Redbridge LSCB
Local Safeguarding Children Board

Redbridge Local Safeguarding Children Board

ANNUAL REPORT

2018 –2019

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Foreword

I am pleased to introduce the Annual Report of the Redbridge Local Safeguarding Children Board for 2018/19.

As the introduction to the body of the report explains, this is also the final report of the LSCB, which ceased to exist as a statutory body on 29th September 2019 with the implementation of the Children and Social Work Act 2017. The Board was originally established under the Children Act 2004, and since its inception has made a significant contribution to what Ofsted have consistently found to be the good or outstanding performance of children's services in Redbridge. The LSCB itself was also consistently assessed by Ofsted, in inspections and performance assessments between 2007 and 2016, as variously 'highly effective', 'providing positive leadership', overseeing and promoting 'strong partnership working', and, most recently in 2016, as providing "effective and robust challenge to partner agencies in order that they provide sound, coordinated services for children, young people and families in Redbridge.. a culture where constructive challenge and scrutiny are welcomed in order to improve service provision effectively." Alan Wood, in his review of Local Safeguarding Children Boards which led to the changes to the architecture of children's safeguarding made by the 2017 legislation, reported what he believed to be "a widely held view" that "LSCBs, for a variety of reasons, are not sufficiently effective". Whether this finding was based on evidence or not, or was a pre-formed conclusion, it clearly did not describe the Redbridge LSCB. I make this point to emphasise that the LSCB in Redbridge will leave a very strong legacy of a driving commitment to continuous improvement in the safeguarding of children and young people. I hope and am confident that the new partnership arrangements, again described in the introduction to the report, will build on and develop that legacy. Everybody who has been involved in the work of the Redbridge Local Safeguarding Children Board over the fifteen years of its existence has every cause to be proud of what their work and the work of the Board has achieved over those years.

This is the fifth LSCB Annual Report for which I have been responsible since I began chairing the Board in August 2014. I have made the point in a number of previous reports that I believe that the fundamental purpose of the Report is to answer the question: how well are children and young people safeguarded? I am very pleased that overall this year's Annual Report is able once again to give a very positive answer to that question. In their report published in June 2019, following the inspection of children's social care services carried out in April / May, Ofsted assessed the performance of those services as outstanding. "Senior managers and leaders demonstrate relentless drive and ambition for children, which lead to the

provision of consistently strong and highly effective services for them." While Ofsted focus here on the importance of management and leadership, this statement is, of course equally a tribute to the hundreds of front line staff who deliver those "consistently strong and highly effective services" on the ground, day in and day out.

2018/19 was also a year of continuous service innovation. NELFT's new Emotional Health and Wellbeing Service was launched in June 2018, offering a single point of access, rapid triage and initial assessment. This Annual Report describes some of the evidence considered by the Board during the year that gave assurance that, after a number of years of great difficulty, services for young people with mental health problems were beginning to show some significant improvement.

The reconfiguration of early help services in the multi-disciplinary, multi-agency Families Together Hub, described in Chapter 4 of this report, and the launch of the Family Intervention Team which works with young people on the edge of care or at risk of all forms of exploitation, have been particularly significant. Their impact is already clear. This report describes "a determined and successful drive to seek and deliver interventions which safeguard children and support families in the least intrusive and invasive ways consistent with the paramountcy of the child's welfare." Fewer children are being made subject to a child protection plan – 348 new plans made in 2018/19, compared to 477 in 2017/18. Only 49 Redbridge children were the subject of care proceedings brought by Redbridge in 2018/19, compared to 114 the year before – a 57% reduction, compared to a national fall in care proceedings of less than 5%.

This has also been a year in which there has been a strong corporate commitment to safeguarding children and young people. Two senior management conferences in the Council, opened up to colleagues from partner agencies, were devoted to developing organisation-wide responses to safeguarding issues, and the responsibility of all staff, whatever their area of work, for safeguarding: one on child sexual exploitation, and one on transitional safeguarding.

None of this, of course, should be read as meaning that the pressures on services, or on families and young people, have reduced. Referrals to children's social care were up in 2018/19 by 9%, and have continued to rise since. Practitioners report that the pressures of family poverty are a significant factor in this increase. For adolescents, fear of knife crime is an escalating issue, even if the reality of the statistics does not always support that escalation. Sexual exploitation, gang affiliation, exposure to being drawn or coerced into a lucrative and sometimes violent drugs market, involvement in county lines – these are real risks for young people in Redbridge.

I am very pleased that, in establishing the new multi-agency safeguarding arrangements required by the 2017 Act, the statutory partners (local authorities, police, and the Clinical Commissioning Groups) have recognised the continuing

importance of maintaining a strong partnership body which will continue to focus on local needs and local accountability within the 'tri-borough' arrangements. I am sure that the Redbridge Safeguarding Children Partnership will sustain that focus, and in many respects will carry forward the work and the legacy of the LSCB. I am equally sure, however, that there are huge gains to be made from working more effectively between the local authorities, a single police command, and effectively a single NHS body across the wider Barking and Dagenham, Havering and Redbridge area. The prime example of this is the challenge of finding ways of effectively safeguarding vulnerable adolescents in the context of the risks outlined above – 'contextual safeguarding', where risk is located outside the family and in relation to which it is widely recognised that traditional safeguarding and child protection responses are often ineffective. The published BHR Partnership Plan puts this clearly:

> "The most obvious area where this approach currently applies is in the area of adolescent risk, dangerous drug networks, gang membership and knife crime. This is 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."

The new arrangements should be better placed than traditional single borough structures to develop a co-ordinated approach to this challenge. They should also recognise more effectively than perhaps LSCB arrangements have done the frustrations faced by partners like our NHS Trusts, who work across the BHR footprint and who have had to engage with three different sets of social care referral arrangements and thresholds, three separate LSCB quality assurance and multi-agency audit programmes, three different multi-agency training programmes, three different case review processes, and so on. There is now a new opportunity for streamlining and co-ordination. The published BHR Partnership Plan, quoted in Chapter 6 of this report, is again clear on its commitment to developing a shared programme of reviews across the whole area, with a shared methodology and shared learning.

The new arrangements are of course at a very early and probably evolutionary stage and can be expected to take some time to bed down. Next year the partners will be required to report on the effectiveness of the arrangements, and I hope that they will be able to report significant progress against these opportunities and challenges.

I want to finish by returning to what I hope will be the LSCB's legacy. I think it is twofold. First, the commitment to what Ofsted described as that "effective and robust challenge to partner agencies" and culture of "constructive challenge and scrutiny". This has been a strong feature of the LSCB's work over the past few years and is key, as Ofsted said, to ensuring the continuing provision of "sound, coordinated services for children, young people and families in Redbridge". There are still areas in which it needs to be strengthened. Limited performance

information, for example, has been available from the police. This means that there is no way of assessing whether the quality of police safeguarding work in Redbridge is better or worse than that found in the HMICFRS post inspection review of child protection practice across the Metropolitan Police as a whole, referenced later in this report, in which inspectors concluded that "consistency of effective practice remains weak", with practice judged to be good in only 31% of cases audited and 27% assessed as inadequate. I hope that, in their new role as a statutory and equally accountable Safeguarding Partner, the police will find ways of making more transparent performance information available to the partnership.

The other crucial legacy of the LSCB which we must and will ensure is taken forward into the work of the new BHR Partnership and the Redbridge Safeguarding Children Partnership is the commitment enshrined in the terms of reference that the LSCB adopted in 2017:

> "The experience and voice of young people is central to all the LSCB's work...[it will] seek to ensure that the voices of children and young people are heard in everything it does."

The LSCB has sought to deliver on this commitment through for example a conference led by young people in 2016 on peer on peer sexual harassment, through engaging young people in all its multi-agency audit work, through regular meetings between the Chair and the Youth Council, and through inviting young people to speak to the Board about their safeguarding priorities. It's unfortunate that one of the few actions in the LSCB's Business Plan for 2018/19 which was not achieved was the commitment to secure the involvement of young people in the development of new multi-agency safeguarding arrangements. However, the BHR Partnership Plan makes a strong commitment that in developing its arrangements for the independent scrutiny required by legislation, the partners will ensure "a particular focus on the views of children, young people and families". If safeguarding arrangements are not founded on understanding the lived experiences of children and young people, they will fail in their most fundamental purpose: to improve outcomes for children.

It has been a great privilege to chair the Redbridge Local Safeguarding Children Board since 2014. I owe huge thanks to everybody who has contributed to the work of the Board and supported me in the role – it would be invidious to start naming names, as there are too many to acknowledge. I look forward now to chairing the Redbridge Safeguarding Children Partnership in the first phase of its work.

John Goldup

Independent Chair, Redbridge Local Safeguarding Children Board 2014-2019

Independent Chair, Redbridge Safeguarding Children Partnership

1. Introduction

This is the final Annual Report of the Redbridge Local Safeguarding Children Board (LSCB). The Children and Social Work Act 2017 abolished the statutory requirement for the establishment of LSCBs. It defined instead three statutory 'safeguarding partners': the local authority, the police, and the Clinical Commissioning Group (CCG). 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 those 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 Basic Command Unit (BCU) which is responsible for policing the three boroughs, have agreed to establish a single set of arrangements across the BHR area – the BHR Safeguarding Partnership. The core of this will be a Safeguarding Partners Group – the three Directors of Children's Services, the East BCU Detective Superintendent with responsibility for safeguarding, and the CCG Chief Nurse. 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), modelled initially on the LSCB, will continue to be independently chaired. It will be 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 both locally and contributing on a cross borough basis.

