NEWHAM LOCAL SAFEGUARDING CHILDREN BOARD

Annual Report for 2017-18

Newham London

East London NHS Foundation Trust

NHS Newham Clinical Commissioning Group

Barts Health NHS Trust

Metropolitan Police Working together for a safer London

London Community Rehabilitation Company Probation

National Probation Service

Youth Offending Service

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Introduction and Executive Summary

Newham's children are growing up in a borough characterised by opportunity and optimism, as well as challenges. We know that many children in the borough live in poverty or are growing up in inadequate housing and as the data and insights in this report illustrate, some children are growing up in families that aren't able to nurture and care for them as they deserve. It is in this context that Newham's Local Safeguarding Children Board is charged with bringing together partners across the borough to scrutinise the effectiveness of our child protection arrangements, and to work together to improve outcomes for children and families.

We can see steps forward but we have further to travel before we can be confident that partner agencies are doing all they can to protect children at risk in Newham. Throughout the year partners have remained committed to collaboration and innovation for Newham's children, despite both the challenging environment and organisational change in several of the statutory partner organisations. In particular, there has been a strong commitment to implementing learning from Serious Case Reviews and Learning Reviews, and to finding new ways of working to address high levels of criminal exploitation in the borough.

Over the year ahead, if we are to make a meaningful impact, we must focus our energies on delivering the fundamental building blocks of the safeguarding system to a high standard and not just an adequate one. We must also build our understanding of the complex safeguarding challenges we face: developing robust problem profiles, evaluating the impact of new interventions, and holding each other to account for delivering real change in the lives of vulnerable children.

Nancy Kelley.
LSCB independent Chair May 2017 - December 2018

1. Profile of Demography and Need in Newham

1.1 Demography

Newham has a population of 338,600 people and 82,500 children and young people under the age of 18, which means that children and young people make up 24.4% of the population. (2017 estimate).

- In the 2011 Census, Newham had the highest BAME population (71%) of all Local Authorities in England and Wales: and the greatest diversity in terms of ethnicity: 11% White British, 9% mixed ethnicity, 44% Asian or Asian British, 25% Black or Black British, and 3% White.

- 51.8% of the Newham population were born abroad, with earlier immigration originating primarily from India, Bangladesh and Pakistan, and more recent immigration originating primarily from Romania, Bulgaria and India. (GIS 2013-01 Greater London Authority).

- 40% of the population are Christian; 32% are Muslim; 8.8% are Hindu; 2.1% are Sikh; 1.2% recorded as another religion; 9.5 % have no religion and 6.4% did not state their religion.

- Newham is the most linguistically diverse local authority in England and Wales. In 2017, 74% of primary school pupils and 66% of secondary school pupils in Newham spoke a first language other than English. This is higher than the Inner London average (54% and 49%) and the English average (21% and 16%).

1.2 Need

- Newham has high levels of deprivation. It is ranked the 25th most deprived local authority area in England and the 4th in London (based on Indices of Multiple Deprivation) and ranked 7th for Income Deprivation Affecting Children Index (IDACI).

- 11,930 children in Newham live in households where at least one parent or guardian is claiming an out of work benefit.

- The unemployment rate in Newham is higher than that its neighbours at 9.1%, compared with 6.4% and 5.1 % for Inner London and England respectively. Youth unemployment is higher than in Inner London at 7% compared with 6.4% and 5.1% for England.

- The rate of young people without education, employment or training (NEET) is 4.8% (2017). This is similar to the Inner London average at 4.6% but lower than the NEET rate for England as a whole, which is 5.6%.

- At the time of the last UK Census (2011) Newham had the highest level of overcrowding of all London boroughs. 43% of households with dependent children are classified as overcrowded. Newham also had the largest average household size in London.

- Newham has a 19.4% population turnover every year. It is a densely populated Borough with 94.5 people living per hectare, which is a little lower than the Inner London average of 109.2.

- Child Mortality: Newham has an infant mortality rate of 3.0 per 10,000 which is similar to other London authorities. It has the second highest number of child deaths 16.3 (just below Islington at 16.6.)

- In the 12 months to June 2018, Newham had 2,528 under 18's recorded as victims of crime which is the second highest number in London (Croydon had 2,761 victims).

1.3 Global Safeguarding Data

Triage, Referral and Assessment, Children in need

Newham has in recent years had very high numbers of contacts and referrals and one of the highest referral rates in London. Importantly, Newham has had very high rates of assessments resulting in no further action. This has been interpreted as an indicator that the early help offer and the MASH have not been effective in identifying and diverting children with lower of levels of need. These findings were confirmed by an independent review of practice in the Triage and Referral and Assessment service in 2016.

This trend has continued although the improved triage of contacts now results in fewer referrals and there are now fewer referrals that result in no further action.

A Focussed Ofsted Visit in February 2018 reported the following:

> Comment: *"Significant work over the last 12 months has resulted in an improved response to contacts and referrals. Partnership working in the multi-agency safeguarding hub (MASH) results in effective decision-making to safeguarding children. However, there are delays in decision-making which could be improved through timelier responses from partners when information is requested".*

DATA AND PERFORMANCE 2017-18

- While the number of contacts continues to be high these have reduced for the second consecutive year. Last year, there were 24, 624 contacts compared to 27,365 in the previous year and 28,390 in 2015/16.

- The number of referrals and referral rate has increased this year:
  There were 6,261 referrals last year compared to 4,974 in the previous year. The referral rate was 733 per 10,000 which was an increase on the previous two years rates at 593 (16/17) and 711 (15/16).

- The improved triage of contacts resulting in fewer referrals has continued for the third consecutive year with a 26% conversion rate of contact to referral.

- There also continue to be fewer referrals that result in no further action: 12.7% of referrals resulted in no further action, and did not proceed to an assessment which is in line with London and statistical neighbours and indicates that the decision making by Triage is effective.

- *Newham still completes high numbers of assessments compared to its neighbours.* Last year, Newham completed 4,337 assessments resulting in a rate of 505 per 10,000 which is line with the national average of 515 but higher than the London average (460). This may indicate that the London rate is too low rather than that the Newham rate is too high.

- *There were too many unnecessary assessments completed.* In 2016-17 Newham reported to the DfE that 1123 or 22.6% of assessments carried out determined that the child was not in need and this number was twice as high as the inner London average. In 2017/18, 2725 or 36% assessments ended in no further statutory action.

