Relation to Gangs
Managing Allegations Against Staff and Volunteers	Working Together to Safeguard Children
Modern Slavery Awareness	Workshop to Raise Awareness of Prevent
Neglect Toolkit Workshop	
Safer Recruitment	

Safeguarding Children from Honour Based Abuse and Forced Marriage	

The courses on Child Protection Conferences and the Strengthening Needs Approach, Safeguarding through Relationship and Sex Education, Supervising Safeguarding Practice, and Understanding Drug Use and the Impact on Children were new courses, commissioned in 2019/20 in response to demand, ongoing training needs analysis, and developments in legislation, guidance and practice.

The great bulk of attendances were by children's social care staff (50%), schools and colleges (19%), and the voluntary sector (14%). Only 4 health professionals attended a RSCP training event, compared to 16 in 2018/19. This is disappointing, but it should be noted that all health providers have extensive training programmes and requirements for their own staff. They achieve a generally high level of compliance with mandatory training targets, although in relation to Level 3 training is less strong in the acute hospital sector. A Level 3 training session at BHRUT was booked for the end of March, but was cancelled due to the impact of the coronavirus pandemic. If this had taken place, it would have increased the compliance rate to 90%.

Health Providers Safeguarding Children Training Compliance		
Agency	**Year End 2019 – 2020**	
	Level 2	**Level 3**
NELFT	92.2%	95.8%
BHRUT	92.1%	87.2%
PELC	95%	End of year data not available – 100% at end of Q3
Bart's Health	91%	80%

Other groups represented at RSCP training events included the Council's Education and Inclusion Service including early years (45 attendances), and private sector providers (21 attendances). There is virtually no attendance at multi-agency training by the police. To repeat the comment made in the LSCB Annual Report for 2018/19:

> "To some extent this is understandable, given operational demands and shift working patterns. However, if only away from the front line, it would not be impossible to create opportunities for participation in multi-agency training. That these opportunities are not being taken is a loss both to the professional development of the officers who could be involved and to the culture and practice of multi-agency work."

The central feature of the new multi-agency safeguarding arrangements under the Children and Social Work Act 2017 is that they define the police and the Clinical

Commissioning Group as equal partners with the local authority in ensuring the effective safeguarding of children. It may be hoped, therefore, that one outcome of this equal responsibility will be the increased participation of health and police staff in multi-agency training, which is at present limited or very limited.

Post training online evaluation 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 2019/20 was 62%, up from 54% in 2018/19. Participant satisfaction continued to be very high with 98% of respondents saying they had achieved their learning objectives, 99.7% agreeing that the training had equipped them to transfer learning into the workplace, and 98% of trainees reporting that they would recommend it to a colleague. Evaluation forms included many extraordinarily positive comments on the impact of training on the respondent's practice – including, for example, one headteacher who described the Understanding Race and Culture course as "a truly life changing course".

Total expenditure on LSCB training was £14,029. Income from attendance and non-attendance was £37.365. Between 2014/15 and 2017/18, the deficit on the LSCB training budget was reduced from almost £12000 to just under £2000. In 2019/20, for the second year in a row, the training programme was not only self-financing, but contributed a surplus of to the overall LSCB budget - £14,500 in 2018/19, and £23,336 in 2019/20. Critically, 65% of training content is now delivered by colleagues working within RSCP agencies: not only reducing expenditure, but also, and perhaps more importantly, sharing and valuing the expertise that we have within our own workforce. In 2019/20, in addition to the established input from Haven House Hospice, and colleagues from children's social care, Community Safety, and the Families Together Hub, the Westminster Drug Project delivered a new course on Understanding Drug Use and its Impact on Children.

The coronavirus pandemic and the restrictions it required had an immediate impact on training in the second half of the period covered by this report – April to September 2020. All training was cancelled from mid-March to the beginning of September. The Training Sub-Group, led by Graeme Gail-McAndrew as Chair, Amanda Jones, RSCP Training Manager, and Andrew Reed, RSCP Senior Administrator, put a huge amount of work into identifying options for resuming the training programme. In July the RSCP agreed that as full a programme as possible should be rescheduled to run from September 2020 to March 2021; that is should be delivered online at least until the end of December; and that course fees for the duration of the online offer should be reduced from £65 to £50 for full day courses and from £35 to £25 for half days. It now appears likely that all training will be delivered online at least until March 2021. It was acknowledged that the likely take up of online training could not be predicted with any certainty. In the event, take up has been excellent. Five courses were scheduled for September 2020. All available places – 77 in total – were fully booked.

Part Two

Safeguarding children and young people during the coronavirus pandemic

It is impossible to overestimate the impact which the coronavirus pandemic had on services, on staff, and on children, young people and families for more than half the period which is covered by this report. It began to emerge as a major issue early in 2020, and concern rapidly escalated in March. On 18 March, with two days' notice, schools closed to all except "vulnerable" children and the children of key workers, and remained largely closed to most children until September. On 23 March the country went into lockdown. All agencies were required overnight to reorganise their mode of delivery while at the same time continuing to provide essential services. Many staff moved immediately to working from home, face to face contact with the public and with service users was dramatically curtailed, and a range of provisions to meet urgent needs had to be put in place. The speed and the efficiency with which public services, and the voluntary sector, responded to this challenge was extraordinary: a huge achievement on the part of managers and staff at all levels, and a massive demonstration of the strength of public service values at a time of crisis.

At the beginning of May, as the radically revised service arrangements stabilised, senior leaders in partner agencies (the local authority, the CCG, the police, BHRUT and NELFT) came together to develop a RSCP multi-agency risk register to identify key safeguarding risks to children and young people during the pandemic, the actions in place to mitigate those risks, and potential actions that could be taken to mitigate them further. In total, eighteen potential risks were identified, each "RAG rated" as high, medium or low risk. Five "red' risks were identified:

- Increased stress on families leads to increase in abuse and neglect
- New cases of abuse and neglect are not effectively recognised or referred due to lack of professional, family and community contact
- High vulnerability of babies and young children to abuse, compounded by lockdown and closure of early years settings
- Young people at risk of deteriorating mental health and wellbeing, with reduced access to services
- Children and young people at increased risk as a result of increase in parental mental ill health

The risk register was reviewed and updated at the beginning of July and reviewed by the full partnership at the RSCP meeting on 14 July. At that meeting the RSCP also agreed that one of its top three priorities for 2020/21 was to continue to monitor and support the multi-agency safeguarding response to the coronavirus pandemic. A

further report, covering the period to the end of September, was considered by the RSCP at its most recent meeting.

The summary risk register, updated at the beginning of July, is attached to this report as **Appendix B**.

