Redbridge Safeguarding Children Partnership

Annual Scrutiny Report 2020 – 2021

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The **Children and Social Work Act 2017** requires that "at least once in every 12 month period" the statutory safeguarding partners (the local authority, the police, and the Clinical Commissioning Group) "must prepare and publish a report on what the safeguarding partners and relevant agencies for the local authority area have done as a result of the multi-agency safeguarding arrangements, and how effective the arrangements have been in practice." It also requires that arrangements are in place for independent scrutiny of the partners' Annual Report. I have been the independent chair of the Redbridge Safeguarding Children Partnership (RSCP) since its launch in September 2019 and have acted as independent scrutineer of the effectiveness of multi-agency safeguarding arrangements as they operate in Redbridge.

In North East London, the statutory partnership responsible for the effectiveness of multi- agency safeguarding arrangements currently sits at a tri-borough level. 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 Service East Area Basic Command Unit (BCU) agreed in 2019 to establish a single set of arrangements across the BHR area – the BHR Safeguarding Partnership. Meetings of the BHR Partnership have been valuable in facilitating information sharing across the wider footprint and some discussion of common issues. However, 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 such a complex matrix, it has been difficult for the BHR Partnership to demonstrate a significant impact on the quality of multi-agency practice and outcomes for children across the wider BHR area. Additionally, the BHR Partnership has not been able to put arrangements in place to meet all those responsibilities which sit at its level. It has not produced an Annual Report since its establishment in 2019. The safeguarding partners have now agreed to move towards re-establishing the statutory partnerships at Borough level, with a continued emphasis on collaborative working across the BHR footprint wherever that adds value. I welcome this decision.

There is no statutory requirement for the publication of an Annual Report specific to Redbridge, as the statutory responsibility is with the BHR Safeguarding Partnership. Public reporting by the safeguarding partners on the effectiveness of multi-agency safeguarding arrangements is thus rather limited by the complexity of the current arrangements. The responsibility for public reporting will be clarified when the statutory partnership is re-established at borough level. In the meantime, I have agreed to produce this brief scrutiny report on the effectiveness of the arrangements as they operated in Redbridge in the twelve months from September 2020.

Statutory Guidance **Working Together 2018** requires independent scrutiny to 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. I can report with some confidence that in Redbridge the arrangements generally work effectively for children and families and for practitioners, and that senior leadership by the safeguarding partners is strong. My confidence derives substantially from the evidence considered at the quarterly meetings of the RSCP. The RSCP is a multi-agency partnership which is responsible 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 from the activities that it oversees. It publishes a quarterly newsletter, and more information about the issues it has discussed, the challenges it has raised, and the actions it has taken can be found in those newsletters. They are available to view on the **RSCP website**.

Last year's **Annual Scrutiny Report** reported in detail on the experience and impact of the first six months of the Covid pandemic, and the extraordinary way in which services and practitioners responded to its unprecedented demands. Sadly, this continued to dominate the partnership's work for much of the year now under review. The RSCP reviewed at every meeting during the year the ongoing and emerging needs, demands, and risks arising from the pandemic, and agency responses. The pattern observed in the first national lockdown, in March 2020, was repeated during the two lockdowns in force during the year covered by this report, with an initial reduction in referrals to children's social care during periods of lockdown, and a surge when restrictions were lifted. Over the period April 2020 to March 2021 as a whole, the number of referrals to children's social care fell by 23% compared to the previous period. Given that referrals were on an upward trend prior to the pandemic (up by 19% in the year to March 2020), it does appear that the recognition of need and risk was significantly suppressed at the height of the pandemic. Similarly, throughout the winter lockdowns of 2020/21, the police reported that referrals for child sexual exploitation were down by 20% from the levels of previous years, and referrals to children's social care relating to criminal exploitation or gang involvement fell even more sharply. However, by September 2021 the overall number of referrals to social care had almost returned to pre-pandemic levels.

Throughout the period, social care performance on all quantitative measures (timeliness of assessment, child protection case conferences, reviews, and visits to children on child protection plans) remained strong. Early help services made a very significant contribution to supporting children and families during this period. The number of early help assessments undertaken under the Common Assessment Framework (CAFs) increased by over a third in the twelve months from September 2020. 2020/2021 was another year of expansion and innovation for the Families Together Hub, providing a wide range of early intervention services managed within Children's Services. Referrals to the Hub were up by 10% compared to the year before.