On 29 September 2019, with the coming into force of the relevant sections of the Children and Social Work Act, the LSCB ceased to exist, giving way to its successor body within the BHR Safeguarding Partnership, the Redbridge Safeguarding Children Partnership (RSCP). The RSCP held its first meeting in October 2019.

Every LSCB was required to publish an Annual Report, and this report fulfils that statutory requirement for the last eighteen months of Redbridge LSCB's existence. It reports on the work of the LSCB from 1 April 2018 to 29 September 2019. Activity data, however, relates to the twelve-month period, 1 April 2018 to 31 March 2019. Published benchmarking data, however, where quoted, relates to 2017/18, as comparative data for 2018/19 has not yet been published. This report, like previous LSCB Annual Reports, seeks to meet the requirements of the statutory guidance in place during the LSCB's life: that it should *"provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to*

address them as well as other proposals for action. The report should include lessons from reviews undertaken within the reporting period".

The 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. It is envisaged that, either as part of that report or separately, the RSCP will publish its own annual report focusing on safeguarding in Redbridge.

2. Redbridge LSCB in 2018 - 2019

Section 13 of the Children Act 2004, now repealed, required every local authority with children's services responsibilities to establish a Local Safeguarding Children Board (LSCB) in their area, with a wide-ranging multi-agency membership. Its statutory functions were defined as:

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

Regulations and statutory guidance further expanded on the role and responsibilities of LSCBs. In particular, an LSCB was expected to:

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

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

Statutory regulations required that the LSCB had an Independent Chair. The Board was chaired by John Goldup from August 2014 to September 2019. He was National Director of Social Care in Ofsted from 2009 to 2013, and from 2012 Deputy Chief Inspector. He has also chaired the Redbridge Safeguarding Adults Board since June 2017, and is currently serving as Independent Chair of the Redbridge Safeguarding Children Partnership.

Redbridge LSCB held its last full meeting in July 2019.

LSCB Membership (as at July 2019)
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
Dr Dianne Borien, Head of Early Years
Beau Stanford Francis, Head of Neighbourhood Street Scene
Chris Ma, Head of Positive Activities
Gladys Xavier, Director of Public Health (Interim) (Vice Chair)
Jackie Odunoye, Operational Director, Housing Services
Health Representatives
Bob Edwards, NELFT Integrated Care Director for Redbridge **NELFT**
Graeme Gail-McAndrew, Named Professional Safeguarding Children **NELFT**
Jacqui Himbury, Nurse Director **Redbridge CCG**
Caroline Alexander, Chief Nurse **Bart's Health NHS Trust**
Named Nurse Safeguarding Children (Vacant) **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
DS Shab Chaudhri **East Area Basic Command Unit (BCU), MPS**
DCI Maxine Blackledge **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**
Merherun Hamid, Head Teacher **Apex Primary School**
James Brownlie, Head Teacher **Little Heath School**
Rebecca Drysdale, Head Teacher **Ilford County High School**
Carley Smith, Executive Head Teacher **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
I'sha Hussain, Service Manager **Refuge**
Anna Reilly, Specialist CSE Project Manager **Safer London**
Suzanne Turner-Jones, Assistant Director **Barnardo's**
Ann Garrard, Trustee, RedbridgeCVS representing **Redbridge Children and Young People's Network (RYPN)**
Vinaya Sharma **Redbridge Faith Forum**
Lay Members
Rabiya Rehman
Nahim Hanif
Shabana Shaukat
Participant Observer
Cllr Elaine Norman Lead Member for Children's Services and Deputy Leader of the Council
Advisors to the Board
Bahia Daifi, Assistant Solicitor, Redbridge Legal Services
Lesley Perry, LSCB & RSAB Manager

Structure

The full **Board** met in April, July, and October 2018, and in January, May, and July 2019. Detailed work was undertaken through an Executive Group and Sub Groups, reporting to the main Board.

The **Executive Group**, chaired by the LSCB Independent Chair, provided strategic leadership to the LSCB. It scrutinised key areas of work in detail prior to consideration at the full Board, dealt with budget issues, set the agenda for board meetings, and co-ordinated the development of the LSCB Business Plan. It met twice during the period covered by this report.

The **Child Death Overview Panel (CDOP)** was chaired by Gladys Xavier, Director of Public Health and Vice Chair of the LSCB. In accordance with regulations and statutory guidance, the Panel was responsible for reviewing all deaths of children aged between the ages of 0 and 17 in the Borough, with the exception of stillbirths and planned terminations of pregnancy. The Panel held a Rapid Response Meeting in all cases of the unexpected death of a child. There were 32 child deaths in Redbridge in 2018-19. The Panel assessed whether there were any 'modifiable factors' involved in the death: modifiable factors are defined as 'those where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced'. Examples include smoking in pregnancy, maternal obesity, unsafe sleeping, and parental consanguinity. Modifiable factors were identified in only 3% of the deaths reviewed in 2018/19, although the risk factor remained unknown at the close of the year in a significant number of cases as investigations were ongoing. In contrast to previous years, parental consanguinity was not identified as a factor in any of the cases reviewed where the risk factor was known.

The Panel met on ten occasions during the period covered by this report, and in addition held 17 Rapid Response meetings. On a single borough basis, the numbers of deaths to be considered is, fortunately, too low to allow any reliable conclusions to be drawn or trends identified. Under the Children and Social Work Act 2017, the responsibility for the child death review process is jointly held by the local authority and the CCG. From September 2019 a single child death review process will operate across the three boroughs of Barking and Dagenham, Havering and Redbridge. This will produce more meaningful data across a larger population.

The **Training Subgroup** continued to be chaired in 2018 – 2019 by Graeme Gail-McAndrew, Named Nurse Safeguarding Children, NELFT. The Subgroup was responsible for undertaking training needs analysis across partner agencies, commissioning the LSCB's own Training Programme and quality assuring safeguarding training, including an evaluation of its impact on frontline practice. The Group met six times during this period.

The **Learning and Improvement Subgroup** continued to be chaired in 2018 – 2019 by Judy Daniels, Principal Child and Family Social Worker and Head of Safeguarding and Quality Assurance in LB Redbridge. The role of the Subgroup was to ensure continuous improvement in line with the LSCB's Learning and Improvement Framework. It was responsible for the development and delivery of the LSCB's Multi-Agency Audit Programme, reporting on both strengths and areas for improvement in front line multi-agency practice, and for identifying and disseminating the lessons to be learned. The findings of and learning from the multi-agency audit programme are discussed later in this report. The Group met six times during the period.

A **Serious Case Review (SCR) Panel** was established when required to oversee the completion and publication of an independent review of a case which met the statutory criteria for an SCR, as they were in force until 29 September 2019 – that either a child has died, or a child has been seriously harmed and there is cause for concern about the way agencies have worked together to safeguard the child, and in either case abuse or neglect is known or suspected. An SCR Panel to review a case meeting these criteria was convened in March 2018. The Panel met eight times during the period covered by this report, and the review report will be published by the end of 2019.

Funding

The table on the next page shows the contributions to the LSCB budget for the financial year 2018/19 from partner agencies, and the expenditure incurred.

Income		Expenditure	
Training attendance/non-attendance fees	29,965	Office Expenses	903
LB Redbridge *(comprising of contributions from Children's Services, Adult Services, Public Health & Housing)*	66,680	LSCB Training Programme	12,350
LB Redbridge, Corporate funding	72,793	LSCB Independent Chair	33,335
Metropolitan Police	5,000	LSCB Business Manager *(pro-rata with 30% re-charged to Redbridge SAB from June 2017)*	53,263
National Probation Service (NPS)	1,100	LSCB Quality Assurance Manager	60,096
London Community Rehabilitation Company (CRC)	1000	LSCB Training Manager *(Part Time)*	32,836
Cafcass	550	LSCB Senior Admin Officer	33,401
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)	500		
Total Income	224,049	**Total Expenditure**	224,049

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

The Metropolitan Police contribution was 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 may continue 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'. The published plan for the BHR Partnership: Multi Agency Safeguarding Arrangements 2019-20 states only however that "Existing funding levels will continue; SPs do not intend that this Plan will increase costs". While there should be no necessary expectation that costs will increase, and indeed with more cross-borough work there may be efficiencies to be realised, the distribution of those costs may remain an issue.

Throughout the period covered by this report, the LSCB Team was:

- Business Manager – Lesley Perry
- Senior Administrator – Andrew Reed
- Quality Assurance Manager – Andrea Barrell – to February 2019
- Training Manager – Amanda Jones
- National Management Trainee - Paree Bhanu – Oct 2018 – April 2019

The Quality Assurance Manager post has been held vacant due to budget constraints since Andrea Barrell left in February 2019.

Business Planning

The Board's Business Plan in 2018/19 was structured around six priorities:

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

Progress against the Business Plan was reviewed at every Board meeting in 2018/19, with slippages identified and corrective actions agreed. At the final review in May 2019, of the 34 discrete actions in the Plan, 29 were assessed as 'Green' - fully completed, and 5 as 'Red' – not completed.