- *The timeliness of assessments has significantly improved.* Last year, 71% of assessments were completed within 45 days compared to 57.34% in 2016/17.

Comment:
"The majority of assessments recognise risk, with most providing a clear analysis and appropriate recommendations. Assessments are generally timely and include children's views, wishes and feelings, although they do not always reflect their lived experiences". **Focussed Ofsted visit in February 2018**

- *Newham continues to have higher than average numbers of children in need:* on the 31st March 2018 there were 3,915 open child in need cases compared to 3,154 in the previous year. This equates to a rate of 457 per 10,000 compared to 370 per 10, 00 in the previous year and is much higher than the rates for London (402) and England (330).

- *Newham has the highest rate of open child in need cases in England* Over the course of last year, there were 8,903 child in need episodes compared to 7401 in 16/17. Last year, the rate was 1,038 per 10,000 compared to 863 per 10,000 in the previous year. 4,922 child in need episodes were closed last year.

Child in Need Snapshot 2017/18

Headline numbers	CIN 2017/18 Census
Number of CIN episodes open at 31 March 2018:	3,915
Number of Referrals in year:	6,261
Number of CIN episodes closing in the year:	4,922
Number of CLA open at 31 March 2018:	403
Number of CP Plan open at 31 March 2018:	325
Number of Assessments Completed:	4,337
Section 47s initiated	1,373

Initial / Pre-birth CP Conferences in year (excluding 'Transfer In' conferences)	337
Transfer in Initial Child Protection Conferences recorded	48
CP Plans started during year	386
CP Plans ended during year	382

1.4 Child Protection:

Multi-agency strategy meetings

- *There has been some improvement in partner contributions to multi-agency strategy meetings and discussion as a result of joint efforts by the partnership.* In 2016/17, the findings from an external audit showed that section 47 discussions were not consistently multi-agency and often involved Children's Social Care and the police only. In 2017/18, the LSCB addressed this by establishing a multi-agency task and finish group which rolled out awareness-raising training to key agencies. In 2017/18, the Quarter 4 data extracted from the Children's Social Care Azeus recording system showed that the level of multi agency participation (3 or more agencies) in S47 strategy discussions had improved and reached 69% at year end. Performance is now reported quarterly to the Executive Board and an improvement target of 85% set.

Section 47 enquiries

- *The threshold for a s section 47 continued to be applied more consistently in 2017/18 from a low starting point in 2015/16.* In 2015-16 the Newham rate of 47s per 10,000 was well behind the Inner London average rate per 10,000. In 2016-17 the number of section 47s increased by 23.3% and reached a rate per 10,000 of 143.00. In 2017/18 there has been a further rise with 1,373 enquires over the year compared to 1,222 in 16/17 and a rate of 160 per 10,000. This data suggests that Newham is intervening more consistently to address safeguarding concerns, although it will be important to compare performance against statistical neighbours when the national and regional figures for 2018-19 are published. Management action continues to be

taken to ensure that all children who require a section 47 enquiry receive one.

Children with Child Protection plans

- *In Newham, approximately the right number of children who are at risk of significant harm and need a child protection plan receive one.* 325 children were subject to a child protection plan on 31st March 2018, which represents a slight increase on the previous year (319). Over the course of the year, plans were started for 386 children and ended for 382 children. In 2018/19 the rate of child protection plans was 37 per 10,000 which is close to the Inner London average of 36 per 10,000.

- *98.6% of child protection plans were reviewed in timescale.* This is good performance and exceeds that of the average performance in Inner London and England for 97.5% and 93.7% respectively taken from 2016/17 data.

- *Fewer children in Newham are subject to repeat child protection plans compared to other authorities.* In Newham, 32 children (8.3%) compared to 9.1% the previous year, were the subject of a repeat child protection plan in 2017-2018. This is much lower than for children in other Inner London authorities 14.5% and England 17.9% (2016/17 data).

- *The number and rate of children subject to a child protection plan for over two years has improved.* Of plans ceasing over the year, 15 children had been the subject of a child protection plan for over 2 years compared to 21 children in the previous year. The rate has reduced from 5% to 3.4% compared to a London rate of 5.2% and England rate of 3.4% (2016/17 data).

Comment: *Taken together, these two indicators suggest that children in Newham subject to a child protection plan are more likely to receive work that is effective over time, but that they may remain subject to a plan for longer than children in the country. The findings of the Child Protection Panel who reviewed children on a child protection plan for over 18 months were that a number of them were subject to ineffective work and drift. The Child Protection Panel set out a robust set of recommendations to strengthen oversight at the 9 months point. More robust oversight from managers and the core group has seen these figures come down now to 15.9% (12mths) and 1.8% (24 mths) which is below the England and London averages.*

The profile of category, age and gender for children on a child protection plan is broadly the same as that of London.

Of the population of 325 children on a child protection as at March 31st 2018, the breakdown of category was as follows in 2017/18 at year end was as follows:

Newham		England	
Neglect	147 (45.2%)	Neglect	44.8%
Emotional Abuse	140 (43%)	Emotional Abuse	35.4%
Physical Abuse	29 (8.9%)	Physical Abuse	9.8%
Sexual Abuse	17 (5.2%)	Sexual Abuse	4.7%
Multiple Categories	0	Multiple Categories	5.3%

Of the population of children subject to a child protection plan the largest categories are neglect and emotional abuse, which is in line with national patterns. Emotional abuse is frequently used to indicate domestic abuse within the family and the higher rate in Newham reflects the high rate of domestic abuse as a risk factor in Newham case loads.

We know that in Newham as elsewhere child sexual abuse is under-reported and this was an agreed priority area for the LSCB in 2017/18. Although the numbers remain low, it should be noted that there were 12 more children at March 2018 with this category of plan than in the previous year.

The gender balance between children on child protection plans is even and stable compared with last year.

The ethnic breakdown of children with child protection plans and children looked after does not reflect the ethnic breakdown of the school population in Newham. White British children make up 5% of the school population and are represented in 10% of contacts to Triage, 14% of Child Protection plans and as 18% of the Child Looked after (CLA) population. Asian and Asian British children who make up 47% of the school population are represented in 30% of contacts to Triage, 34% of child protection plans and make up 20% of the CLA population.

As this data could indicate that the safeguarding partnership is not providing as effective a service to Asian children and families, the LSCB should ask for further information and an analysis of ethnicity and case progression from referral onwards.