From the onset of the pandemic, children's social care prioritised the risk assessment of all children on social work caseloads to ensure the most appropriate oversight and contact. Over 90% of young people on children on child protection plans have had regular face to face meetings with their social worker every ten days or more often in cases where safeguarding concerns dictated that was necessary. 100% of looked after children have been contacted virtually or face to face. Where face to face visits cannot be undertaken for children and young people rated as 'red', these have been actively discussed with a senior manager to see what alternative arrangements can be put in place including joint visits with police where appropriate. In some cases families have been nervous about allowing social workers into the home, even when protective personal equipment has been used, or may have used this an opportunity to deny entry. Access to children on remand, and who are therefore looked after children, has been difficult due to the restrictions on entering secure settings. Weekly food parcels and other practical items of support such as toiletries and small amounts of emergency cash have been delivered by social workers, family support workers, and support staff.

During the initial lockdown phase (April/May 2020), referrals to social care were at less than 50% of the normal level, with a reduction in referrals, not only from schools, but also from other agencies such as the police and hospitals. Considering the vulnerability of very young children in the lockdown context, it was of concern that in the first two months the number of contacts concerning children under one fell by 25%. In June 2020 the total number of contacts raised with social care was comparable to June 2019, with contacts from police and hospitals recovering to the same or a higher level. Contacts concerning children under five had recovered to above June 2019 levels, and there was a spike in contacts relating to unborn babies and children under one year, up by over 30% compared to the same month a year before. It appears that the re-referral rate between April and June jumped considerably to around 30% of the referrals received, although final data is still being validated. Referrals increased sharply between July and September. Practitioners are clear, though, that the increase in contacts and referrals reflects the impact of the pandemic on families struggling to cope with lockdown, school closures, job losses and poverty. As one put it, "we are seeing families we would never have seen before". Depending on the course of the pandemic and economic disruption, it is possible that these stresses will intensify over the coming months. There appears also to be a significant increase in families moving into the borough and presenting with needs for support to social care. Neighbouring boroughs appear to be placing more homeless families in temporary accommodation and more families with no recourse to public

funds in Redbridge. Feedback from the MASH suggests that high current rates of referral may also reflect high levels of professional anxiety in the current situation. Referral levels in the three months to September were exceptionally high for domestic abuse and concerns about the mental health of young people. Feedback from community paediatric services reports very few child protection medicals relating to physical or sexual abuse being requested by Redbridge in August and September, contrasting with the position in neighbouring boroughs.

Between April and August 2020, 233 referrals were received from schools, compared to 464 in the same period last year. As expected, the number of school referrals went up in September when schools reopened, although not yet to the level which was at one point predicted. 137 referrals were received from schools in September 2020, compared to 110 in September 2019: a 25% increase, compared to the 50% fall over the previous five months.

At the beginning of lockdown, the MASH worked remotely, but returned to office-based working at an early stage. The police presence in the MASH, however, has remained virtual, with some inevitable impact on rapid information sharing and shared decision making. Officers working remotely, while being able to access Metropolitan Police information systems, do not have access to the Police National Computer, which may limit information available for the assessment and management of risk.

Social workers have maximised the creative use of digital communication options, including the use of online resources to facilitate remote access, using phones, messaging services such as WhatsApp, and video conferencing software such as Skype, Zoom Pro, and Microsoft Teams to deliver sessions. Child protection conferences and reviews for looked after children have taken place on virtual platforms since the beginning of lockdown and continue to do so, and these meetings have continued within statutory timescales. One consequence of this has been a significant increase in the proportion of professionals invited who have been able to attend. However, practitioners report that redeployment of staff in some agencies as part of the Covid response has led on occasion to representation by a professional who does not know the child and can only repeat what is in the report. They also comment that effective advocacy for children at child protection case conferences has sometimes been difficult, when children's views may be shared virtually and may be overheard by parents, which might in some circumstances place children at increased risk. While digital communication has been very effective with many young people, social workers have had to be vigilant about "who else is in the room" when speaking with young people. Overall, managers comment that staff have been very committed to developing new ways of working and reaching young people, allowing flexibility and maximum contact time with children and young people. They have gone to great lengths to reach young people, even though face-to-face contact has been difficult and remote support is often challenging.

The wide range of early intervention services in the Families Together Hub (FTH) moved online very quickly at the onset of the pandemic, although face to face contact continued with a small number of families where it was assessed to be essential. As an immediate response to the crisis, services focused on delivering practical support to families coping with the impact of lockdown, with parenting programmes and other interventions pursuing longer term change goals suspended for a period. As the pandemic developed, there was a significant expansion of online outreach and support work, both by directly employed support staff and by voluntary sector organisations commissioned by or working in partnership with the FTH. The Parenting Team have adapted all their accredited parenting programmes for online delivery, as well as keeping up regular contact with individual families, offering practical support in response to immediate needs. Take up of parenting programmes more than doubled during the pandemic: 206 parents enrolled on programmes between April and July, compared to 93 in the first three months of the year. In September, the team were running 40 sessions a week, with a maximum of 6 participants per session, with a range of measures in place to protect anonymity and the family's location if appropriate. Box Up Crime delivered a whole range of mentoring, boxing training, educational and nutritional support via Instagram, WhatsApp, Zoom, and Houseparty. Lifeline, commissioned during 2019/20 to provide mentoring support in a number of schools for young people at risk of criminal exploitation, or experiencing anxiety and depression, expanded their online outreach support. Free Your Mind, a voluntary sector project offering direct support to children affected by domestic violence, received 30 referrals in the first month of lockdown, compared to 5 in the same month a year earlier. Between March and September, they worked with 85 children and their families, with a maximum waiting time between referral and engagement of 4 weeks. The Barnardos Phoenix Project, another service working to support children affected by domestic violence, responded to 50 referrals in the six months from April 2020, compared to 19 in the previous six months. Children's Centres closed at the beginning of lockdown and remained closed at the end of September. A range of online resources to support parents, and some telephone support, were however available.

The Housing Team in the FTH are working with Housing Service colleagues to identify vulnerable families at risk of eviction when the current Government moratorium on completing eviction proceedings come to an end.