As referrals to children's social care surged in April and May 2021, the Council's Director of People wrote to partner agencies to stress the importance in that context of ensuring the quality and timeliness of referrals, and consideration of the thresholds for referral: "You will appreciate that when dealing with literally hundreds of contacts, receiving those with missing information, no clarification on what the safeguarding concern is, or misdirected referrals, impacts negatively on our response to all children at risk." This led to a very productive discussion at the RSCP meeting. It is always open to agencies to contact the MASH for advice about potential referrals, and colleagues commented in particular on how useful this, and the support of the CAF Team, are in considering the appropriate channelling of referrals. Partners particularly valued the opportunity to participate in the fortnightly multi-agency Thresholds and Referrals Meeting which is open to professionals working with children, young people, and families in Redbridge. The meeting provides an opportunity to discuss thresholds and gain feedback on the quality, timeliness and appropriateness of referrals submitted to the MASH. It is also a forum for agencies, including health providers, schools, and voluntary sector organisations to feedback to children's social care. While ensuring consistency in the quality and timeliness of referrals remains a continuing challenge, the clear partnership approach to addressing it highlights a key strength of multi-agency safeguarding and its leadership in Redbridge.

Another strength that has been particularly marked during the year has been the partnership's openness to challenge. Small task and finish groups led self-assessments on behalf of the partnership of local performance against two national reports which had been published earlier in 2020 – a Joint Targeted Area Inspection of the multi-agency response to child sexual abuse within the family, and a report from the national Child Protection Practice Review Panel on the understanding of and response to child criminal exploitation (**It Was Hard to Escape**). In reporting their findings to the RSCP, both groups, while identifying much good practice, were frank about areas for improvement and the action required to address them. It seems clear that child sexual abuse within the family is under-recognised in Redbridge, as it is nationally. Only 1.2% of children subject to child protection plans in the borough are subject to those plans under the category of sexual abuse; yet early childhood experiences of sexual abuse frequently come to light later in presentations to both adolescent and adult mental health services. There is good awareness of child criminal exploitation in some areas of the partnership, but it is patchy. On criminal exploitation, the RSCP asked for a follow up report from the Education and Inclusion Directorate within the Council on Redbridge's performance in arranging alternative full-time education for young people permanently excluded from school. **It Was Hard to Escape** identified this as a vital issue in preventing the escalation of risk of harm. The partnership was pleased to learn that Redbridge performs strongly, with the great majority of excluded young people back in education within six days.

Locally and nationally, there has been a massive increase in domestic abuse during the pandemic. The Board received a report on the incidence of and response to domestic abuse in the borough, based on a review by SafeLives carried out over more

than a year from February 2020. Even though this is recognised as a massively important and prevalent issue by all local agencies, the review nevertheless found that there is very significant under-reporting to the police and other services. Perhaps most shocking was some of the professional attitudes reported to the researchers. 43% of professionals in Redbridge surveyed thought that victims and perpetrators were “as bad as each other”. 36% believe it is the victim’s responsibility to protect children. 18% believe that there are a lot of malicious reports of domestic abuse. Clearly there is no room for complacency.

At the same meeting in early October 2021, the partnership received and discussed a very open presentation from Detective Superintendent John Carroll on improvement work going on across the Metropolitan Police Service (MPS) to improve safeguarding outcomes for children. The initial concentration has been on developing targets for improved performance in a victim-focused approach in the areas of domestic violence, child abuse, rape, and sexual offences. Of the 40 measures so far defined, the East Area BCU is currently meeting targets in eleven of them, although this is in the upper half of performance in the MPS as a whole. An improvement programme has invested in audit activity, which is beginning to demonstrate some improvement in practice. However, it was acknowledged that this is improvement from a very low base: in the baseline audits, the BCU’s response in 67% of the cases sampled was judged as either inadequate or requiring improvement.