Legal proceedings to safeguard children in 2017/18

During the year, 226 legal planning meetings (LPMs) were held to discuss whether threshold had been met to commence legal proceedings. This equates to almost one legal planning

meeting per working day. The average number of LPMs per quarter for 2017/18 can now be calculated as 56.5 which is higher than 2016/17's quarterly average of 44.

Of the cases going into LPM, 83 (37%) of the cases were already subject to CP plans. From the 226 cases, the decision was taken to issue care proceedings in 99 cases (44%). 49 were directed to start or continue with pre-proceedings work under the Public Law Outline (PLO), equating to 22%. The remaining cases (approximately one third of the total) were deemed to be better served by a child protection plan or another way forward for the families.

The number of sets of care proceedings during the year was relatively stable at between 55 and 65 at any one time. The number of children had increased by the end of the year to 108 however; this is expected to drop back to around 100 in early 2018-19.

Outcomes from care proceedings for 2017/18 as a whole (counted by child, rather than by family) were as follows:

Order	Number	%
Total Care Orders	44	26
Total Child Arrangement Orders	19	11
Total Supervision Orders	64	38
Total Placement Orders	11	7
Total SGOs	21	13
Total Transfers to Designated LA	6	4
Total No Orders	2	1
Total	**167**	**100**

N.B there are no comparator figures compiled for 2016-17.

The average time taken to conclude cases remained above 26 weeks at around 29 weeks. In spite of this being outside the target of 26 weeks, it compares favourably with the other boroughs served by the East London Family Court.

Analysis of data. What is this telling us about outcomes for children?
There is a concerted effort in CYPS to address 'drift' in cases. Audits have taken place and cases which have been identified as having no plan for permanence were being referred to Legal Planning Meetings. There was an influx of this kind of case towards the middle of the year however this stabilised by the fourth quarter.

Once in court some cases progress quickly and smoothly and others experience delay. Issues with East London Family Court capacity have caused some delays, as has the complexity of Newham care proceedings cases. There have also been internal reasons for delay such as unexpected changes in social worker or some instances of a lack of management grip.

Details of quality assurance activity during the year
Information presented at LPMs is now routinely checked so that the most relevant details are available to inform decision-making. There are occasions where LPMs are postponed in order for the social work team to provide fuller information. Issues once in court are being

addressed individually by service managers. There are also monthly performance reports which highlight areas of good, and problematic, performance.

Children Looked After (CLA)

- *Newham continues to take fewer children into care compared to national and statistical neighbours although the number of entrants and leavers is higher.* Newham has the fourth lowest rate of CLA in London. The rate and number of CLA has remained stable over the past two years: 47 per 10,000 compared with 46 per 10,000 the previous year; and 415 LAC children at year end compared to 397 in 2016/17.

- *In 2017/18, 78 of the 256 new entrants started via police protection route which is very high.* A robust, joint response to reduce the number of unplanned admissions to care was taken by the Police and Children's Social Care and in the first 6 months of 2018/19 unplanned admissions had reduced to 19 cases.

- *Last year, nearly half of the leavers had been CLA for 6 months or less.*

Under 1 week	37 children
1 week – 1 month	20 children
1-6 months	63 children
6-12 months	52 children
12 months+	77 children

- *The majority of Newham's CLA population are over 10 years old.* Additional resources are being developed by the local authority to provide and edge of care service to help keep older children at home safely and achieve good outcomes in the community.

- *In Newham's CLA population Asian or Asian British children are under represented and White and White British children are over represented.* Asian children make up 47% of the schools population and 20% of the CLA population. In comparison, White British children make up 5% of the school population and 18% of the CLA population.

- *The percentage of CLA placed over 20 miles from their home is low (16%) and compares favourably to statistical neighbours (20%) and England (14%).*

- *Placement stability for Newham LAC is good. 91% of children have less than 3 plus changes of placement which compares favourable with statistical neighbours and England.*

- *The educational attainment of Newham LAC is good and there is strong partnership working to support children to do well.* Noting that the results at this stage are provisional and could change when the DfE first statistical review is published in 2019,

the Executive Head Teacher for LAC Newham provided the following report:

"*Looked after children achieved very pleasing results at all stages last year – and were above the National LAC averages in all year groups that were assessed; from year 1 phonics to Attainment and Progress 8 at the end of year 11. There was also a good result with the older children with 19 young people starting university this year – again likely to be above most other authorities in the country. These results are a result of excellent work from all the partners around the children – social care, health, foster carers, the Virtual School, their school or college, and most importantly the children and young people themselves. We were pleased to celebrate their achievements at our recent Celebration evening (attended by the Mayor and Deputy Mayor). As one of our children wrote "We as children in care can have aspirations too. We as children in care can achieve the unachievable" Words by L*."

1.4 Children and Young People at risk of Child Sexual Exploitation (CSE) and Missing in Newham 2017/18

The CSE Problem Profile for 2017/18 is drawn from MPS data, CSC records and a multi-agency audit of 33 live open cases at December 2017:

- The data from Newham provided by the Metropolitan Police recorded 21 victims of CSE from July 2017-March 2018

- In Newham, around 9 cases a month were open to Children's Social Care as active CSE cases.

- The profile of the average child at risk of CSE in Newham is female, white British, aged between 14 – 15. There are more victims of an Asian ethnic background, but White British children are over represented in the cohort. Boys are significantly under represented as victims.

- This profile is also being reflected in other areas of adolescent vulnerability, with the age of children going missing and those involved in/affected by gangs and youth violence being lower than we have previously seen

- There is overlap with other vulnerabilities – the most common link was with missing, followed by gang association and self-harm. Social media use and vulnerability online was also a common feature in cases.

- 40% of CSE victims were looked after, 60% were children living at home and 12.5% were on a child protection plan.

- Offenders – Peer on peer is the most common mode of CSE (63%). The offender profile is: male, White British aged under 18.

Comment: The local authority data for CSE and or children missing from home and care has been based on a manual collection and as such is not wholly reliable. A more robust data set is being developed along side a demand and needs profile which will identify our most vulnerable children

with complex safeguarding needs. This will include missing, CSE, county lines and criminal exploitation including gang association/affiliation. An initial date of June 2018 has been extended in order to obtain a through live profile of children who present with complex needs.
A CSE/Exploitation flag is being developed which will greatly increase our ability to track and monitor.

Children Missing from Home and Care 2017/18

- Over the course of the year, an average of 25 children were missing from care each month. This equated to 46 missing episodes a month.