The actions which were graded 'Red' were:

- **Gathering of intelligence and analysis to identify self-harm trends in particular schools or colleges**

  It proved to be not possible to extract this data from the Children's Services information system.

- **Review of multi-agency arrangements to identify young people at risk of all forms of exploitation**

  This action was primarily concerned with extending the remit of the MASE (multi-agency sexual exploitation panel) to include criminal exploitation. This action has been completed in 2019/20

- **Review effectiveness of Missing Children Panel and relationship with MASE**

  This action was linked to the one above.

- **Development and agreement of new safeguarding partnership in consultation with key stakeholders by statutory partners, in consultation with the wider LSCB.**

  Although the arrangements had not been fully agreed by year end, the BHR Plan was published in line with the statutory deadline at the end of June 2019.

- **Secure involvement of young people in development of new multi-agency safeguarding arrangements**

  This was not achieved.

At its meeting in May 2019, the LSCB agreed four priorities for its work in 2019/20 which have subsequently also been adopted by the Redbridge Safeguarding Children Partnership:

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

3. Safeguarding in Redbridge: demand, response and performance

Safeguarding in Redbridge: need, risk, and demand

The demand on children's social care, measured by the number of referrals received, fell from a peak of over 5000 referrals in 2014/15 to under 4200 in 2017/18. However, it is clearly beginning to rise again; up by 9.1% to 4540 in 2018/19, with indications that the rise in demand is accelerating in the first few months of 2019/20.

Referrals to Children's Social Care						
2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
3648	4718	5175	5086	4125	4161	4540

Referrals from BHRUT fell slightly, from 448 in 2017/18 to 349 in 2018/19. Across all local authorities, there were 354 referrals made to children's social care made as a result of concerns identified from an adult attendance – encouraging evidence of a 'Think Family' approach.

There were 1240 referrals to children's social care in the first three months of 2019/20, compared to 1022 in the same quarter the year before: a 21% increase.

'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					
2013/14	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
482	676	1038	1173	1175	1263

The increase in Section 47 activity is approximately proportionate to the increase in referrals. 386 Section 47 enquiries were completed in the first quarter of 2019/20, compared to 318 in the same quarter of 2018//19.

Historically, as the table shows, Redbridge had a very low rate of S47 enquiries, which gave rise to some concern that the bar for 'reasonable suspicion' might be being set too high. The rate of S47 enquiries relative to population, at 166.8 per 10,000 children, is now identical with the rate for England as a whole. While the number of Section 47 enquiries has increased, the percentage of enquiries that lead to an initial case conference in 2018/19 fell from 41% to 33%. In the first quarter of 2017/18 only 20.2% of Section 47 enquiries led to an initial case conference. It

appears 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.

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.

On 31 March 2019, 249 children in Redbridge were subject to a child protection plan, compared to 298 a year earlier and 380 the year before that.

Children subject to child protection plans on 31 March					
2013/14	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
188	268	349	380	298	249

Nationally, for the second year in a row, the number of care proceeding applications fell in 2018/19, by 4.6%. However, the fall in the number of children who were the subject of care proceedings brought by Redbridge was much more dramatic: proceedings involved 114 children in 2017/18, and only 49 in 2018/19 – a 57% reduction. By contrast, the number of early help assessments completed in Redbridge using the Common Assessment Framework (CAF) increased, from 867 in 2017/18 to 1123 in 2018/19 – a 30% increase.

In recent years, while the number of children subject to child protection plans at year end has fallen year on year, the number of new plans made during the year has continued to rise, suggesting that the average duration of plans was becoming shorter. However, in 2018/19, this trend was reversed: the number of new plans made fell from 477 to 348, a reduction of 27%.

Number of children becoming subject to a child protection plan during the year								
2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
184	189	153	228	309	409	459	477	348

It seems clear that there has been a determined and successful drive to seek and deliver interventions which safeguard children and support families in the least intrusive and invasive ways consistent with the paramountcy of the child's welfare. It is of course essential to have assurance that this approach does not result in any failure to address real risks. Very strong assurance on this point was given by Ofsted's report on their inspection of children's services in May 2019. While describing "purposeful work to keep children at home safely whenever it is possible and safe to do so", inspectors were also clear that "authoritative action" is taken when children are at high risk of harm.

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. Again, for several years, this pattern has been reversed in Redbridge: 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, however, although emotional abuse remained the largest single category of risk recorded, it accounted for only 50% of plans made, with neglect the main grounds for concern in 44% of cases. This may reflect a reduction in the number of plans made in relation to older young people, and this in turn may reflect the impact of the Family Intervention Team, launched in April 2018 and described later in this report, with its intensive focus on finding new ways of working with adolescents at risk. In the previous three years there was a year on year increase in the number of young people aged 16 or 17 made subject to child protection plans, reflecting an increasing awareness of the vulnerability of adolescents at risk: 15 in 2015/16, 25 in 2016/17, and 32 in 2017/18. In 2018/19 only 15 plans were made on young people aged 16 or over.

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 2018/19	As a % of children subject to a CP Plan 2017/18	As a % of children subject to a CP Plan 2016/17	As a % of the 0-17 population in Redbridge (GLA projection 2017)
White	30%	20%	25%	22%
Mixed	13%	23%	10%	10%
Asian or Asian British	40%	40%	49%	55%
Black or Black British	14%	13%	14%	10%
Other ethnic groups	2%	3%	1%	3%
Unknown (unborn)	1%	1%	1%	0%

No clear conclusions should be drawn from year on year fluctuations in this data. It may be noted, though, that 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.

Alongside the launch of the Family Intervention Team, Early Intervention services were radically reconfigured in May 2018, bringing together a whole range of services and skills with the explicit aim of offering a coherent system of support at the earliest possible stage as families begin to experience difficulties, and avoiding the need for more intrusive interventions further down the road. These developments, which appear to have had a significant impact, are described more fully later in this report.

Safeguarding in Redbridge: performance, quality and outcomes

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

Indicator	Redbridge 2018/19	Redbridge 2017/18	Redbridge 2016/17	National 2018/19	Statistical Neighbours 2018/19
% of repeat referrals within 12 months	17.1%	15.3%	17.9%	21%	20%
% of assessments completed within 45 days	97.3%	91%	93.5%	83.1%	84.9%
% of initial child protection case conferences held within 15 days of strategy meeting	96.9%	89.2%	86.0%	79%	74%
% of child protection plans reviewed within required timescales	98.2%	99%	96.3%	91.8%	92%
% of children becoming subject to a second or subsequent child protection plan	10.6%	7.4%	4.1%	20.8%	19.1%
% of children whose plan ended during the year who had been on a plan for two years or more	2.5%	3.4%	1.7%	3.3%	2.6%

Several points emerge from analysis of this data.

- The percentage of repeat referrals to children's social care has risen slightly for the first time in at least three years. However, it remains below that for both statistical neighbours and England as a whole. 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.
- 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, and to improve upon what was already very good performance.

- The percentage of children becoming subject to a child protection plan for a second or subsequent time has increased, although it is still well below both statistical neighbour and national averages. 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 caution should be exercised in commenting on one year's 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 can be noted however that data for the first few months of 2019/20 show a very low percentage of repeat plans – just 1.3% of the plans made between April and June 2019.
- The percentage of plans which were ended during the year which had been in place for two years or more fell in 2018/19, having peaked the year before. Again, the data is subject to fluctuation due to the make-up of the cohort. Reported performance may though indicate the impact of a focus on the effective review of plans and on ensuring that they do not last any longer than necessary.

Inspection evidence

In addition to the performance data discussed above, performance has been externally evaluated in 2018/19 through a range of inspection activity.

Ofsted's inspection of children's social care services in the London Borough of Redbridge

The report of this inspection, published on 11 June 2019, has already been referred to. The inspection was carried out between 29 April and 3 May 2019.

Overall, children's services in Redbridge were judged to be **outstanding**. The impact of leaders on social work practice with children and families, and the experiences and progress of children who need help and protection, were both judged to be outstanding. The experiences and progress of children in care and care leavers were judged to be good.

In their Executive Summary, inspectors said:

> Children's services in Redbridge are outstanding. The appointment of the current director of children's services (DCS) in October 2016 led to the further strengthening of services following the previous inspection in 2016, when services were judged to be good. He is supported effectively by purposeful

and informed political leaders and a stable and appropriately authoritative senior management team. Senior managers and leaders demonstrate relentless drive and ambition for children, which lead to the provision of consistently strong and highly effective services for them.

This exceptional leadership is, in equal parts, enabling and challenging, promoting best practice and innovation. Staff enjoy working in Redbridge. They feel safe and well supported. This results in purposeful work to keep children at home safely whenever it is possible and safe to do so. This exemplary management has created conditions that afford workers the time, professional expertise and capacity to get to know children and young people well and exercise their professional expertise. This best practice secures positive experiences and good progress for children.

The changing nature of the needs of Redbridge children and young people means that expertise and services need to be developed to address emerging risks associated with gangs, county lines and exploitation. Leaders and managers are ensuring that they understand these changing needs and are meeting these challenges well. There is clear evidence of a reflective and questioning working culture, and this results in a local authority that knows itself well and takes determined and proactive steps to improve outcomes for children.