In the first three months of lockdown, the number of young people reported missing fell sharply. Reports of missing children received by the police fell by 30% between April and June. Over the whole six months of the pandemic covered by this report, there was a 32% reduction in the number of children reported as missing from home. However, over the same period, there was an increase of 26% in the number of young people reported as missing from care, and an 80% increase in the number of episodes – more young people going missing, more often. It is likely that more of these young people have been exposed to risk of or have suffered exploitation. Reports have been

received of a whole range of ways in which those operating county lines adapted their modus operandi to the circumstances of the pandemic, particularly during the lockdown phase – for example, dealers meeting at supermarkets while people were getting their essentials in order to look less suspicious; pretending to be key workers, using badges and uniforms to avoid detection; and arranging for fictitious GP appointments to be sent to their phones to provide a reason for breaking lockdown if challenged. There is a concern that networks may begin to increase the collection and enforcement of drug debts built up by customers during lockdown. Overall, however, crime levels fell during the first phase of the pandemic. The reductions in robbery (substantially related to the absence of young people, both victims and perpetrators, on the way to and from school) and burglary were sustained, as of the end of September. Violent offences, excluding domestic violence, also fell in the first phase, but by September had returned to previous levels. The number of violent offences in reported in Redbridge in August 2020 was the second highest for a single month in two years. In April and May BCU officers visited a number of young people known to have been involved with gang violence and criminal exploitation to proactively offer diversion activities to encourage them not to return to their temporarily suspended criminal involvements.

Many NHS staff were redeployed during the first wave of the pandemic to support the frontline NHS response to the crisis. Many staff working in the 0-19 universal service (in particular health visitors and school nurses) were redeployed, although at the time of writing all redeployed staff have now returned to their substantive positions. However, there should be no large-scale redeployment in any second wave. On 7th October NHS England, Public Health England and the Local Government Association wrote to all Directors of Nursing to advise that over the forthcoming winter professionals supporting children and families, such as health visitors, school nurses, designated safeguarding officers and nurses supporting children with special educational needs should not be redeployed to other services and should be supported to provide services in pregnancy, early years (0-19) and to the most vulnerable families.

During this first stage, though, health visiting capacity was significantly reduced. A Duty Team operated from Monday to Friday, with a Health Visitor and School Nurse triaging all referrals on a daily basis. A telephone or video consultation was offered to all families referred, and home visits were undertaken with protective personal equipment if assessed as essential. All families with children subject to either a child protection plan or a child in need plan continued to have contact from their named health practitioner, and face to face visits continued to take place if required, subject to risk assessment. Children and families on the Universal Plus or Partnership Plus caseloads were also contacted or visited during this period. New birth visits have continued through the pandemic. Maternal mood assessments have been carried out at all new births and any concerns followed up by the allocated health visitor or

referred to perinatal mental health or specialist perinatal health visitor services which have continued to operate throughout the crisis. There is a backlog of developmental checks for one- and two-year olds. However, checks for children on Universal Plus and Partnership Plus caseloads have been prioritised. The National Child Measurement Programme has been suspended until 2021. This will impact on identifying children with weight issues, which may be a particularly significant issue following lockdown.

Access to or take up of other health services was also heavily affected by the pandemic. The number of children attending A&E in BHRUT fell by 70% in April and May, compared to the same period a year earlier. Take up of antenatal services also fell. Between July and September attendance at face to face bookings increased. However the number of safeguarding concerns identified in Maternity Services fell by 26% compared to the equivalent three months in 2019.

Sexual health services were significantly disrupted by the pandemic. Clinics at Queens Hospital and satellite hubs in Loxford and Hainault closed in early April, and services were only available from the Barking Hospital Hub. Emergency contraception requests from young people aged 16-19 fell by 45% in April, compared to February. A walk-in service was however maintained for vulnerable and young service users, and people who had experienced sexual assault. Between April and June a significant number of service staff were redeployed to support the Covid response. The number of people using the service in March 2020 was 67% of the number in the same month in 2019. Activity levels slowly increased over the next few months, but activity in August was still only 50% of the level in August 2019. Demand however is now at pre-pandemic levels.

There has been a clear rise in the incidence of domestic abuse during the pandemic. Domestic abuse reported to the police increased by approximately 25% across the BCU area in the first three months of lockdown. Levels reduced over the summer, but by the end of September were still 10% above the same period in 2019. Since the onset of the pandemic, the Multi-Agency Risk Assessment Conference, co-ordinating support to victims of the most serious domestic abuse, has moved to weekly from three weekly meetings. The Council moved rapidly to establish Reach Out, a new domestic abuse support service launched on 14 April providing a range of services, including support for the victim and their children, referral to targeted services, counselling and practical advice on issues such as housing, finance and benefits. It established close links with Housing to provide a fast track response to support with housing, and with alcohol and substance misuse services. It also offered perpetrators a direct pathway to relevant programmes to address their behaviour. Children affected by domestic violence could be linked in with the Phoenix Project and Free Your Mind in the Families Together Hub. While it has not been possible to collate activity and outcome data for the Reach Out Service for this report, it might be noted that in the

two weeks after its launch children's social care received referrals for twice as many families affected by domestic abuse as in the two weeks before.

Over the past six months a weight of evidence has accumulated of the damage done to young people's mental health and wellbeing, while simultaneously their access to services has been reduced. Planned access to mental health services for young people has been largely limited to online referral, assessment and treatment. Referrals to CAMHS were down by 56% in April and May, and by 50% in June. As expected, they increased in September when schools reopened. However they had still not returned to pre-pandemic levels by the end of the month. There were 118 referrals in September, compared to an average of 170 in each of the first three months of 2020. Practitioners have reported a significant increase in the number of young people seen with suicidal ideation, with parents extremely anxious and unable to cope. They also report acute pressure on the availability of in-patient Tier 4 beds. Another theme in the increased number of referrals has been heightened levels of anxiety around the return to school. There are also reports of young people's mental health and emotional wellbeing being adversely affected by parental anxiety and stress related to financial insecurity and potential or actual job loss. There have also been reports of increased anxiety among children with autism about returning to school, and the new routines and expectations involved, with some increase in self-harming behaviour. Across specialist services, practitioners report that some parents have found it increasingly difficult to manage the behaviours of children with autism and learning difficulties.

With reduced access to planned and face to face services, high levels of need have been displaced into emergency presentation, and that pressure intensified rather than reduced in the second phase of the pandemic. In July, the Safeguarding Team at BHRUT received 99 requests for support or advice about young people with mental health problems. Six young people were admitted to a paediatric ward as a result of a mental health condition. In August the Team had 151 contacts about young people's mental health, and there were 5 ward admissions. In September there were 331 contacts, and 11 ward admissions – an unprecedented number in a single month. There were continuing issues about the lack of in-patient children's psychiatric (Tier 4) beds. One young person waited in A&E at Queens Hospital for five days for a Tier 4 bed to become available, and was eventually sectioned and placed in a secure unit. To address some of these issues, escalation procedures between BHRUT, the CCG, and NELFT are being reviewed. The CCG have reported that an initiative is underway across the North Central and East London Collaborative to improve the availability and effective use of Tier 4 beds.