- 62% of these episodes related to CLA placed in Newham by another local authority

- There were an average of 17 children missing from home over the course of the year. This equated to 19.5 missing episodes each month.

- Newham has the 8th highest number of missing children in London (Met police missing data)

Comment: There was a rise in the number of individual children missing from home and missing from care and a rise in the number of episodes in the second half of the year. This is most likely to reflect an increase in recording missing events due to better monitoring systems being put in place. The data for missing from home and care is based on a manual collection and the challenges of this and improvement plans in place are detailed in the previous section covering CSE.

Return home interviews (RHIs)

Return home interviews are not being held consistently for all children who go missing and where carried out they are not always within the 72 hour timescale. The former CSE and Missing Co-ordinator had responsibility for tracking all RHIs on a weekly basis to ascertain the intelligence and be in a stronger position to inform intervention, disruption and prevention. Although training on RHIs was delivered by the Co-ordinator to CSC staff, a follow up audit found little evidence of improvement.

Analysis of return home interviews indicates that the key reasons why children go missing from care are the pull factors of friends or boyfriends/girl friends, unhappiness with the rules of a placement or the placement itself, seeking family contact outside prescribed arrangements.

A comprehensive review of the Missing and RHI process was undertaken by the Strategic Lead for Complex Safeguarding in Q4 of the year and as result of this, bespoke training on missing and the introduction of new arrangements for conducting RHIs has been launched in the second half o 2018.

Multi-agency arrangements

*Multi-agency Safeguarding Hub (*MASH) - there continues to be a strong, integrated response to tackling child sexual exploitation in Newham. The Police Child Sexual Exploitation team was formally integrated into the MASH in 2016 and provides an effective intelligence product with risk assessment, supported by a clearly recorded rationale for operational use at the earliest stage. Linked to an increase in the Operation Anzen remit (see section 3.4) a decision has been made that there will be an additional two police officers added to the team to ensure the success of this operation, effectively creating a police Child Criminal Exploitation Team. The team will be based at Newham Dockside alongside the CSE team in the MASH. Moving forwards, the plan will be to merge the Anzen team with the CSE team to have a child exploitation team as we know from the local problem profiles that young people have overlapping vulnerabilities.

MASE operates as a strategic panel and using Police data locations of CSE, perpetrators, and victims, and activity across county lines and cross borough. This enables a better intelligence picture and helps to make disruption more effective. The MASE now has a problem profile based on analysis of 40 cases which gives a breakdown of the trends and patterns of CSE activity in Newham, which assists agencies in strategic planning. The YOS is now monitoring gang links and reporting gang related activities to the Community Safety Partnership and the MASE to inform disruption.

Health professionals are now more regular partners in strategy discussions. A new system has been set up to notify ELFT and Bart's Health of children subject to CSE strategy discussions, so that the appropriate professional can contribute. They also cross reference for any involvement with CAMHS. This is leading to better information sharing and intelligence on the risks and needs of children at risk.

Missing Risk Management Meetings (MRMM)
There is a robust response to children missing from care and home in Newham by the local authority that hold bi-weekly MRMMs to target the top 5 missing children and support practitioners to risk assess effectively. The MRMM is a multi-agency meeting and members include, CAMHS, police, YOT and the CSE & Missing Coordinator. These are supplemented by daily missing meetings held by the police in MASH with other agencies who discuss safety plans and liaise with other local authorities for out of borough children. The local authority has a dedicated chair to lead missing children strategy meetings and train Practice Leaders to conduct these effectively.

Role of the CSE and Missing Co-ordinator
In 2017/18, this role moved from the LSCB team to the Multi-agency Safeguarding Hub (MASH) under the supervision of the MASH Service Manager in order to drive improvements in operational service delivery. The Co-ordinator was responsible for a portfolio of work covering prevention, intervention, training and procedures. Amongst the activities delivered were workshops for staff at the Pupil Referral Unit and commissioned services working with disabled young people and looked after children/care leavers. In the lead up to National CSE Awareness day, sessions were delivered to young people attending the Youth Hubs; the Youth Offending team and a facilitated session with a parent peer support group. At the request of this group, the Coordinator has arranged for Safer London to deliver a series of

monthly parent/carer peer support sessions within Newham, which will be open to all parents/carers.

Disruption
In 2016-17 the police ran operation Make Safe Phase 1 and visited businesses, hotels, and licensed premises to raise awareness of CSE. In Make Safe Phase 2 they visited all seven of the care homes in the Borough to raise awareness of the signs and symptoms and referral pathways. The police also monitor referrals from each of the schools in Newham and those outside to target the ones that do not make many referrals.

In 2017/18, the police conducted 5 Makesafe visits and delivered CSE awareness and Operation Makesafe training to the Police and Security team at Westfield Shopping Centre around CSE awareness and Operation Makesafe.

The East Sexual Exploitation Team (SET) have visited hotels as a result of intelligence led enquiries and also been engaged in Operation Grandbye, a new four strand multi-agency initiative that is predominantly targeting those at risk of CSE in and around Stratford Mall. The four strands of this initiative are peer education, raising retailer awareness, raising security staff awareness of Operation Makesafe.

Early assessment indicates that the operation is having a number of successful outcomes with 9 arrests, with Child Abduction Warning Notices being served. Over 50 young people have been spoken to and there have been 6 new Level 1 CSE records being created. A full update on the results will be presented at the completion of the operation which will continue for the next couple of months.

Quality Assurance – Two audits were carried out last year: a multi-agency audit of open cases in December 2017 and a schools audit of CSE safeguarding work. The findings are reported in section 4.

Advocacy work with young people
A programme of 1-1 work with young people, aimed at increasing personal safety, understanding healthy relationships, resilience and engagement with education/training/employment, was delivered this year by an advocate for Safer London. Going forward, funding from 2019-21 has been obtained from MOPAC for a Young People's Advocate to be based full time in Newham at Dockside) to offer 1:1 support to young people at risk of/experiencing CSE. In addition the advocate will also deliver universal group work sessions in schools as well as professionals training sessions and consultation.

Children Missing Education 2017/18

The processes for recording and tracking children missing education (CME) and children awaiting placement (CMO) have been reviewed and updated to improve the speed and accuracy of reporting.

At March 2018, there were 199 open CME cases, 98 CMO open cases and 5 cases awaiting assessment. The most commonly recorded reason for CME was children leaving the area

(53%) followed by the absence of a school application (35%). Checks and actions are carried out on each of the unconfirmed cases until these are resolved.