Purposeful and persistent activity has resulted in a significant and widespread strengthening of key areas of practice since 2016. For example, independent reviewing officers offer strong challenge and oversight, and permanence planning is carefully tracked and begins at the earliest opportunity. Robust assessments of connected carers are carefully overseen. Services found to be outstanding in 2016, including the 'front door', have been further enhanced, meaning that even the best services have further improved.

Children in care receive a thoughtful and proactive service from workers who know them exceptionally well. Direct work and the promotion of the voice of the child are particularly strong. Carers provide stable homes and are supportive and ambitious for the children for whom they care. The local authority has an effective mechanism that informs and assures leaders about the quality of practice across all service areas. This has enabled senior managers to develop ambitious and credible plans to further improve services for all care leavers so that they receive consistently good planning and support into adulthood.

The service for care leavers is provided through a commissioned service and has been a priority area for development for senior managers. Progress has been made for care leavers and the pace has increased since a focused visit in December 2018. However, there is still more work to be done to ensure

> consistency of experience for all care leavers. Senior strategic overview and ownership of the service for care leavers ensure that this focus continues to build further on the achievements so far.

The one area for improvement identified in the inspection was in the consistency of the quality of practice for all care leavers.

Joint Ofsted and Care Quality Commission local area SEND (special educational needs and disabilities) inspection

This inspection was carried out in June 2018, and the letter containing the findings was published in August. Overall inspectors identified both significant strengths and significant areas for improvement. Safeguarding, however, was found to be a particular strength:

> "Safeguarding is managed well by the local area. Leaders have a strong focus on knife crime and gang culture, the specific issues that affect young people's safety and well-being in Redbridge. Initiatives include working closely with schools and a programme of drama workshops to help raise pupils' awareness. Typically, children and young people who have SEN and/or disabilities feel safe."

HM Inspectorate of Constabulary, Fire and Rescue Services, Child Protection Post-Inspection Review, Metropolitan Police Service (MPS)

This review was carried out in October 2018. It followed up on the extremely critical findings of the original inspection in 2016, and a series of quarterly reports reviewing progress against the recommendations form that inspection published in 2017. The post-inspection review report was published in March 2019. The review considered the position across the whole of London, and no specific conclusions about practice in Redbridge can be drawn from it. Overall, the review found that since 2016 the MPS had continued to make changes and improvements in child protection. However, it found that in some areas of practice progress had been slow. Inspectors were particularly concerned about how the MPS responds to indecent images of children and online child sexual exploitation: "We found that the current arrangements for investigating online cases involving IIOC and sexual exploitation are not working." They were also concerned about arrangements for the management of registered sex offenders. In some areas, sex offender managers were managing over 100 offenders each, compared to the 50/60 that were found in the 2016 inspection. It is encouraging to report, however, that in the East BCU the average caseload remains at 50 cases. More broadly, based on an analysis of over 300 case files, inspectors concluded that "consistency of effective practice remains weak", with practice judged to be good in only 31% of cases, with 27% assessed as inadequate. Unfortunately, no information is available on audit outcomes on cases

audited in Redbridge or the wider BCU, so it is not possible to make an evidenced assessment of the consistency of effective practice locally.

HM Inspectorate of Probation, Inspection of London Community Rehabilitation Service

This inspection was carried out in April 2019, with the report published in August. Again, it covered practice across the whole of London. The inspection found very considerable improvement since the London CRC had been judged to be inadequate in 2016, and in his foreword to the inspection report the Chief Inspector wrote that the overall rating came 'close' to good. However, it settled at 'requires improvement' due to continuing weaknesses in some case supervision. These particularly impacted on safeguarding and managing the risk of harm to victims and others: "risk of harm work is failing to take sufficient account of information from partners, such as the police or children's social care services, or of past aggressive behaviour."

The government has announced its intention to change the arrangements for delivering probation services, and has given notice to CRCs that it will terminate their contracts early, by spring 2021, with responsibility for offender management passing back to the National Probation Service at that point.

There were no inspections of NHS providers with a relevant focus on children's safeguarding in the period covered by this report. However, data monitored by the LSCB demonstrated that NELFT, BHRUT and PELC all achieved over 95% compliance with mandatory safeguarding training requirements during the year. Compliance at Whipps Cross Hospital (Bart's Health NHS Trust) was lower, at 87%, although data was incomplete. Compliance with safeguarding supervision standards was 94% at BHRUT and 87.7% at NELFT. BHRUT produce regular Safeguarding Bulletins for circulation to all staff. Eleven Special Safeguarding Bulletins were produced during the period covered by this report. Subjects covered included the crucial importance for practice of the Child Protection Information System (CP-IS) which among other functionalities alerts health staff if a child attending hospital is subject to a child protection plan, and alerts social care to unscheduled hospital attendances by a child subject to a plan; the 'Think Family' approach; and female genital mutilation. The implementation of CP-IS at BHRUT was the subject of a 'good practice' article published by the NHS Leading Change, Adding Value team in October 2018. One of the Special Bulletins was devoted to the lessons learned from a Redbridge LSCB multi-agency audit of work with children affected by parental ill health.

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

This Chapter reports on some of the key areas of work and provision with which the LSCB 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.

Early help can be provided by the Families Together Hub (formerly the Early Intervention and Family Support Service - EIFSS), a multi-disciplinary service which sits within the Council. Alternatively, it may be provided by partner organisations and universal services, by 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'. In 2018/19, 13% of the contacts received by children's social care were referred to early intervention services, up from 10.5% the year before. In each year, referral to early intervention was the outcome in approximately 20% of the referrals that proceeded to a full social care assessment. Overall over the last two years, the number of referrals to the EIFSS / Families Together has fallen slightly. However, the number of completed CAFs has increased each year – by almost 30% in 2018/19.

	2016/17	2017/18	2018/19
Referrals to EIFSS / FTH	4787	4491	4393
Completed CAFs	789	867	1123

The Families Together Hub was launched in May 2018. It brings together a range of social care and family support services with commissioned services from voluntary sector organisations working with drug misuse, gang affiliated young people, child sexual exploitation, and harmful sexual behaviour. It has strong links with employment and other community services. 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". Specialist services offered include parenting assessments and programmes, CAF support, intensive work with young people at risk of exploitation and with families experiencing intergenerational parenting issues, and a partnership with Box Up Crime, an innovative community

based project using boxing as a way of offering young people a route away from crime and gang involvement.

In their report on the inspection of children's services that took place in April / May 2019, Ofsted described the reconfigured Families Together 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".

Help for young people experiencing mental health difficulties

Serious deficiencies in the services available for young people experiencing mental health difficulties have been a major focus of concern for the LSCB for some time. The Annual Report for 2016/17 described an emerging crisis in these services – "a crisis which, without being melodramatic, could place some of our most vulnerable young people at substantially increased risk". The Chair's foreword to that report was clear: "If young people in Redbridge are to be adequately safeguarded, we have to see dramatic and rapid improvements in a system that promotes resilience in all young people and provides appropriately intensive and timely help for those young people in most need." The 2017/18 Report recorded continuing difficulties in the delivery and availability of the service, but some grounds for optimism about the future:

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

It is therefore pleasing to be able to report that in 2018/19 the LSCB received a number of reports which gave assurance of 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 Wellbeing Hub provides a single point of access, rapid triage and initial assessment. Schools have particularly welcomed the introduction and visibility of STAR (Support and Recovery Time Workers), whose role

is to offer outreach support to schools, to develop drop in sessions and support to school staff with making referrals to the service. They will also provide direct brief intervention support to children and young people where appropriate. The Board was assured in October 2018 that the service was now in a position to accept all referrals, in stark contrast with the situation a year earlier, when what was then the CAMHS service was able to accept less than half the referrals for treatment received. As well as an initial telephone assessment within 36 hours of referral, young people were offered a face to face assessment within four weeks of referral. The average waiting time from referral to treatment (as opposed to assessment) increased in 2018/19 from 9.7 weeks to 11.6 weeks. However, the percentage entering treatment within the national target time of 18 weeks increased from 91.4% to 97%.

It will be timely for the Redbridge Safeguarding Children Partnership to receive a report at its first meeting in 2020, to ensure that the welcome improvements reported have been sustained and enhanced.

Exploitation

Improving the protection and support of children who are sexually exploited, and strengthening our work in identifying, disrupting and prosecuting child sexual exploitation, have been priorities for the LSCB for several years. The Board receives a comprehensive annual report on the identification, management and disruption of CSE in the Borough. Increasingly, however, the Board has recognised that while tackling the sexual exploitation of children remains a critically important issue, the exploitation of young people takes many different forms, often interrelated and affecting 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. Children's social care made 13 referrals to the National Referral Mechanism, the body charged with supporting victims of modern slavery and trafficking, in 2018/19. The Board has welcomed and supported the increasing focus on exploitation in its wide sense in both strategic planning and service delivery.

It is widely recognised that traditional safeguarding and child protection responses, which have been developed primarily to deal with intra-familial abuse of children, are often ineffective for these young people. We recognised this in the LSCB's Annual Report for 2017/18:

> “One of the challenges of safeguarding work is that it operates in a changing landscape. New issues emerge over time, demanding new and innovative responses. It became clearer during 2017/18, for example, that gang affiliation, the risks it poses to young people, the associated phenomenon of ‘county lines’ activity, and potential links with child sexual exploitation, are more significant issues in Redbridge than had previously been recognised. It is also increasingly recognised that these challenges demand new approaches to engaging with young people.”