This links with a wider theme. There is a strong strategic relationship between the safeguarding partners at a senior level. However, this does not always follow through to relationships at the front line. For example, concerns have been raised on a number of occasions by children’s social care staff about difficulties in securing police attendance at child protection strategy meetings, or agreement to participate in joint visits with social workers. There have been occasions when misplaced assumptions appear to have been made by the police that if the location of a young person reported as missing is known, the matter can automatically be categorised as ‘low risk’. Strong relationships at a senior level need to be used collaboratively to drive equally strong relationships at the front line.

Similarly, it has been recognised for some time that improving collaborative working between Child and Adolescent Mental Health Services (known in Redbridge as Emotional Wellbeing and Mental Health Services – EWMHS) and children’s social care is an urgent safeguarding priority. The pandemic has seen a very steep rise in referrals to children’s social care of children with some level of mental health difficulty. However, despite efforts on both sides and some progress, social care staff continue to describe considerable difficulty in accessing the support or engagement from mental health services that they feel they need in responding to these children’s needs. One of the many issues is that there is a clear gap in services for children who do not have a mental health diagnosis but who nevertheless do have very clear needs relating to their emotional wellbeing or functioning. The safeguarding partners conducted one Rapid Review, following the notification of a ‘serious incident’ to the national Child

Safeguarding Practice Review Panel, in the year under review. It concerned the tragic death of a 12-year-old boy who was at the time believed to have committed suicide, although an inquest subsequently recorded a finding of accidental death. The review was clear that the child's death was not in any way foreseeable or preventable. However, it did find in the broader context of work with the family that there had been insufficiently clear pathways and expectations between children's social care and EWMHS. These findings resonated to some degree with those of the review of the case of a 15-year-old boy who committed suicide, described in last year's Scrutiny Report. That review found that there were still elements of silo working within the Redbridge multi-agency system. 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. As an outcome of the most recent review, the safeguarding partners resolved to progress a strategic piece of work to consider the interface between the EWMHS service and other agencies. The review would be undertaken with the aim of reducing silo working across all services when considering children and young people's mental health and improving the connectivity of planning and interventions. In the context of the particular pressures of the last year, this review has not yet been undertaken. It should be a priority to progress it as soon as possible.

Last year's Scrutiny Report recorded a high level of concern about 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 assessment 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. I am pleased to be able to report that the RSCP has recently been assured of significant progress on this issue. In October 2021 the RSCP received a report from the North Central and East London CAMHS Provider Collaborative on the work they have done to improve the management of and access to Tier 4 (specialist inpatient) beds for young people with acute mental health problems. The Board was pleased to learn that in the first year of the programme, admissions to Tier 4 beds had reduced by 34%, out of area placements were down by 73%, admissions for children living with autistic spectrum conditions were down by 50%, and average length of stay had been reduced by 43%. It noted, however, that out of hours response and provision remained problematic.

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. Participation in the 2020/21 programme remained very strong, despite a four-month suspension of the programme at the beginning of the pandemic and the move of all training on to a virtual platform. Pro-rata to the duration of the programme, average monthly attendance increased by 30%.

Overall, my judgement is that the multi-agency safeguarding arrangements in Redbridge work effectively for children and their families, and for practitioners, and have continued to do so despite the enormous challenges and pressures of the pandemic. There are inevitably areas for improvement, some of which have been highlighted in this report. The leadership from the safeguarding partners is strong, although it needs to more consistently be followed though to influence multi-agency practice at the front line. I think that the re-establishment of the statutory partnership and accountability at borough level, with a much clearer focus on safeguarding specifically in Redbridge, will support this. I think that the biggest challenge that the partnership needs to address, as part of that refocusing, is the need to re-establish a strong multi-agency audit programme. This is a key element in 'the clear line of sight' into practice which is an essential characteristic of an effective partnership. Due to budget restrictions, the post of RSCP 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. It was anticipated that the BHR Safeguarding Partnership would deliver a multi-agency audit programme evaluating practice across the footprint. One audit has been delivered, on the response to suicidal ideation among young people. However, I think that the Redbridge safeguarding partners should have oversight of a programme which regularly reports on the quality of multi-agency practice in Redbridge. I urge them to consider that as a priority as the revised, borough based multi-agency safeguarding arrangements come into place in April 2022.

John Goldup

Independent Chair and Scrutineer, Redbridge Safeguarding Children Partnership

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