In March 2018, there were 221 children being electively home educated. The most commonly recorded reason for home education is philosophical or ideological views and religious or cultural beliefs (33%). The next most commonly recorded reason is dissatisfaction with the school system and a short term intervention for a particular reason which usually reflect cases where parents have declined a school place offered and are hoping for a place at a school they prefer (30%). Of the 72 children whose parents have identified religious/philosophical views 34 children were accessing a locally based Education Centre and 30 of these children are of Muslim faith. 139 of the 221 children were of primary school age and 82 were of secondary school age. 52% were boys and 48% girls.

2. KEY AREAS OF NEED AND LSCB priorities for 2017/18

Improving services is critical to improving outcomes to children. By training staff, providing bespoke services that meet specific needs, and by developing protocols, referral pathways and a common language and understanding, agencies are able to work together more effectively to meet children's needs.

In 2017/18 the Board identified the following priorities:

1. Child sexual abuse
2. Preventing extremism
3. Suicide and self-harm
4. Youth Violence

And worked closely with partners to ensure that agreed outcomes were achieved in relation to the following areas:

5. Domestic Abuse
6. Neglect
7. Parental Mental Health

2.1 Child Sexual Abuse

OUTCOMES TO BE ACHIEVED 2017/18
Children at risk of sexual abuse are identified and supported in making disclosure and receive therapeutic and trauma-informed services.

The local workforce work closely together to prevent and detect child sexual abuse and respond to the needs of child victims

DATA AND PERFORMANCE 2017/18
During the year, there were 199 children in need assessments which identified sexual abuse as a risk factor at the end of assessment which represented a 22% increase on the previous year. Of these 199 cases: 61 were deescalated to non-statutory services; 38 resulted in no

further action; 52 led to a child in need plan; 42 to an initial child protection conference and 4 children became looked after.

While the number of children with child protection plans under the category of sexual abuse remains low, over the course of the year, the number of plans were higher this year and averaged 15.25 compared to 5 in the previous year.

PROGRESS AND IMPACT 2017/18
Quality assurance activity was undertaken by the partnership in order to assess the quality of response to referrals and interventions for children subject to child protection plans.

In June 2017, the LSCB commissioned an external audit of the response to referrals of child sexual abuse in response to a recommendation from the KA serious case review (May 2017). This audit raised concerns about thresholds and found there were significant delays in progressing section 47 enquiries for CSA cases and that joint enquiries were likely to be police led. Following this audit, a multi-agency task and finish group to improve the section 47 processes was established and training started to be rolled out to key agencies during the time of the next audit period.

Findings
A follow up audit of 6 cases in late 2017, carried out by the Head of Safeguarding, CSC and Detective Inspector of the CAIT team found evidence of improvement:

- In cases where CAIT and CSC worked together there was evidence of positive joint working which included timely responses.
- The application of threshold showed evidence of improvement; it was appropriately applied in five of the six cases. This compares with concerns about the application of threshold in four of the eight cases audited in June 2017

The area where less progress had been made since the June audit was the engagement of partners in the strategy discussion/meeting and subsequent safety planning.

- Education were involved in two of the six cases and it is possible that the views of education were taken into account in the remaining cases, but this was not clearly recorded within the strategy discussion as per the expectations of the guidance within Working Together (Feb 2017).
- Health and CAMHS were not consulted at the point of strategy discussion on any of the six cases and given all cases involved referrals of CSA this is a serious concern, which requires improvement.

The audit concluded that the absence of multi-agency working impacted on the ability to conduct a holistic risk assessment and robust interim safety plans and identified that further training and quality assurance activity was required.

Action(s) taken to improve practice
Targeted training has been rolled out across the partnership to reinforce the responsibilities of safeguarding partners regarding strategy meetings. The Q4 data for 17/18 showed that

the level of multi agency participation (3 or more agencies) in S47 strategy discussions had improved and reached 69% with a further improvement to 81% at the end of Q1 18/19

Performance in this area is now monitored quarterly by the Executive Board and a follow up CSA audit is scheduled for Q3 18/19.

A task and finish group to review the partnership's response to sexual abuse took place in 2017/18 and recommended that the training programme was refreshed and targeted training provided to support the local workforce to work closely together to prevent and detect child sexual abuse and respond to the needs of child victims. This training will include:

- Bespoke training for social workers and Practice Leaders to build knowledge and increase confidence in working with cases, including cases where disclosures do not result in criminal prosecution.
- Level 2 awareness raising course for other professionals

Review of CP plans for children at risk of child sexual abuse

In Q4 of 2018/19, the multi-agency Child Protection Quality panel scrutinised the child protection plans of children in seven families. In most of the cases reviewed, children at risk of sexual abuse had been identified and supported in making disclosures and offered therapeutic and trauma-informed services.

- Of the 7 children reviewed with CP plans for sexual abuse, 4 were rated as green and 3 as amber

- In all cases, the CP plans were keeping children safe and preventing further abuse as the perpetrators were not living as part of the household

- Police investigations had been held in all cases and in two cases had led to the successful prosecution of the offender

- Despite a clear disclosure of abuse and subsequent police investigation, young people were not always believed by other family members and in two cases the survivors of abuse had left the family home and were estranged from their family

- There was a variable response to requests to fund specialist assessments indicating the need for clearer practice guidance

- Therapeutic interventions were offered in all cases – although not always taken up

2.2 Preventing Extremism

OUTCOMES TO BE ACHIEVED 2017/18

Children who are at risk of extremism and radicalization are protected through effective and timely intelligence sharing, identification and intervention.

DATA AND PERFORMANCE 2017/18

- Newham is a Tier 1 authority, meaning the threat of extremism is deemed to be higher and so the Prevent team is supported accordingly. According to an internal risk assessment produced by the Community Resilience Team, Newham is a significant borough for extremist activity, with comparatively high levels of Islamist radicalisation.

- Newham has the 2nd highest number of TACT offenders in London (24) and had the joint highest number of terrorism-related arrests in 2016-17 (21). Far-right activity has been noted but it has a limited presence.

- The number of referrals to the Channel Panel increased significantly over the year from 15 to 62 and 20 of these referrals concerned a young person under 18 years of age.

- There were a total number of 108 referrals to Children's Social Care extremism with a particularly high number in the first half of year the year following the Westminster Bridge and London Bridge terrorist attacks. A widespread police operation investigating allegations in relation to a tutor in a Mosque resulting in a successful prosecution accounted for a large number of these referrals.