In the survey of young people's experiences during lockdown which has been reported in Section 3 of this report, a quarter of young people stated that they are feeling down and a slightly higher number said that mental health is something that they have been worried about during lockdown. Those suffering with anxiety, depression and stress

commented that lockdown had compounded their issues further, particularly young people who have been unable to speak to or see their therapists and counsellors. Overall it seems clear that the risks to children and young people's mental health and wellbeing from the pandemic experience remain high. It is likely that the longer the pandemic continues, the greater those risks will be, with anxiety about a possible return to further restrictions, the frightening resurgence of infections, increased family financial uncertainty, and, particularly for older young people, uncertainty about their future, both in the medium term relating to education and what will happen with exams in summer 2021 and in the longer term as they contemplate adulthood in a changed world. It is important to establish whether services have the capacity and resources to respond effectively. Additional funding is being made available from NHS England to support child and adolescent mental health services during the pandemic, and NELFT are in a position to recruit additional staff for the service.

By their nature, specialist health services for children and young people are seeking to meet very complex needs. That complexity has been intensified by the effects of the Covid-19 pandemic. A positive response has been the strengthening of multi-agency working, with a regular partnership meeting now established with NELFT Specialist Services, the CCG, social care and education to discuss complex cases. This is reported to have led to better communication across all agencies, supporting the development of more effective plans for meeting the needs of children and young people as well as the escalation of any safeguarding concerns. Following the review of an individual case, a number of steps have been taken or are in progress to strengthen the relationship between children's social care and specialist mental health services, including the identification of a single point of contact (SPOC) in mental health services for all frontline children's social care services and the establishment of a weekly panel with the MASH, EWMHS, and the SPOCs to discuss cases of concern.

Given the potential association between parental mental ill-health and risk to children, it should be noted that the same pattern of reduced access to mainstream services being displaced into emergency presentations has also been apparent in adult mental health services. Referrals to NELFT's adult mental health services fell in April and May, and although they started to increase as lockdown eased, had not returned by the end of June to 2019 levels. At the same time the police reported a 20-30% increase in calls involving mental health issues. For the first six months of 2020/21, referrals to community adult mental health were 18% down on the same period in 2019/20.

It must of course be noted that many of the potential risks identified on the risk register in **Appendix B** were successfully managed and remained at amber or green throughout. For example:

- It was anticipated that there would be very low take up of the school places available during lockdown for vulnerable children. Nationally, a figure of 5% take up was widely quoted. In Redbridge, 26% of vulnerable children were

recorded as at school on 1 July. Schools and other professionals worked immensely hard to monitor and encourage attendance.

- The risk register identified increased risk to children with drug abusing parents during lockdown. The R3 service developed a risk register, identifying all service users at increased risk, which was reviewed daily. This included substance misusing parents who received increased contact, sometimes daily, to continually monitor and assess risk. All parents using the service were provided with lockable medication boxes to ensure that children could not get hold of dangerous controlled medications. The service launched an online support group for parents, providing practical advice and offering coping strategies.
- It was anticipated that there could be increased resort to emergency rather than planned responses, such as Emergency Protection Orders and the use of Police Protection powers, as a result of the pressure on services. This risk did not materialise. Children's social care continued to function at near normal levels, including proactive care planning practice.
- Although a risk of increased care placement breakdown was identified, a high level of placement stability was maintained. An extensive range of measures were put in place to support foster carers through the crisis.

The report considered by the RSCP in early October, "Safeguarding children and young people during the Covid19 Pandemic: beyond lockdown", concluded:

> "There are three themes that stand out from this summary.
>
> Firstly, the ongoing picture of adaptation, flexibility, and determination to continue to provide the best services possible across all agencies in the most difficult of circumstances is immensely striking and impressive. Staff at all levels in all agencies have made extraordinary efforts and shown extraordinary commitment.
>
> Secondly, it is clear that levels of need in the community and the stresses on families and young people have not abated as full lockdown has ended. Rather, there is clear evidence that they are intensifying, and are likely to continue to intensify the longer we are living with Covid-19. The impact on the mental health and wellbeing of young people, the impact on families of financial insecurity and anxiety, levels of domestic abuse – these will remain critical issues for the foreseeable future. Maintaining the capacity and resourcing of services to meet these demands, and enhancing it when necessary, may become increasingly difficult as costs rise and budget pressures intensify.

And finally, while practitioners speak much more readily about the impact on children and families than they do about the impact on themselves, that impact must be fully recognised and continue to be addressed.

Many staff have experienced stress in their own personal circumstances – sickness in the family, bereavement, anxiety about extended family overseas. Working from home can be very difficult for staff with limited space and the demands of childcare. The boundary between work and home can become blurred, and this can impact on family life. One practitioner felt that staff working remotely can sometimes feel uncomfortable asking a manager for support in case they are busy. Another said simply' "People are fragile". The Designated Officer (LADO), responsible for dealing with allegations against professionals working with children, reports an increase in the number of cases referred over the course of the pandemic, much of which relates to issues arising under stress in people's private lives. While many of these issues are common across agencies, some issues can be more specific to specific contexts. Health colleagues report that the experience of redeployment to frontline Covid services has had a significant emotional and psychological impact on some staff. Police report that the murder of Sergeant Matt Ratana, on top of six months of unprecedented and relentless operational activity, has had a major impact on staff, the scale of which is still emerging. Ensuring staff have appropriate support has become a necessary part of daily conversations.

Practitioners speak very highly of the support available to them from their organisations, their managers and their colleagues. It takes many forms: many references were made to more frequent, sometimes daily, team meetings and briefings, virtual coffee meetings and socially distanced lunches, mindfulness sessions, open sessions with senior managers, and other initiatives. Practical support was much appreciated – for example, the care and concern shown by a manager simply disinfecting colleagues' desks. Both individual and group provision were highly prized. Public facing services have been flexed to offer support to staff – NELFT has made the IAPT (Improving Access to Psychological Therapies) support line available to staff, and social care staff have accessed support from the Functional Family Therapy service.

It is unlikely that staff's need for support will diminish the longer the pandemic goes on. From discussions with practitioners, there was a clear message that the support needs of frontline managers need to be particularly attended to. They play the key role in supporting their teams. They are the transmission channel for communication from senior managers and corporate centres, interpreting and unpicking those messages for staff. They absorb anxiety from

below and pressure to deliver and maintain service standards from above. In the vast majority of cases, they are clearly doing an extraordinary job."

These conclusions stand.