Young people involved in these activities may well not recognise themselves as exploited or at risk in any way. These new approaches need to provide and encourage opportunities for them to develop a relationship within which they can be helped to identify and explore risks and self-protection with a trusted professional of their choice, whether that be a youth worker, teacher, social worker, or other. In other words, developing a ‘relational practice model’ requires us to loosen our assumptions about the allocation of professional roles. The LSCB hosted two half day seminars on the development of ‘relational practice’ in September 2018. The seminars were led by Gary Ridgeway, a former senior police officer, who has worked in a number of locations across the country and led a number of successful proactive investigations into child sexual exploitation. The first seminar was multi-agency, attended by professionals from a whole range of Council and NHS services, schools, the voluntary sector and the police. The second seminar was focused on work in children’s social care. The discussions were challenging and stimulating, and attendees reflected that the events made a significant contribution to practice development in this area of work.

171 contacts about individual young people, raising concerns about possible sexual exploitation, were received by children’s social care in 2018/19 - an increase of 44, or 26%. In contrast, the number of new cases of alleged CSE in Redbridge in 2018/19 recorded by the police fell by almost 40%, from 77 to 47 cases. Although there were also falls in the number of new cases recorded by the police in Barking and Dagenham and in Havering, they were much smaller - 9% and 14% respectively. The reasons for these different trends are not clear.

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 – 80% 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. However, not all suspected victims fit this picture: six children under 10 were the subject of CSE strategy meetings. The vast majority of young people who were believed to be potential victims of sexual exploitation lived at home and attended school; significant numbers had experienced mental health difficulties, had lived with domestic violence, and had been recorded as missing from

home or care on at least one occasion. Of the suspected perpetrators for whom details were available, the majority were aged between 18 and 25, although there were a number of both older men and under 18s identified. Half of the suspected offenders were known or believed to be members of gangs.

It remains extremely difficult to accurately estimate the extent of child sexual exploitation. It is even more difficult to quantify the extent of the criminal exploitation of young people – there is no accurate figure for the number of young people engaged in county lines, for example. The sharing of information between police forces about young people arrested in one area of the country for drug offences and resident in another is limited, although it is known, from information and intelligence collated by the Council's Missing Children's Team, that county lines involving young people from Redbridge have been established in Wales, Southampton, Exeter, Bath, Colchester and the Ipswich area. However, with the arrangements put in place at the beginning of 2018 to develop a more strategic and evidence based response to CSE through a reshaped MASE (Multi Agency Sexual Exploitation) Panel, described in last year's Annual Report, information sharing at a strategic level has improved. In particular, the MASE has identified several 'hot spots' in the borough where young people are at particular potential risk of exploitation, and all these areas have been targeted either for police or Community Safety enforcement activity. A significant police operation took place throughout 2018 around Ilford Station, targeting a group of men who were suspected of sexually exploiting young women in exchange for drugs and alcohol. A number of arrests were made, and seven child abduction warning notices were issued. These can be issued against individuals who are suspected of grooming children by stating that they have no permission to associate with the named child and that if they do so they can be arrested. In total the police issued 25 child abduction warning notices in 2018/19, more than three times the number issued in 2017/18, and there were successful prosecutions for breach of the orders in two cases. The police also continued to deliver Operation Makesafe, working with the hospitality trade to promote increased awareness of child sexual exploitation and proactive responses. A number of hotels were targeted, using police cadets posing as children booking into a hotel with an adult. Only one hotel responded appropriately, and work has been undertaken with the other hotels involved to address this.

A Family Intervention Team was established within children's social care in April 2018. The team includes social workers, youth workers, family support workers, and staff from voluntary sector agencies working with young people affected by sexual exploitation, drug misuse, or gang membership. A report to the LSCB on the team's first six months in operation highlighted that while sexual exploitation was the primary cause of concern in 35% of the cases that the team had worked with, gang affiliation was an even more prominent issue – the primary cause of concern in 40% of cases. A new post has also been created in the Council, Manager of Specialist

Services for Exploited Children, to provide strategic leadership for work to tackle the full range of youth exploitation. This broadening of focus has been reflected in partner agencies: during the year NELFT replaced what had been a child sexual exploitation policy with a single policy on 'Protecting Children and Adults against Exploitation', covering sexual, criminal and gang exploitation. Tackling exploitation has also been recognised as a corporate issue. In March 2019 the LSCB Business Manager co-presented a workshop for all senior managers in the Council on child sexual exploitation. The outcome was an action plan on preventing and detecting CSE which engages every Department and section with the Council.

Closely related to all this work is the work of the 'Reducing Group Violence and Exploitation' task and finish group, which met throughout 2018/19. This group's brief is "to review and establish on-going strategies and arrangements for reducing the incidence of serious group violence (gangs) and the exploitation (criminal and sexual) that is associated with gangs". It is led by and reports to the Community Safety Partnership, but the LSCB maintained close contact with it and reviewed both the group's action plan and progress against it during 2018/19. Discussion at the Board was especially useful in both raising awareness among school representatives of the work being undertaken, particularly in a specific locality, and in generating some specific actions to improve the flow of information to schools about the picture of gang activity in the borough and the range of diversionary activities available. An important commitment in the action plan is to work with individual schools to develop bespoke safeguarding plans, focusing on issues such as known problem locations around the school and routes to school, 'problem times', and gang activity in the locality, and to agree multi-agency plans to address the problem issues. Initial pilot discussions have taken place with two schools, but this remains a commitment to deliver in 2019/20.

In May 2019, Redbridge Community Safety Partnership hosted a multi-agency conference on Serious Group Violence for over 200 professionals from across BHR. The conference had a particular focus on the impact of trauma and adverse childhood experiences on adolescent development and behaviour and included a strong presentation promoting trauma-based practice in schools and other settings. Work is also underway to roll out training on trauma-informed practice in children's social care.

As noted in the chapter on Early Help earlier in this report, a partnership with Box Up Crime, a diversionary project, is embedded in the Families Together Hub. This partnership is funded from the Supporting Families Against Youth Crime fund announced by the Government in October 2018.

2018/19 was a year of innovative service development, and one in which significant progress was made in strengthening the partnership's strategic grip on tackling exploitation in all its forms. There is still much to do in developing a really accurate

and granular picture of exploitation in the borough, and targeting action to stamp it out; and the Redbridge Safeguarding Children Partnership will build on the legacy of the LSCB in taking this work forward. The LSCB was particularly struck by a comment made in the national media by a recovering local former crack user and reported to it in its overview of work to tackle exploitation in the borough:

> "There are six or seven dealers in Ilford. They give it to you free to start with. One of the kids that drops the drugs off is no more than 12 years old."

That is the reality on the ground of the exploitation of children.

Transitional safeguarding

Both the LSCB and the Safeguarding Adults Board have become increasingly concerned about what is known as 'transitional safeguarding' – a concern about vulnerable young people who become vulnerable adults and potentially fall through the gaps between two safeguarding systems. Both Boards considered a paper on this subject from the Council's Director of People in April / May 2019. A joint project has now 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. It is expected that the group will report back with proposals to both the Redbridge Safeguarding Children Partnership and the Safeguarding Adults Board by the end of 2019/20.

Children going missing from home and care

Previous Annual Reports have described a range of initiatives and activities which have been established in Redbridge to seek to reduce the incidence of children going missing from home and care. These initiatives have included the development of a dedicated Missing Children's Team in children's social care; a comprehensive Return home interview service; 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; and increased engagement with children's home providers by the police and children's social care. There were further service developments in 2018/19. The Missing Children's Team have extended their direct work with young people, offering time-limited bespoke packages of 1:1 work with children with a pattern of repeated missing episodes. More systematic arrangements have been put in place to follow up issues raised in Return home interviews, and the commitment to provide "a service that best fits their need according to the specific 'push-and-pull' factors" was commended by Ofsted in their report on the 2019 inspection of children's services. For example, 53 young people were referred to a specialist gangs worker following a Return home interview in 2018/19, 33 to specialist CSE services, and 26 to the Youth Service. The Family Intervention Team, established in April

2018 and described earlier in this report, has engaged with young people on the edge of local authority care or at risk of exploitation.

For the first time in several years, the number of children who were reported to the police as missing, either from home or from care, fell in 2017/18. In 2018/19, the number of children who went missing from care at some point in the year was almost unchanged: 51 in 2017/18, and 52 in 2018/19. Some caution should however be exercised in analysing this data as it may be influenced by under-reporting: children's homes and other care providers have reported that the long delays which they experience in getting through to the 101 number on which they report missing young people to the police have led on some occasions to them giving up attempting to make the report. However, in October 2018 the Metropolitan Police introduced new arrangements for online reporting of missing persons, which may make it easier for providers to report young people missing from care. The numbers who went missing from home, however, continued to fall, from 182 in 2017/18 to 163 in 2018/19.

All young people who go missing, whether from home or care, are offered a "return home interview". The aim of the interview is to explore with the young person the reasons they went missing, to develop their understanding of the risks they may have exposed themselves to, and to think about alternative strategies for dealing with issues they may be confronting. Intelligence from return home interviews is shared with the police. Interviews are also offered to parents or carers, to help identify any potential support needs. 80% of young people who are offered a return home interview took up the offer in 2018/19, up from 67% two years ago.