Analysis of Threats and Vulnerabilities

The factors that could be contributing to the prevalence of extremist activity in Newham, and the East London area in general, are:

- Socio-economic deprivation, leading to personal vulnerabilities that are exploited
- The presence of established extremist networks
- The high number of young people
- The high number of students and young people away from home for the first time
- The population churn the borough experiences, leading to a decline in established community structures
- Limited opportunities for meaningful interactions with wider society

PROGRESS AND IMPACT 2017/18

A strategic plan across the partnership for community engagement, awareness raising and prevention work has been developed and implemented. This includes the need to ensure that appropriate e-safety guidance and IT acceptable use policies are in place within all educational, youth and care settings to reduce exposure to the risk of on-line radicalisation. The Council's Community resilience team have delivered a series of presentations to:

- Safeguarding in Education conference;
- Head Teachers;
- DSL forums;
- Youth zones
- Care provider forums

Data provided by the Community Resilience Manager for Newham shows that to date 11,375 individuals across the partnership have received training or a briefing on the PREVENT agenda as shown broken down as follows:

Output	Primary School	Secondary School	FE/HE Sector	LBN Staff	Other	Total
WRAP	5108	1589	1766	555	557	9575
Prevent Briefing	686	671	60	102	281	1800
Total	5794	2260	1826	657	838	**11,375**

There has been an extensive programme of awareness raising targeted at education settings and families including the following:

- The Safeguarding Lead for Education has promoted the Prevent agenda with schools through the Newham Connect newsletter and Designated Safeguarding Lead forums and posted messages in Newham Connect. On-line safety was a topic at the Safeguarding in Education conference and has been covered in all DSL forums.

- A guide for parents about the dangers of radicalisation and other forms of exploitation has been produced and shared with schools.

- In addition to the above training, the LSCB commissioned a 1 day level 3 courses for professionals working with young people exposed to extremist ideologies.

The rise in referrals is evidence that the recognition and identification of children at risk has improved. However, we need to learn more about the impact of interventions in improving outcomes for individual children and families.

To review the effectiveness and quality of current arrangements and to assist with future planning, Newham Council has commissioned a Home Office peer review that will take place at the end of Q3 2018/19.

2.3 Suicide and Self-harm

OUTCOMES TO BE ACHIEVED 2017/18

Design and implement a local strategy to ensure a pro-active and effective approach to suicide prevention within Newham

The LSCB conduct a multi-agency audit of recent cases where young people have been admitted to hospital following an episode of self-harm

Develop and launch Joint Protocol for Discharge Planning

DATA and PERFORMANCE 2017/18

- Nationally the rate of young people being admitted to hospital as a result of self-harm is increasing. This trend is not reflected in Newham data and self harm and suicide attempts in children are lower than the national average.

- Newham hospital admissions as a result of self harm in 10-24 yr. olds: 278/100,000 young people (England average is 423/100,000). Completed suicide rate/100,000 population in Newham: 7.4/100,000 population (all ages) (England average is 10.1).

- However two young people in Newham committed suicide in 2016-17 and both of these deaths led to the LSCB carrying out a serious case review. The KA serious case review completed in June 2017 and was reported in the annual report for 2016/17. The Child J serious case review was completed in November 2017 and is reported below.

- There were 209 assessments where self-harm was identified as a factor which is a significant rise on the previous year (124). We believe this is attributable to a change in practice by the MASH service that is identifying more cases of self-harm cases for assessment, as a consequence of learning from the Child J SCR. The outcomes at the end of assessment have remained unchanged with 54% of assessments leading to a statutory plan.

CHILD J Serious Case Review Key Messages
The LSCB has undertaken a serious case review (SCR) into the sad death by suicide of Child J in 2017. Whilst the review concluded that his death could not been predicted, it raised a number of important learning points about multi-agency work.

The report and its subsequent action plan identified significant areas of improvement for partnership practice that are required in responding effectively to children who self harm and planning their safe discharge from hospital.

Summary of key learning

- Practitioners need to capture the child's voice and their lived experience in all the work they undertake

- To fully understand lived experience, practitioners need to investigate the family and social-cultural environment and be confident to challenge cultural and faith beliefs in the interest of children
- Assessments need to be holistic and include information held by schools and youth services
- Hospital admission and discharge are critical events for children and their families
- Discharge plans need to be clear about risk and safety issues for the child and be formulated with and owned by all key agencies

Learning by Agency

Bart's Health Trust

- The discharge letter (which J had access to) contained confidential information about J's father.

Since the SCR, Bart's have amended their procedure and all discharge letters are now vetted by a senior consultant and this process is subject to audit.

Children's Social Care

The response of CSC did not meet statutory requirements in respect of J being a child in need.

- CSC did not complete the assessment started on J while in hospital, did not contribute to J's discharge plan or have any further contact with J and his family until his death several weeks later
- CSC did not progress the initial section 47 regarding J's sibling and all subsequent enquiries were undertaken by the police

The reasons for these practice issues are believed to be linked to a combination of factors including – high caseloads, practitioner and senior manager shortages over the period and gaps in staff skills and knowledge.

At the end of 2017, all social work practitioners and practice leaders were required to attend mandatory child protection refresher training to ensure that they understood their statutory roles and responsibilities. A series of further mandatory training sessions on sexual abuse and complex exploitation has been arranged for 2018.

East London Foundation Trust – Child and Adolescent Mental Health Services

- The waiting time for J from referral to assessment to intervention
- The medication prescribed to J was contrary to NICE guidance and would have required a consultant assessment which he did not receive. Furthermore the dose was increased without the authorisation of a consultant.

Since the SCR, ELFT have conducted a review of prescribing practice for under 18 year olds and clinicians within CAMHS have been informed that a Consultant must assess and authorise any medication prescribed outside of NICE Guidance. ELFT reported that half of all new referrals are now seen within the 9 week target and urgent referrals are seen within two weeks. The availability of a Duty Clinician at Newham University Hospital has helped to increase response times.

Follow up multi-agency audit

A follow up audit of 5 cases of children who had self-harmed in Q4 found that that the failings identified in the SCR regarding multi- agency information-sharing, risk assessment and discharge planning were being repeated. Subsequent to this audit, the LSCB has worked with partners to develop a protocol to strengthen the identified weaknesses in joint working practice.