Part Three

An evaluation of the effectiveness of the multi-agency safeguarding arrangements of the BHR Partnership

Section 16 of the Children and Social Work Act 2017 requires the "safeguarding partners" (the local authority, the police, and the Clinical Commissioning Group) "to make arrangements for the safeguarding partners and any relevant agencies that they consider appropriate to work together for the purpose of.. safeguarding and promoting the welfare of children in the area" and "to work together to identify and respond to the needs of children in the area".

Section 18 requires the safeguarding partners to publish the arrangements, and that "the arrangements must include arrangements for scrutiny by an independent person".

Section 21 provides for the safeguarding partners for two or more local authority areas to agree "that their areas are to be treated as a single area for [these] purposes".

The three local authorities of Barking and Dagenham, Havering and Redbridge, the East Area BCU (covering all three boroughs), and the three Clinical Commissioning Groups decided in 2019 to use the flexibility given by Section 21 to "treat their areas as a single area" and to agree a single set of "arrangements" for the BHR area. These arrangements were published in June 2019.

The statutory responsibility for the functions defined in Sections 16 to 23 of the Act ("Local arrangements for safeguarding and promoting welfare of children") sits with the BHR Partnership. This includes responsibility for commissioning and overseeing child safeguarding practice reviews and "at least once in every twelve months" preparing and publishing a report on "what the safeguarding partners and relevant agencies ... have done as a result of the arrangements and how effective the arrangements have been". The published arrangements include a commitment, at the first of "three inter-related tiers or levels", to "construct a set of arrangements designed to meet the needs in each of the three areas within the overall BHR footprint". Those arrangements are described very differently for each of the three boroughs. The role of the Redbridge Safeguarding Children Partnership, as it has been reflected in this report, is set out as part of those arrangements. However, the published arrangements are clear that the BHR Safeguarding Partnership has "ultimate responsibility" for multi-agency safeguarding arrangements across the BHR area. It has not always been clear during the course of the year that this was understood in

the same way by all members of the partnership, with some views expressed that the statutory accountability rested with borough-based partnerships. This does now appear to be resolved, with a schedule of responsibilities agreed in September 2020 which sets out those responsibilities held by the statutory partners at BHR level and those delegated to representatives of those partners at borough level.

The BHR Partnership does not yet have arrangements in place to meet all those responsibilities which sit at the BHR level. There are no plans yet to prepare and publish an annual report, as required by statute, on what the BHR safeguarding partners have done as a result of the arrangements entered into and how effective the arrangements have been. There are as yet no arrangements for independent scrutiny at the BHR level: the published schedule of responsibilities says only, "BHR Safeguarding Partnership will engage with scrutineers commissioned by the LSCPs". Those arrangements, however, are very different in different local partnerships, and not fully in place in all of them. The arrangements published in June 2019 stated:

> "The BHR Safeguarding Partnership will, in May 2020, commission an independent scrutineer to review their work and the impact of otherwise of the new arrangements."

It is wholly understandable that this has not yet happened, given the huge demands of responding to the coronavirus pandemic. It remains an outstanding commitment.

There is some debate nationally about what precisely independent scrutiny of "the effectiveness of multi-agency arrangements to safeguard and promote the welfare of all children in a local area" should mean. Some take the view that scrutiny should focus on the way the safeguarding partners work together at a strategic level, rather than on performance on the ground, both within individual agencies and on a multi-agency basis. I acknowledge this debate. My view however is that the only real test of the effectiveness of safeguarding arrangements is, as Working Together 2018 puts it, "how effectively the arrangements are working for children and families as well as for practitioners". In my judgement, therefore, the core questions to be answered in evaluating the effectiveness of the BHR Partnership at the end of its first year in existence are: what difference has it made to the quality of multi-agency working to safeguard children across BHR and to outcomes for children; and what value has it added to partnership working, set against any costs and administrative burdens created?

It would be unreasonable to reach a definitive conclusion on either of those questions after one year, and most particularly a year in which the second six months have been absolutely dominated by the impact of the coronavirus pandemic. In that context, the great bulk of the time in the four meetings of the safeguarding partners which took place between April and the end of September was used to share information about that impact and the response to it in the three boroughs, which participants undoubtedly found extremely valuable. Increased information sharing has been a

positive outcome of the partnership arrangements. However, I think it is fair to say that at this stage the establishment of the BHR Partnership has not yet had an evidenced impact on the quality of safeguarding on the ground.

The arrangements published in June 2019 described the area of "adolescent risk, dangerous drug networks, gang membership and knife crime" as "a clear example of a current pressing issue, felt in all areas, where borough boundaries are irrelevant for both perpetrators and victims of harm and where all agencies have a contribution to make at some level". They stated, "The Safeguarding Partners will commission a task and finish group who will be asked to review current practice, both strategically and operationally, identify areas of good and best practice that can be more widely adopted, examine the roles and contributions of the existing multi-agency arrangements [and] consult with young people and relevant voluntary and community bodies and help shape a way forward that both works across our boundaries but allows for local variation as needed." In November the partners agreed to establish a task and finish group to develop a tri-borough approach to county lines. In the event, this work was not progressed, and the Partnership subsequently decided to adopt domestic violence as its priority for the year rather than adolescent risk. The outbreak of the Covid pandemic however prevented any progress being made on this revised priority.

The arrangements also stated the intention to pursue the alignment of a range of processes across the BHR area to promote greater consistency and reduce duplication, not least for those agencies that operate across the BHR footprint and work with three different local authorities with different structures and processes. This included a commitment to a BHR-wide quality assurance programme. This would be particularly valuable for practitioners in Redbridge, as the RSCP has not yet been able, with the post of Quality Assurance Manager currently held vacant, to identify the capacity locally to undertake multi-agency audits. An ambitious framework was agreed at the Safeguarding Partners Group meeting in January, and the first multi-agency audit across the tri-borough footprint on the theme of domestic violence was due to take place in March. Understandably, this was postponed due to the Covid pandemic.

Work has been undertaken to develop a common template for all BHR agencies to use when contributing information to a Rapid Review of a serious incident. This had not been completed by the end of the year covered by this report, but was close to completion. However, the more ambitious aim of a common process for undertaking, completing and reporting on Rapid Reviews was not achieved, as individual local authorities wished to maintain their separate arrangements.

Plans to develop a BHR-wide training programme and to review the three different threshold documents in place in the three boroughs, with a view to identifying scope for simplifying and aligning, have not yet been progressed. They will no doubt feature in the Partnership's workplan for the forthcoming year

There are no additional costs directly related to the establishment of the BHR Safeguarding Partnership, in addition to the local partnerships. However, the additional workload for existing partnership support staff – in the case of Redbridge, the RSCP and Safeguarding Adults Board Business Manager – has been very considerable: convening and minuting meetings, organising agendas, developing and maintaining an action log and forward plan, and seeking to progress collaborative work arising from the six-weekly meetings. There is a real question of whether the capacity exists in partner organisations for key professional staff to effectively progress work on BHR wide programmes on top of their existing operational and strategic responsibilities, and, at least in Redbridge, the fantastic work they do to support the local partnership.