Information reported to the LSCB on young people who went missing from care during the year shows that:

- On average, young people went missing an average of 8.5 times in the year, compared to an average of 7.85 episodes in 2017/18
- The majority of the young people concerned (83%) were aged 15 or over, and 60% of them were boys.
- There is no significant difference between the ethnic profile of children who went missing from care and that of the 'looked after children' population as a whole.
- 75% of missing episodes lasted one day or less. However, young people went missing from care for 5 days or more on 47 occasions.
- Half of the young people who went missing during the year were missing more than five times during the year. 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.

The profile of young people who go missing from home is different.

- The average number of times young people went missing was 1.63, down from 1.95 in 2017/18
- Younger children are more likely to go missing from home than they are from care. Only 60% of the young people who went missing from home were 15 or over. 30% were aged 13 or 14.
- Almost half the young people who went missing from home were girls
- When they do go missing from home, young people tend to be missing for slightly longer. Only 60% of absences were for one day or less. There were 49 absences for five days or more (18% of the total number of episodes, compared to only 10% for children missing from care.)

There is a particular concern about the number of 14 and 15-year-old girls who go missing from home – 55% of the total number of young women involved in missing episodes during the year. At least a quarter of these young women were identified as either victims or at high risk of sexual exploitation. 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, and perhaps increasingly so. From a range of information and intelligence collated by the Missing Children's Team, it is known that at least 12 of the children who were missing from home for extended periods and 11 children missing from care have been involved in county lines activities. Many of the behaviours that are described within the reports of return home interviews could be described as risky, some acutely so. However, there is practically unanimity from the young people who at the time did not view their behaviours as exposing them to increased risk. This is an ongoing challenge to all professionals working with young people.

Much 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 numbers are high. 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 31.3.19 was 238. There were 529 young people placed in Redbridge by other local authorities in 2018/19,

compared to 404 in 2017/18. 288 of these young people were reported as missing at some point in 2018/19, on a total of 1985 occasions. On average, each young person went missing on just under seven occasions. In 2017/18, considerably more young people placed by other authorities were reported as missing (404 compared to 288), but they went missing less frequently – on average, just over four times in the year.

Female Genital Mutilation

A major priority in the LSCB's Business Plan for 2018/19 was to develop and deliver a multi-agency strategy and action plan to reduce and ultimately eliminate the practice of female genital mutilation (FGM) in the borough; to effectively identify and safeguard children at risk of FGM; and to support young women who themselves have experienced FGM. The strategy was developed by a working group with wide representation: membership included children's social care, the police, BHRUT, NELFT, Public Health, Community Safety, Early Years, Refuge, LBR Community Engagement, and the National FGM Centre run by Barnardo's. The working group identified a range of practice issues which it described in the strategy:

> "Audit work and practice experience suggests that the assessment of risk in this area needs to be improved. On the one hand, assessment can concentrate too exclusively on whether a mother has herself experienced FGM, and overlook the risk that may arise from other familial or cultural pressures. On the other, it can be too easily assumed that the fact that a mother has experienced FGM itself indicates that her baby, child or young person is automatically at risk. Information about discussions with parents and risk assessments undertaken is not effectively shared between agencies, with the result that parents and young people may experience being asked the same questions repeatedly by different professionals. Referrals to social care sometimes do not include sufficient information to enable an appropriate response. Professionals are not always aware of the resources available to support those affected by FGM, or when and how appropriately to refer. While care pathways are in place in individual agencies, there is no single multi-agency integrated referral and care pathway. The multi-agency audit work undertaken in 2017/18 found that the role and influence of fathers and extended family members was not always sufficiently recognised or addressed in the assessment of risk. It also suggested that cases involving concerns around FGM may be too 'automatically' referred to Early Intervention, a Council service delivered by skilled but unqualified family support workers and with which parental engagement is voluntary, and recommended a review of the social care FGM pathway in this regard."

The strategy was agreed by the Board in January 2019. Unlike many strategies, it is deliberately short, because it is intended as a framework for action. It 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 Board in May 2019. The Redbridge Safeguarding Children Partnership will closely monitor progress against the action plan for the remainder of 2019/20 and on into 2020/21.

During 2018/19 the Council entered into a partnership with the National FGM Centre as part of which a specialist FGM social worker has been recruited. The Board monitored on a quarterly basis the number of referrals received by children's social care in which FGM was identified as a risk factor. 49 referrals were received in 2018/19, compared to 40 in 2017/18 and 28 in 2016/17. This suggests an increased awareness of FGM as a potential risk factor, while other data suggests that the number of women in North East London who have experienced FGM may be falling. Female genital mutilation was disclosed by or identified in 199 women attending BHRUT in 2018/19. This was fewer than in 2017/18, when 215 cases were identified, and even fewer than in 2016/17 – 243 cases. All these cases related to adult women. There were no cases identified of, or disclosures by, children under the age of 18 years.

Learning from children, young people and families

Complaints are an important source of learning. The Board commissioned a review of lessons to be learned from complaints about the child protection process made through the LSCB Complaints Procedure in 2018/19, which it considered at its meeting in July 2019. Overall, feedback from parents of their experience of child protection case conferences is positive. 30% of parents completed a feedback form after a child protection case conference in 2018/19, and 89% of those responding said they felt able to participate fully. The number of complaints received and considered under the LSCB procedure is very small. Nevertheless, the analysis highlighted some important themes about what goes wrong for parents when things go wrong: late notice of conferences, late receipt of reports, review conferences going ahead without key professional participants, lack of progress by professionals on the actions assigned to them leading to children remaining on plans when parents feel they have done everything they have been asked to do.

One of the running themes in the complaints received over the past few years has been the late receipt of reports by parents of reports prepared for child protection

case conferences. Too often, parents say that they don't have the opportunity to digest and discuss what professionals are saying about them, and as a result feel disengaged and marginalised from the process, because they don't see the reports that have been prepared until just before or even as they arrive at the conference. For initial conferences, all reports should be received two days before the conference, and for review conferences, diarised well in advance, this should be five days. The Board reviewed performance on this in January 2019. According to the data collated for the most recent twelve-month period for which data was available, 84% of social worker reports were received within the timescale (which of itself means 16% were not) as were 76% of police reports, no more than 70% of reports from other professionals (health visitors, schools, midwives, and school nurses) were delivered on time. For review case conferences, only 32% of social work reports were on time, and no other agency managed to get reports in on time in more than 26% of cases. (it should be noted that data held within the police gave a different picture: in the first three months of 2019 police data recorded virtually 100% compliance for both initial and review case conferences). The Chair wrote to senior management in children's social care and in health agencies to ask what steps what they were taking to improve and monitor their performance, and wrote to all schools to highlight the issue and its significance for parents. There was a positive response, and both children's social care, NELFT, and the police reported that they had introduced revised monitoring and escalation systems to improve performance. The Board felt strongly that achieving and sustaining this improvement is critical to the genuine delivery of the Strengthening Families approach to which the partnership is committed.

In April 2019 the LSCB opened on its website a survey seeking views from young people and from parents on what they identified as the main safeguarding issues in the borough, and what they would like to see done to improve safety for young people. 58 young people responded. The majority said they felt safe in Redbridge all or most of the time, but eleven – almost a fifth – said that they did not feel safe or were unsure. The great majority said they had a trusted adult in their lives – usually a parent and sometimes an older friend, but teachers were rarely mentioned – who they would talk to if for any reason if they felt unsafe. Overwhelmingly, the issue named as the main safety concern for children and young people in Redbridge was knife crime and the fear of knife crime; they wanted to see more police patrols and more police activity. Knife crime was also one of two priority issues and preoccupations around being and feeling safe expressed by the Redbridge Youth Council when the LSCB Chair met with them in April 2019. The second however – not raised by young people who responded to the LSCB survey - was around the prevalence of mental wellbeing issues in young people's lives. They did not necessarily want to use the term 'mental health', but spoke with great feeling about unhappiness, stress, pressure, and the uncertainty of many young people about

where they can turn to with those issues. Knife crime and young people's mental health are also the issues identified as priorities for work in 2019/20 in London by the Youth Parliament.

Only eight parents or carers responded to the LSCB online survey. Those who did respond were more likely than the young people who responded to identify Redbridge as a dangerous place for their children, with again knife crime identified as the key issue.

Dealing with allegations against staff

The Designated Officer (DO) within the local authority is responsible for managing the arrangements in place for responding to allegations that a person who works with children has behaved in a way that has or may have harmed a child, possibly committed a criminal offence against or related to a child, or behaved towards a child or children in a way that indicates that they may pose a risk of harm to children.

The DO recorded 362 contacts on individual cases (including both referrals and consultations) in 2018 /19, compared to 240 in 2017/18. Following a series of interim arrangements in 2017, there has been a permanent DO in post since October of that year, and the service is once again on a stable footing. This, and the amount of outreach work undertaken by the post holder, are the likely explanations for the increase in contacts with the service. It should not necessarily be taken as an indicator that more professionals are harming children and young people, but more as an indicator of increased professional confidence and knowledge of when and how to raise concerns. However, 123 cases were assessed as meeting the threshold, as described above, and were subject to a formal evaluation, compared to 79 in 2017/18.