The purpose of the audit was to assess the implementation of learning from the two local Serious Case Reviews for children who tragically committed suicide. In particular to:

- Ensure referrals are being picked up at the earliest point and preventing further harm
- Review the quality of assessments
- Seek reassurance the discharge planning process is working effectively
- Seek reassurance strategy meetings are happening and are multi agency
- Meet actions arising from recent SCR recommendations

Findings:

- Due to gaps in information-sharing and delays at some points in the child's journey, practice standards were judged to be partially (rather than fully) achieved in 4 cases and not achieved in 1 case. There were no cases that required immediate escalation
- Risk assessment and safety planning standards were partially met in 4 out of 5 cases
- Discharge planning meetings were held in 3 out of 5 cases but not all relevant agencies were invited to attend
- The child's voice and lived experience were captured in 4 out of 5 cases;
- Feedback was received from 3 families. They said the intervention had been helpful and the young people could identify someone they could speak to if they needed help.

Action(s) taken to improve practice:

A joint protocol for safety and discharge planning was developed between Bart's Health Trust, East London Foundation Trust and Children's Social Care in Q1 of 18/19 and launched in September 18. The protocol sets out clear roles and responsibilities for each agency and provides a risk assessment framework for discharge planning. A group of senior leads from each agency are tracking its use and impact on practice.

How the LSCB is monitoring progress:

The LSCB has overseen a robust action plan that has addressed all the concerns cited in the review and sought reassurance and evidence that the lessons have been addressed. Of the 16 recommendations, 12 have now been completed, are 4 are not completed but in progress.

The learning from this review has been disseminated via 8 workshops to 310 staff from Bart's, Education, ELFT, LBN and the Police and each partner agency has taken responsibility for delivering bespoke briefings within their own management teams. Training on suicide and self-harm delivered by a senior clinician from the local CAMHs service has been included in the LSCB training programme for 2018/19.

PROGRESS AND IMPACT 2017/18

The rise in the number of referrals to the MASH which go onto receive a child in need assessment is understood to be linked to the learning from the Child J SCR. Another impact has been an increased use of case escalation by leads from Bart's, ELFT and CSC regarding discharge plans for individual children. Case escalation has meant that plans have been reviewed to ensure they are effective and has increased the level of dialogue and understanding between local agencies.

The design and implementation of a local suicide prevention strategy was delayed this year due to changes of personnel in the Newham Public Health team. A draft strategy was presented to the LSCB Executive Board in Sept 2018 and is expected to be finalised by the end of 2018.

2.4 Youth Violence

OUTCOMES TO BE ACHIEVED
In partnership with the Community Safety Board the safeguarding issues associated with the exceptionally high prevalence of youth violence are understood, addressed and plans in place to reduce this

Serious Incidents and Serious Case Reviews
Newham has the second highest number of child victims of crime in London. This year, there were 57 serious incidents in Newham involving criminal violence to young people and tragically 3 young people died as a result of their injuries. Another 44 young people suffered non-fatal injuries while 10 of the incidents involved young people as perpetrators.

The majority of young people involved in serious incidents had previously been known to Children's Social Care and / or the YOT. In the case of the first young person who died in April 2017, the Youth Offending team conducted a Youth Justice Learning Review. The LSCB conducted a serious case review following the death of a 14 year old boy in October 2017 and a learning review in relation to a 17 year old boy was started in April 2018. These reviews will be completed and reported in late 2018. The early learning and themes from these reviews have informed the wider programme of partnership work to respond more effectively to complex exploitation with the following recommendations and areas highlighted for improvement:

- Professional competence in assessing the risk of criminal exploitation and specialist case work with gang affected and exploited young people using established and evidence based practice models
- Strategically and operationally realigning work with young people at risk of complex exploitation and consider the creation of complex safeguarding hub
- Meeting special educational needs, particularly at the point of secondary transition
- Implementation of changes in practice aimed at improving school engagement and attainment for children and young people vulnerable to criminal exploitation
- Housing relocation policy and process

At the beginning of 2018/19, Children's Social Care appointed an interim strategic lead for complex exploitation to drive improvements in safeguarding policy and practice. Multi-arrangements in the MASH have been strengthened and two new Practice lead posts created. The LSCB has established a Prevention Task and Finish group that will focus on the role of education settings in preventing and reducing the risk of criminal exploitation and has committed resources to ensure there is a comprehensive professional development offer on complex exploitation and safeguarding.

DATA and PERFORMANCE

Custody rates

- The rate of Custody per 1,000 youth population has improved in 2017/18, for the first time in 5 years the rate has gone down by 38% from the previous year. Newham's custody rate of 0.7 per 1,000 youth population is lower than the London average of 0.76 and the YOT Family average of 0.93. Given the complexity of the cases managed in Newham it can be challenging to deliver community disposals as an alternative to custody. Nevertheless, all options are explored and quality assured. The YOT holds a weekly custody review panel to ensure that where custodial sentences are given, they are proportionate to the gravity of the offence. The YOT has a good relationship with Stratford Youth Court, which is reflected in the congruence between YOT recommendations and outcomes at court.

First time entrants (FTE) to the Youth Justice system

- There has been a large increase in knife offences being committed by FTEs add it is now the single biggest contributor to FTEs, some of which is due to an increase in knife offences within schools premises. Newham's rate of 432 FTEs per 100,000 populations is higher than both the London average of 403 and the National average of 313. This performance should be viewed against consistent falls in FTEs for the last five years; however there has been an 11% increase in 2017.

- *The number of First Time Entrants (FTEs) to the Youth Justice System has increased by 18% from the previous year*; the number of FTEs aged between 10 to 13 years has also more then doubled in the same period, from 6% of all FTEs to 18%. There has been a large increase in knife offences being committed by FTEs at 26% and is the single biggest contributor to FTEs compared to 18% in the previous year, some of which is due to an increase in Knife offences within schools premises. Newham's rate of 405 FTEs per 100,000 youth population is higher than both the London average of

380 and the National average of 292, however it is lower then the YOT Family average of 460.

Re-offending rates

- Newham's re-offending rate (i.e. young people found guilty of an offence who re-offend) has fallen by over 3% from 46.1% in the year 2014/15 to 42.6% in the latest yearly data. It is considerably lower than the London average of 47.9% but slightly higher than the National average of 41.9%. The re-offences per re-offender rate (i.e. the number of offences committed by the re-offending cohort) of 3.65 is higher than the London average of 3.47 and the YOT family average of 3.49. Re-offending performance is closely examined and monitored using a live tracker. The borough has identified that the small cohorts of individuals who do re-offend display some common characteristics; they are often not in education, employment or training (NEET) and placed out of borough.