Independent scrutiny is charged under Working Together 2018 with considering, not only "how effectively the arrangements are working for children and families as well as for practitioners", but also with "how well the safeguarding partners are providing strong leadership". Having chaired the RSCP for a year and the LSCB for five years before that, and worked closely with senior leaders of all partners, I can confirm from personal experience that the leadership and commitment at local level is very strong. There is no doubt that the safeguarding partner agencies are also committed to the effectiveness of the BHR Partnership. However the Partnership has not had the benefit of consistent leadership in its first year, and this may have impacted on the speed of its development. There have been significant changes in senior leadership in three of the five agencies that make up the Partnership since the arrangements were agreed: new senior leaders representing the CCG and the BCU, and a change of Director of Children's Services in LB Havering. In the case of the police, there were five changes in the Safeguarding Superintendent role in a year, prior to the very welcome appointment of a permanent postholder in March 2020. More fundamentally, although the intention of the changes made in the Children and Social Work Act 2017 was to confer full and equal responsibility on each of the three safeguarding partners, the local authority clearly remains the lead agency for the protection of children. While the accountability for multi-agency safeguarding arrangements sits at the BHR Safeguarding Partnership level, the accountability for the delivery of core social care and child protection services sits very firmly at borough level. In my view there is some inherent tension, in terms of focus and attention, in the 'division of responsibility" between the BHR Safeguarding Partnership and local democratic accountability. The agreement in September 2020 of a schedule of responsibilities setting out which responsibilities are held by the statutory partners at BHR level and which are delegated to representatives of those partners at borough level may be an important milestone in negotiating that tension.

It is worth repeating that the impact of the demands on senior leaders created by the coronavirus pandemic on the development of the BHR Partnership in the second six months of its existence cannot be overstated. There is no doubt that there would be

great value if the BHR Safeguarding Partnership were able to achieve some of the aims it has set itself: a co-ordinated and consistent response to issues such as county lines, gangs, and other aspects of adolescent safeguarding; common thresholds, referral processes and forms; the sharing of best practice; consistency in the reporting and review of serious incidents; and a co-ordinated approach to quality assurance. A common and consistent approach to workforce development could be of benefit to practitioners across the footprint, who at the moment are almost certainly unaware of the existence of the BHR Partnership and any impact on their practice or on outcomes for the children and families they work with. There is no doubt either of the value of regular information sharing across boundaries, although this does not necessarily require a formal infrastructure to support it. Does the BHR Safeguarding Partnership have the potential to deliver on those gains, given the inevitable limitation of capacity in partner organisations to work at both the BHR and the local level, and what I have suggested is an inherent degree of tension between those two levels?

Inevitably at the end of such a disrupted first year, the jury is out. Given the extraordinary events that have dominated the first year of the BHR Partnership's life, it would be entirely premature to offer an answer to the question. I would, however, strongly recommend that, as and when the world returns to some kind of normality, priority is given to following up on the original commitment to an independent review of the Partnership and the impact of the new arrangements.

Redbridge Safeguarding Children Partnership: Terms of Reference

1. Purpose and functions

1.1 The Redbridge Safeguarding Children Partnership (RSCP) is part of the BHR (Barking and Dagenham, Havering and Redbridge) Safeguarding Children Partnership. Its role reflects the recognition articulated in the BHR Partnership arrangements that:

"Children, young people and their families live in local neighbourhoods and communities. Their prime reference points are firstly those local areas and secondly the boroughs made up by those communities. The core part of our Plan therefore is designed to reflect those realities and ensure we build arrangements that best meet local needs."

1.2 The RSCP is committed to supporting effective safeguarding across the BHR area, and to supporting and contributing to the strategic priorities agreed by the BHR Safeguarding Partnership. Within that, the overall purpose of the RSCP is to ensure effective multi-agency working to safeguard children within the London Borough of Redbridge. It exists to co-ordinate, monitor, evaluate, challenge and drive improvement in the work of all agencies, separately and together, to safeguard and promote the welfare of children in the Borough.

1.3 Specifically, the functions of the RSCP include:

- Identifying and co-ordinating action to deliver local safeguarding priorities
- Co-ordinating the contribution of Redbridge agencies and services to deliver on the strategic priorities of the BHR Partnership
- Monitoring and challenging safeguarding performance in Redbridge across all relevant agencies
- Co-ordinating the response to local and emerging safeguarding risks in Redbridge
- Supporting Child Safeguarding Practice Reviews commissioned by the statutory Safeguarding Partners, and ensuring the local dissemination of learning

1.4 Effective multi-agency audits of practice are a key part of quality assurance in safeguarding. It is currently envisaged that multi-agency audits will be co-ordinated on a BHR basis. It may be that in the future multi-agency training will also be delivered on a BHR basis. However, for 2020/21 and pending future developments, the RSCP will take responsibility for planning and delivering a Redbridge Multi-Agency Training Programme. The RSCP will continue to apply the training policies and procedures of the former Local Safeguarding Children's Board (LSCB), including those relating to training charges. The RSCP will seek opportunities to open training to staff and organisations across the BHR area, where appropriate.

1.5 Pending future developments at the BHR level, the RSCP will adopt and continue to apply all policies, procedures and strategies agreed by the Redbridge LSCB before 29 September 2019. This includes the document, "Are you worried about a child? How to access early help, and thresholds for referral to children's social care", September 2018. A full list of LSCB policies, procedures and strategy can be found on the RSCP website, www.redbridgescp.org.uk.

2 Values

2.1 The RSCP has adopted and adapted the values and principles agreed by the LSCB, as follows.

2.2 The Partnership will conduct all its business on the basis of the following core values and principles:

- The Partnership 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 experiences and voices of children and young people are central to all the Partnership's work. The Partnership will work closely with the Redbridge Youth Council, and seek to ensure that the voices of children and young people are heard in everything it does.
- Similarly, the Partnership will at all times seek to understand, listen to and engage with front line practitioners
- The Partnership is concerned with the safety and welfare of children at all stages in the child's journey including early help and early intervention
- The Partnership will pay particular attention to safeguarding and promoting the welfare of the most vulnerable children and young people, including (but not restricted to) children who are or at risk of abuse, neglect or 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 in custody; children who are vulnerable to being radicalised; disabled children; and children and young people affected by gangs.
- The Partnership 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 is of equal value.