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

Of those referrals subject to formal evaluation:				
	2018	2017	2016	2015
Number resulting in criminal investigation	21	14	14	4
Number resulting in criminal conviction	0	1	1	0
Number resulting in dismissal	5	9	6	0

Number resulting in other forms of disciplinary action	13	8	6	2
Number resulting in referral to a regulatory body	1	3	7	1
Number resulting in referral to the Disclosure and Barring Service	7	3	6	5

The Designated Officer has been particularly concerned 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. Joint visits and meetings have taken place with the police, and the DO has taken steps to ensure that the individuals concerned are fully aware of the expectations around their professional conduct towards children and 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 a leaflet for parents and carers, is available on the Redbridge Safeguarding Children Partnership website.

Supporting schools

Schools and other educational providers are not statutory safeguarding partners in the terms defined by the Children and Social Work Act 2017. Some concern was expressed at the LSCB during 2018/19 that the restricted definition of 'statutory safeguarding partners' may inadvertently diminish recognition of the crucial role of educational settings in safeguarding, the importance of adequate support to them in delivering on that role, and the importance of their engagement in multi-agency working and decision making. Schools and other educational establishments are increasingly in the front line of responding to mental ill health among young people, in a context where a recent survey of National Education Union members found that over 80% of teachers said that mental health among their students has deteriorated in the past two years, Schools face challenging and contested requirements for the delivery of sex and relationship education, which has a significant safeguarding dimension, from 2020. Redbridge schools are fully engaged in the local safeguarding partnership; it is a priority to ensure that this engagement continues to be supported and if possible strengthened under the new arrangements. The LSCB surveyed all schools in the first half of 2019/20 to ask what kind of support would be helpful to them in delivering on their safeguarding responsibilities. 29 schools

responded. The outcomes of this consultation, and a programme of work to deliver on what schools have said, will be taken forward by the Redbridge Safeguarding Children Partnership.

During 2018/19 the LSCB supported and promoted the roll out in Redbridge of Operation Encompass, under which the police will notify schools by the beginning of the next school day of any incident of domestic violence affecting a pupil at the school – something schools for which have been asking for several years. By the end of September 58 out of 77 Redbridge schools had signed up to the service.

Following some concerns raised by the MASH (Multi-Agency Safeguarding Hub) the LSCB Chair wrote to all schools in June 2018, emphasising the importance of urgency in making safeguarding referrals when concerns are identified. The letter also stressed that, while generally schools and others should discuss their concerns with the child or young person's parents or carers and seek their consent to share information, the crucial rider to this is that they should not do so if there was reasonable cause to believe that this would place the child at risk of significant harm. The multi-agency 'thresholds document', Are You Worried About A Child?, was amended in September 2018 to reflect this emphasis more clearly.

The Healthy Child Programme

The integrated Healthy Child Programme 0-25 is led by health visiting and school nursing services. The service is delivered through a 'skill mix' model, utilising a wider range of staff than qualified health visitors and school nurses. Qualified health visitors directly undertake the first stage of work with new born babies and their parents and ongoing more complex work, and oversee the work of community nursery nurses and clinical assistants responsible for the ongoing review programme. While recognising the benefits that such a model might deliver, the Board has sought assurance that it would deliver high quality and safe services in practice. A report evaluating the impact of the new model was considered by the Board in January 2019. The Board accepted the assurance that the model was safe, in line with national guidance, and demonstrating its effectiveness. "Using the skills-mix model, led by the Health Visitor or school nurse, means they can ensure effective establishment and continuity of relationships that encourage parental trust and confidence, and delegate selectively according to the complexity of health needs and family circumstance." It noted that performance on four key indicators (percentage of required new birth visits undertaken, and of 6-8 reviews, 12-month development reviews, and 2/2.5 years reviews) was on an upward trend. However, on the most recent data it remained below England and London averages on three of the four indicators reported. The percentage of new birth visits completed, at 99.4%, exceeded performance across both London and England as a whole. The Board was pleased to learn that at 6.1% the vacancy rate in the health visiting workforce was

at the lowest level ever. At the end of June 2019, the reported health visitor vacancy rate stood at 6.9%

Child Friendly Redbridge

Throughout the period covered by this report the LSCB 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. The LSCB Team are leading on co-ordinating the safeguarding strand of the Child Friendly UNICEF Programme.

Communication, publicity and engagement

Throughout 2017/18 the LSCB continued to expand its work on communication, publicity, and engagement. The LSCB newsletter, published online after every Board meeting, has a circulation of several hundred professionals working across all sectors. As well as information about a whole range of LSCB activities, the newsletter includes full briefing on the issues and outcomes discussed at the Board, and a 'service highlight' page publicising the work of an individual service. Featured services and developments have included the work of the Redbridge Children and Young People's Network (RCYPN), the work of the Families Together Hub and the Family Intervention Team, the Child Friendly Borough Programme, the Prevent Programme, and the work of the Safeguarding Adults Board.

The LSCB also contributes regularly to RedPEN, which goes to all Redbridge schools, to the Clinical Commissioning Group newsletter which is distributed to all GPs in the borough, and to Redbridge CVS eNews, widely circulated throughout the voluntary sector. The LSCB's Twitter feed now has over almost two thousand followers. Twitter was used extensively throughout the year particularly to promote national and international safeguarding awareness days including Safer Internet Day, National CSE Awareness Day, Young Carers Awareness Day, and Domestic Violence Day. It was also the channel used for joining in with the Government's national Tackle Child Abuse Campaign. The LSCB has 600 followers on Instagram, and uses it to communicate positive messages, particularly around exam periods, and links to support for young people. The LSCB Facebook page has over 150 'likes'. It is planned to establish a YouTube channel presence during 2019/20.

Community-based activity has been led by Lesley Perry, Business Manager, and the LSCB Team, with a huge contribution made by the Lay Members of the Board. In June 2018 the LSCB fielded a team of willing volunteers from across the partnership, including the lay members, to take part in the MPS Junior Citizenship Fortnight. They worked intensively for two weeks, in the middle of a heatwave, with 1700 Year 6 children, helping them to identify and speak for themselves about some of the

challenging 'keep yourself safe' issues they could face in the transition from primary to secondary school. The LSCB team used a scenario on the topic of peer-on-peer abuse and the changing dynamics in a friendship group.

> "We touched on themes such as bullying, e-safety, boundaries, help seeking, friendship and staying safe. We learnt a lot about young people's views on the concept of trusted adult, how difficult they find it assessing whether a peer might offer a positive relationship, and their feelings about social media and its impact."

Receiving a report on the programme at their July 2018 meeting, Board members commented that this was a great example of the LSCB promoting safeguarding where it really counts – in direct contact with children.

The LSCB team took part in a number of outreach events in Central Ilford during the course of the year, including the Redbridge Community Day in August. There was an active programme of presentation to a range of forums including the Designated Safeguarding Leads in Redbridge schools, the Early Years Safeguarding Leads, the Children's Centre Advisory Group, and elected member training and induction events. The LSCB team were also actively involved in a number of consultations and stakeholder events.

All of this work and more is presented and reflected in the ever-expanding and changing LSCB website, already described by Ofsted in November 2016 as "excellent… interactive and informative, with up to date information for professionals, children and young people and parents… Information is particularly well presented in a range of age-specific categories, providing information in visual and audio format." The news page is updated on an almost daily basis, disseminating information on national developments and research as well as local content. The website is now rebranded as the Redbridge Safeguarding Children Partnership website – www.redbridgescp.org.uk.

4. Safeguarding Training

In 2018/19, the LSCB continued to commission and deliver a substantial training programme for multi-agency staff working in Redbridge. In spite of clear workload and caseload pressures, the number of professionals attending LSCB training events has continued to increase, from a low of 397 in 2015/16.

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

There were 127 non-attendances (individuals who booked a place on a course but did not attend) – a 26% decrease on the previous year.

In total, 73 training course and events were planned as part of the LSCB Training programme for 2018/19. In the event, eight events were cancelled due to low take up or other unforeseen circumstances. Topics covered in the programme, many of which ran several times, were:

Abuse in Teenage Relationships Awareness of CSE CSE for Practitioners Child Trafficking Across Borders CAF – An Introduction CAF – Assessment and Planning for Practitioners Domestic Abuse and the Effects on Children Harmful Sexual Behaviours Introduction to Child and Adolescent Mental Health Managing Allegations Against Staff and Volunteers Modern Slavery Awareness Neglect Toolkit Workshop Private Fostering Awareness R U Ready Safeguarding Families from the Practice of FGM Safeguarding Children from Honour Based Abuse and Forced Marriage	Safeguarding Children in a Digital Age and Online Bullying Safeguarding Children who go Missing Safeguarding Children with Disabilities Working Together to Safeguard Children – A Shared Responsibility LSCB Designated Safeguarding Lead Safeguarding Refugee and Vulnerable Migrant Children Safer Recruitment Understanding Loss, Grief and Bereavement Understanding Peer on Peer Abuse Understanding the Roma Community Understanding Thresholds Voice of the Child and Safeguarding Working with Race, Culture and Belief Working with Young People in Relation to Gangs Workshop to Raise Awareness of Prevent

The great bulk of attendances were by children's social care staff (44%), schools and colleges (27%), and the voluntary sector (11%). Only 16 health professionals attended a LSCB training event. This is disappointing, but it should be noted that all health providers have extensive training programmes and requirements for their own staff, and achieve a high level of compliance with mandatory training targets.