2.3 The RSCP does not itself commission or deliver services. It does not have the power to direct partner organisations. It does however have a responsibility to highlight where change or improvements for children are needed. Each partner retains its existing line of accountability for safeguarding and promoting the welfare of children, including action or otherwise on RSCP recommendations and challenges.

3 Structure and governance

3.1 The full Partnership meets four times a year. Any Partnership member may request the inclusion of an item on the agenda. Standing items on each agenda will include:

- Scrutiny of a multi- agency performance data set
- A report from the BHR Safeguarding Partnership
- A review of progress against the agreed priorities for the year, identifying and seeking to resolve any blockages to progress

3.2 The Partnership undertakes much of its work through a number of subgroups. Currently the standing sub-groups are:

- Learning and Improvement subgroup;
- Training subgroup

3.3 The structure, terms and reference, and number of subgroups are subject to review.

3.4 The LSCB will be chaired by an independent person, appointed by the Chief Executive of the Council with advice from partners. The Chair is accountable to the Chief Executive for the effective functioning of the RSCP. A Vice-Chair will be appointed from among the members of the Partnership.

3.5 The LSCB operates within a cross Board Governance Protocol, which sets out the relationships and arrangements for joint working between the Health and Wellbeing Board, the RSCP, the Safeguarding Adults Board, and the Community Safety Partnership. The Chair of the LSCB is an ex officio member of the Health and Wellbeing Board.

4 Membership

4.1 RSCP member organisations will designate a senior officer as their representative at the Partnership, to ensure that there is consistency and continuity in the membership of the RSCP. With the agreement of the Chair, an agency may be represented by more than one person. Members will be sufficiently senior to be able to:

- speak for their organisation with authority;
- Commit their organisation on policy and practice matters;
- Hold their organisation to account;
- Share information about their organisation's approach to safeguarding and promotion of children's well-being; and
- Ensure the dissemination of information within their organisation, regarding the RSCP's work and activities.

4.2 The following agencies will be represented on the RSCP:

- Corporate Director of People, LB Redbridge (which incorporates the role of Director of Children's Services)
- LB Redbridge Lead Member for Children's Services
- LB Redbridge Director of Public Health
- LB Redbridge Children's Social Care Services
- LB Redbridge Housing Service

- Metropolitan Police Service
- Probation Service
- Redbridge Clinical Commissioning Group
- NELFT
- Barking Havering and Redbridge University Hospitals NHS Trust
- Barts Health NHS Trust
- Representatives of maintained primary and secondary schools, academies, special schools and private schools within the Borough
- New City College (Redbridge Campus)
- Partnership of East London Co-operatives (PELC) Ltd.

4.3 Up to five representatives of the voluntary sector will be appointed to serve on the Partnership.

4.4 Three lay members, drawn from the different communities in Redbridge, will be appointed to serve on the Partnership. Appointments will be for three years, and may be renewed. Lay members have equal status with other Partnership members across all areas of the Partnership's work. They have a particular role in:

- Supporting stronger public engagement in local safeguarding issues and contributing to an improved understanding of the Partnership's work in the wider community;
- Challenging the RSCP on the accessibility to the public and to children and young people of its plans, policies, and procedures; and
- Helping to make links between the RSCP and community groups.

4.5 Voluntary sector and lay member representatives will be appointed by the Chair, following appropriate consultation.

4.6 The Chairs of the RSCP sub-groups will be invited to attend meetings of the Partnership.

5 Challenge and scrutiny

5.1 The Children and Social Work Act 2017 requires the statutory Safeguarding Partners to ensure, in making their arrangements for multi-agency working, that they include "arrangements for the scrutiny by an independent person of the effectiveness of the arrangements". At a BHR level, arrangements for independent scrutiny will be agreed by the BHR Safeguarding Partnership. In Redbridge, the RSCP itself, given that these terms of reference include responsibility for monitoring and challenging safeguarding performance in Redbridge across all relevant agencies, is an important part of the scrutiny arrangements. In addition to any scrutiny arrangements that may be agreed, the Independent Chair will act as an independent scrutineer of the effectiveness of the arrangements as they operate in Redbridge.

5.2 The Chair will publish an Annual Report on the effectiveness of the arrangements for safeguarding children in Redbridge. The report will seek to provide a rigorous and transparent assessment of the performance and effectiveness of local services. It will 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 will be submitted to the BHR Safeguarding Partnership for consideration as part of the Annual Report that they are required to publish under the Children and Social Work Act 2017 on the effectiveness of the BHR arrangements.

APPENDIX B

Redbridge Safeguarding Children Partnership (RSCP) COVID-19 Safeguarding Risk Register[1]

1. Increased stress on families leads to increase in abuse and neglect.
Risk assessment 27.5.20: Range of support services in place but this is a high risk inherent in lockdown, scale of which unlikely to be clear before recovery phase. 25% increase in domestic abuse referrals to police between January and March 2020.
Update 7.7.20: Number of contacts has increased. Total number of contacts with social care in June comparable to June 2019. More contacts subject to MASH inquiries and a greater percentage assessed as high risk. Underlying position unlikely to be clear prior to full return to school in September. There has been an increase in the re-referral rate. Increase in referrals involving physical abuse and domestic abuse. Rate of increase in domestic violence referrals to police has slowed in East Area BCU, against trend in rest of London. Reach Out service working well with increased take up of perpetrator programmes.
2. Professionals are not in effective contact with children and families to monitor and implement protection plans
Risk assessment 27.5.20: Over 90% of children on child protection plans have been visited during lockdown. High levels of professional engagement in online case conferences and strategy meetings. Operation Panpan rolled out in BCU to alert neighbourhood police to children on plans.
Update 7.7.20: As above.
3. New cases of abuse and neglect are not effectively recognised or referred due to lack of professional, family and community contact.
Risk assessment 27.5.20: Referrals to social care approximately 60% of normal rate. Contacts from schools down 70% in April / May, but also from other agencies –contacts from police down by 17%, contacts from hospitals down by 30%.
Update 7.7.20: Total number of contacts with social care in June comparable to June 2019. While contacts from schools still down by 58% (although doubled compared to May), contacts from hospitals and police have recovered to same or higher level compared to June 2019.
4. Reduction in face to face assessment may lead to less effective identification of risk
Risk assessment 27.5.20: Social care are confident that rigour of assessment is being maintained, but impact will need to be evaluated over longer period (e.g. if rate of re-referral increases)
Update 7.7.20: As above.

[1] RAG ratings reflect risk assessment as at 27 May 2020.

5. High vulnerability of babies and young children to abuse, compounded by lockdown and closure of early years settings.
Risk assessment 27.5.20: Babies and young children are highest risk group. Number of referrals of unborn children and pre-birth case conferences have not reduced, but contacts re children under 1 down by 25% in April/May.
Update 7.7.20: Contacts in June for children under five 20% recovered to above June 2019 numbers. 109 contacts re unborn babies or children under 1, compared to 83 in June 2019.
6. Young people at risk of deteriorating mental health and wellbeing, with reduced access to services.
Risk assessment 27.5.20: Multi-disciplinary network being used to identify cases where mental health deteriorating, but referrals to EWMHS have reduced by 56% in spite of expected increase in need.
Update 7.7.20: 28% of respondents to survey of young people said they had worried about their mental health during lockdown, and 22% are worried about their future mental health. Referrals to EWMHS in June remain down by 50%. Main referral themes self-harm/ suicidal ideation, anxiety, behavioural problems. Anecdotal evidence of increase in referrals from A&E. Social distancing requirements continue to impact on scope for face to face work and appointment availability. However, some services, where appropriate, can be delivered more time effectively online. There was a spike in referrals from GPs in two weeks following publicised 15-year-old suicide. Safeguarding Partners are undertaking a rapid review of this case to identify potential learning and consider any need for further review.
7. Children and young people at increased risk as a result of increase in parental mental ill-health.
Risk assessment 27.5.20: Adult mental health services reporting significantly lower levels of contact which may be placing children at increased risk.
Update 7.7.20: Referrals have started to increase since the easing of the lockdown although not yet at 2019 levels. However there has been a 20-30% increase in calls involving mental health issues to police. Mental health services have returned to a business as usual configuration in terms of RAABIT (mental health access team) and IAPT services. Social distancing requirements continue to impact on scope for face to face work and appointment availability. However, some services, where appropriate, can be delivered more time effectively online.
8. Risk to vulnerable children and young people identified as priority for school and college places not attending.
Risk assessment 27.5.20: Attendance running at about 11% as of mid-May. Ongoing case by case risk assessment in place. Some young people with EHCPs are shielding and therefore unable to attend school.
Update 7.7.20: Based on return from 52 schools, 26% of vulnerable children attended on 1st July.
9. Increased stress on parents of children with disabilities, and their children, if child not in school or attending other provision

Risk assessment 27.5.20: Increased stress recognised but not leading to safeguarding concerns. Range of supports in place. Families generally well known to and familiar with services so more likely to raise concerns if necessary.
Update 7.7.20: As above. Overall 10% increase in Direct Payments and care packages.
10. Children with EHCP plans not able to take up school places due to lack of capacity in special schools with requirement for social distancing.
Risk assessment 27.5.20: Demand for places in special schools exceeds the number of places that can be offered as a result of social distancing, but schools' response has been based on multi-disciplinary case by case discussion, well-structured and effectively implemented.
Update 7.7.20: As above. Detailed planning underway for September – unlikely that social distancing will allow all children to return full time.
11. Reduced take up of antenatal services increases risks to mothers and new-born babies.
Risk assessment 27.5.20: Risks mitigated by liaison between hospital maternity and community services, and targeting of assessments, but overall there has been a reduction in the available workforce due to redeployment and reduction in number of contacts.
Update 7.7.20: As above.
12. Increased risk of online grooming, radicalisation and abuse, including peer-on-peer abuse.
Risk assessment 27.5.20: Identified as potential risk but evidence not yet apparent. Likely to emerge as children return to school.
Update 7.7.20: As above. No increase in online abuse reported to police, although there is often a time lag in such reporting due to international dimension. Some increase reported in distribution of indecent images within peer groups.
13. Risk of increased use of crisis / emergency responses – PPO/EPO.
Risk assessment 27.5.20: The risk has not materialised. Children's social care has continued to function at near normal levels, including proactive care planning practice.
Update 7.7.20: As above.
14. Reduced access to drug and alcohol services leading to increased risk to children with substance abusing parents.
Risk assessment 27.5.20: Although few cases to date, this risk is inherent in current situation. Increased stress of parenting a factor as well as reduction in availability of services. Substance abuse services have implemented measures to ensure risks identified and mitigated.
Update 7.7.20: As above**.** The R3 service has developed a risk management register which identifies all service users at increased risk as a result of COVID 19, which is reviewed daily. This includes substance misusing parents who receive increased contact from the service (daily in many cases) in order to continually monitor and assess risk. All parents accessing the service are provided with lockable

medication boxes to use at home to ensure children cannot get hold of dangerous controlled medications. The service has also now launched support groups via zoom which includes a group specifically for parents providing practical advice and coping strategies for those that are struggling as a result of COVID 19
15. Stress on carers leading to increased placement breakdown.
Risk assessment 27.5.20: Placements have been well supported and placement stability has not been compromised. Small number of adolescent placements under pressure due to resistance to compliance with social distancing requirements.
Update 7.7.20: High level of placement stability has been maintained.
16. Risk of increase in criminal and other contextual exploitation as perpetrators take advantage of disruption and pressure on services.
Risk assessment 27.5.20: There has not been an increase in identified cases but county lines networks and dealers have adapted modes of operation in response to lockdown context. MPS have been visiting young people involved in gang violence and criminal exploitation to proactively offer diversion activities to encourage them not to return to criminal involvements which are temporarily suspended.
Update 7.7.20: As above. Number of missing children reports down by 30% compared to same period last year.
17. Increased risks to care leavers as they are a vulnerable group who often have few other sources of support outside of care leaving services.
Risk assessment 27.5.20: Increased isolation is very difficult for young people who are often already quite isolated. Leaving Care workers are maintaining contact with as many care leavers as possible, and support has included provision of IT equipment to enable maintenance of social contact. All cases have been RAG rated to enable prioritisation of work.
Update 7.7.20: As above. Most vulnerable young people have continued to be seen face to face. Care leavers' weekly allowance has been increased in recognition of increased costs of internet usage during lockdown.
18. Risk of surge in demand as lockdown restrictions ease, particularly when children return to school, stretching service capacity to respond.
Risk assessment 27.5.20: All agencies are beginning to develop recovery plans including response to potential second wave of virus. Return to school likely to be very slow and gradual which will probably dampen any surge in referrals to social care. MPS anticipating 10-20% increase in safeguarding referrals in recovery phase.
Update 7.7.20: As above. There is strong multi-agency interest in continuing to maximise use of e.g. online meetings, case conferences etc to allow most effective use of time to support recovery. CCG are discussing with NELFT options for addressing anticipated increased demand on EWMHS.