Health Providers Safeguarding Children Training Compliance		
Agency	**Year End 2018 – 2019**	
	Level 2	**Level 3**
NELFT	100%	96.2%
BHRUT	96.4%	96.4%
PELC	96%	95%
Bart's Health	94% (missing 2 quarters data)	87% (missing 2 quarters data)

As part of the LSCB's role in quality assuring the training provided by partner agencies, a number of the Level 3 courses were observed during the year by the LSCB Training Manager. All the facilitators demonstrated good knowledge in their fields and good understanding of practice and its challenges in their settings. However, a limiting factor for learning was the size of the training groups – up to 55 participants.

Other groups represented at training events included the Council's Education and Inclusion Division including early years (68 attendances), and private sector providers (35 attendances. There is virtually no attendance at multi-agency training by the police. 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.

As has already been noted, schools are increasingly on the front line of child protection. Participation by school- based staff in the LSCB training programme continues to increase: 78 attendances in 2016/17, 133 in 2017/18, and 205 in 2018/19. In this last year, this has been partly due to the introduction of a new course for Designated Safeguarding Leads.

In addition to the extensive safeguarding training provided within NHS organisations, other individual partner agencies and commissioned providers have also delivered a wide range of single agency safeguarding training for their own staff. 44 Foster

Carers received safeguarding training in 2018/19. The Education Welfare Service provide a traded service to schools. In 2018/19 the service trained:

- 1202 school staff at Standard Level across 19 school settings
- 208 Designated Safeguarding Leads and Senior Leadership Team staff at Advanced level across 23 school settings
- 27 Staff at Extended level across 9 schools.

The service delivered additional briefing sessions on topics such as female genital mutilation, child sexual exploitation, harmful sexual behaviours and peer on peer abuse, and good referral practice; and supported foster carer, school governor, educational psychologists' and newly qualified teachers' training.

The LSCB Training Sub Group undertakes an ongoing training needs assessment. New courses introduced in the training programme for 2018/19 included a half day course on Managing Allegations against Staff and Volunteers, delivered by the Local Authority Designated Officer, and an advanced safeguarding course for Designated Safeguarding Leads in schools. This full day course was offered six times during the year, and had very high take up.

In 2016 the LSCB agreed a Framework and Principles for Safeguarding Children Training which set out the mechanisms for both quality assuring the safeguarding training provided by individual partners, and for evaluating the impact of training. 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 2018/19 was 54%. Participant satisfaction continued to be high with 98% of respondents saying they were satisfied or very satisfied with the programme attended, and 95% of trainees reporting that they would recommend it to a colleague. Evaluation forms included many individual comments on the impact of training on the respondent's practice. As an example of face to face follow up, the impact of the Designated Safeguarding Leads course was evaluated through a series of follow up focus groups with participants. Although virtually all involved felt the subject matter needed more time than could be given to it on a none day course, the overall evaluation was exceptionally positive, with a recurring theme being greater confidence in the role as a key outcome.

Total expenditure on LSCB training was £14,485. Income from attendance and non-attendance was £28.965. Between 2014/15 and 2017/18, the deficit on the LSCB training budget was reduced from almost £12000 to just under £2000. In 2018/19, for the first time, the training programme was not only self-financing, but contributed a surplus of £14,500 to the overall LSCB budget.

The regulations which governed the work of LSCBs laid upon Boards a statutory responsibility to promote multi-agency training. There is no equivalent provision in

the Children and Social Work Act 2017. Ofsted, in their inspections of multi-agency working through the Joint Targeted Area Inspection programme are very clear:

“Training helps. We think multi-agency training is even more important. Helping practitioners to have a shared understanding and be better sighted in each other’s roles can make a positive difference to front line practice”.

The BHR Safeguarding Partners have identified training as an area in which a common programme across the footprint may be of benefit:

> “We will identify a training programme across the wider BHR area that is designed to focus on those issues that most benefit from multi agency training and that make the biggest impact on children and young people’s safeguarding. Learning from our collective quality assurance work, being responsive to local need and ensuring a relentless focus on practice essentials will be our key drivers.”

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.

5. Learning and Improvement: learning from practice

The multi-agency audit of practice is a key ingredient for learning and improvement - ensuring that the partnership has a clear grip on the quality of practice at the front line. It is also difficult and challenging to get right – balancing the necessary rigour and creating the necessary opportunities for shared reflection, and engaging the expertise of front line practitioners in evaluating the quality of each other's practice, while not making unrealistic demands on very pressurised staff in all partner agencies.

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

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

Four multi-agency audits were completed in 2018/19. The topics were:

- Children subject to exploitation;
- A 'success review'
- Children experiencing mental health problems
- Peer on peer abuse

The audit of work with children subject to exploitation graphically illustrated the interconnection between sexual, criminal and other forms of exploitation, and the limitations of responding to them in compartmentalised ways. It highlighted what felt like a proliferation of both multi-agency and single agency panels and other processes seeking to respond to different aspects of these issues, and the need to streamline and integrate this architecture in a much more co-ordinated way. Throughout the year, much work was undertaken to develop a more co-ordinated approach to exploitation in all its forms, which has been described earlier in this report.

In the audit of practice and outcomes with for young people experiencing mental ill-health it was encouraging, given the Board's concerns over the last couple of years about mental health services for young people, to find that CAMHS assessments were timely and robust. Generally, the findings in relation to health services were good. The communication between acute and community services was effective, and

health services were better than other services at eliciting the views of young people themselves. However, and surprisingly, while substance misuse was a recurring issue in the cases audited, there was little consideration of the relationship between that and the mental health difficulties experienced, and there was not enough evidence of the involvement of young people or families in the development and implementation of child in need plans.

The audit of work with children and young people experiencing peer on peer abuse including harmful sexual behaviours evidenced increased professional awareness of the issue since a previous audit in 2017, and some excellent multi-agency working leading to positive outcomes for the young people affected. Areas identified for improvement included the need for more consistent exploration of risks to siblings and the influence of peer groups, and schools' need for support as they prepare to deliver the mandatory Sex and Relationship Education requirements from September 2020.

The 'success review', presented to the Board in October 2018, was an innovation this year. It was based on the premise that while traditional audit tends to focus on identifying areas for improvement, there is as much to be learned from an in depth review of cases where high quality multi-agency work has delivered huge improvements in outcomes for children. The experiences of four children, aged between 10 and 17, were reviewed. The views of the children themselves were sought as a crucial part of the audit. Common success factors included:

- In every case it was clear that the voice of the child was heard, listened to and acted upon. The end result was child-focused decision making.
- There were strong links to educational support for all the children, including special schools, primary and secondary school, and the Virtual School for children looked after.
- Multi-agency involvement was key in every case – no one agency can implement change alone.
- All the children and their parents or carers had a strong relationship with at least one safeguarding practitioner, whether that was a social worker or another professional.
- Professional challenge when needed was purposeful and effective.

The learning from audit was disseminated through multi-briefings offered to staff from all agencies after each audit has been completed. It informed both training activity and service development. The Board was also concerned to monitor more systematically the action taken by agencies to act on audit findings. In July 2018 it considered a report tracking agency actions taken in response to a multi-agency audit of work with neglect, completed in early 2017. Encouragingly, there was clear evidence of action taken to embed much of the learning from the audit in practice. Recommendations arising from audit findings were followed up by the LSCB team

after discussion at the Board, and the actions taken reported to the next meeting. For example, one of the recommendations of the audit on work with young people experiencing mental ill-health was that all agencies should include in their supervision templates a requirement to record the voice of the child. The Board was pleased to learn at a subsequent meeting that all agencies had reviewed their supervision templates to ensure that this was in place.

In commenting on the lessons to be learned about effective multi-agency working from the Joint Area Targeted Inspection (JTAI) Programme, Ofsted's National Director of social Care commented:

"When multi-agency audits are done well, they enable significant insight into both individual agency practice, multi-agency practice and the impact on the lives of children and families. They act as a driver for improvement."

The Redbridge Board was fortunate that in Andrea Barrell it had a Quality Assurance Manager whose passion, dedication, and inexhaustible commitment to young people had developed and driven a creative multi-agency audit programme which gave an increasingly clear picture of the quality of practice, its many strengths and areas for improvement. Sadly for the LSCB and excitingly for her, Andrea left in February 2019 to take up a new opportunity in Australia. As a result of budget constraints, it has not been possible to recruit to her post, and as a result the LSCB and now the Redbridge Safeguarding Children Partnership does not have the capacity to continue a multi-agency safeguarding audit programme. This is a serious lack. However, the BHR Partnership has committed to developing a programme across the wider footprint:

> "We are committed to developing a culture of learning and improvement across the whole area. Relevant staff across the three areas will come together to develop a shared programme of reviews across the local system, the outcomes of which will be shared across the whole area; they will identify an agreed methodology(ies) for these reviews with a particular focus on not just involving front-line practitioners but enabling them to conduct and lead on practice evaluations; and to identify examples of good effective safeguarding practice that can be reviewed and analysed and findings disseminated. We will use the development of this shared programme to both reduce demand on those agencies which work across the whole footprint and to ensure the full engagement of our relevant agencies and local partners."