Diversion

- The YOT currently operates a triage system of diversion from the criminal justice system. This allows police and YOT to make joint decisions on disposal options and if appropriate divert young people away from the formal youth justice system and carry out an intervention with them to prevent further offending. Young people who have been identified as of concern by professionals particularly those that are at risk of gang association can be referred to YOT for engagement in work to address risk of entering into offending behaviour.

Operation Anzen

This engagement and diversion scheme for those linked to one local gang has been very successful this year and shown a significant reduction in missing episodes by those on the matrix. Trident has estimated this to have resulted in £45K in savings to the MPS and partners. Since the introduction of Project Anzen in July 2017, there have been 95 referrals with 28 live cases at March 18. The remit has now expanded from young people at risk of coercion into gang activity by two local gangs to include any gang. The team now also deal with a large number of enquiries around children vulnerable to being criminalised by others.

Case examples

A 17 year old male who had been in local authority care and with a history of going missing had become involved in County Lines exploitation. Through Anzen officers continued engagement with him and liaison with various agencies he has now gained an employment card to work on construction sites. Officers will continue to support him until these positive changes are permanently embedded.

In another case, a young person who had returned to London was successfully engaged with by a police officer was posted to a local youth club. Officers were also able to highlight housing concerns affecting the family which have now been addressed.

Employment, Education and Training (EET)

- EET performance is very good at 77% of the young offender population in suitable education, training and employment during 2017/18 according to Newham's internal Performance indicator. According to the YJB data Newham performed considerably better at 43% then both the London average of 35% and YOT family average of 34%. This reflects the partnership work between the YOT, Education Services, and third sector providers to deliver and provide a personalised and robust offer to young people who are NEET.

Newham Youth Offending Team

- Newham's performance against the three Youth Justice Board national indicators is good. It is generally in line with the London average and in some cases, better than the YOT Family average. This is a result of a combination of focused supervision, effective partnership working, robust quality assurance framework and reflective practice. Although performance is positive, the cases managed by the YOT are growing increasingly complex and the YOT Management Board are acutely aware of the challenge of maintaining and improving the service provided.

2.5 Domestic Abuse 2017/18

INTENDED OUTCOMES from the NEW DAY DOMESTIC ABUSE INTERVENTION PROGRAMME

- *Practitioners are skilled to promote change*
- *Vulnerable children achieve their learning potential*
- *Children's experiences are central to behaviour change*

DATA AND PERFORMANCE

- Newham continues to have a high prevalence of domestic abuse with a slight reduction from the previous year. A total of 6,572 incidents were reported to the Police. This equates to 19.6 per 10,000 of the population making it the eighth highest rate across London.

- 17% of referrals indicated domestic abuse as a concern compared to just under a quarter in the previous year.

- 37% of CSC assessments identified domestic abuse as a factor – against a London average of 30%

- Out of 3436 assessments completed by Newham Children's Services between April 2017 and March 2018, domestic violence was a reported assessment factor in 1876 assessments (54.6%).

- Over the course of the year, there were 70 more single assessments with domestic abuse recorded as a risk factor that in the previous year. 57% of these cases were de-escalated or led to no further statutory action at the end of the assessment, a similar performance to the previous year (59%).

- Data from the Metropolitan police showed that 148 children were recorded as victims on domestic abuse reports in Newham between July 2017 and March 2018

- At 31st March 201, 63% of 319 child protection plans had an indicator for domestic abuse recorded during assessment.

- The number of children discussed at the Multi-agency Risk Assessment Conference (MARAC) continued to increase and was 608 compared to 571 2016-17.

- Since 2010, Newham has had a total of 8 Domestic Homicide Reviews.

PROGRESS AND IMPACT

- The multi-agency response to working with high risk victims and their children has been effective in addressing risk and planning to keep people safe and performance is improving. The MARAC received 491 referrals of high risk victims and considered 608 children as part of its work. The referrals are higher than last year and are above the Safe Lives target of 450.

- Children's Social Care made fewer referrals to the MARAC this year but partners agreed that due to joint working with the Domestic and Sexual Abuse Support service, more referrals are being made directly than via the MARAC.

- There were 275 referrals to the Domestic Abuse One-Stop shop from Children's Services which represents a 34% increase on the pervious year. It is believed that this increase is due to the location of the two Domestic Abuse providers within Children's Triage contributing to stronger integrated working.

- The repeat referral rate is the same as last year 29% (144 out of 491 referrals) which is just above the target set by Safe Lives who recommend a repeat rate between 28-40%. The more repeat referrals to the MARAC the more involvement MRACH has with families as risks are re-evaluated and the multi-agency response can work to help people to be safe.

- Domestic abuse support services delivered through the Newham One Stop Shop are effective in reducing risk and re-victimisation. 100% of women using the support services for low- medium risk violence and high risk independent domestic/sexual violence advocate (IDVSA) service reported a reduction in risk due to the support and services offered. The figures for those who are repeat victims fro the low to medium risk DSV case work service stands at 7.9% and 5.9% for the high risk IDSVA service.

<u>The NewDAy Innovation Programme</u>

The NewDAy programme is a response to the finding that the old approaches to working with domestic abuse were not working for the populace of Newham. Conventional approaches in social care as a response to domestic abuse have tended to force the separation of parents, however NewDAy works with parents to help them to stay together

or separate safely, all the while helping parents to understand the impact of abuse on children and create a safe environment for children to grow up, free from abuse.

NewDAy delivers six possible interventions to suit families in different circumstances who could benefit from therapeutic support. The evidence-based approaches are new and fill a gap in demand within the borough, meeting the needs of families, which are not covered by any other service in Newham.

The core offer centres on working with the person experiencing abuse, the person using abuse, and their children. NewDAy also offers short term individual interventions for users of abuse who aren't ready to participate in longer term intervention support and interventions to help to strengthen parent-child relationships. NewDAy has recently launched Caring Dads which is a group work for fathers who have abused or neglected their children. Across our range of interventions, NewDAy has completed direct work interventions with 71 parents and 85 children to date. By the end of the 2019 we aim to finish working with at least 50 more families.

NewDAy's education arm, is working with children known to social services, or in early help, who are affected by domestic abuse and need additional help with education or school. NewDAy advisory teachers work with professionals and young people to target improvement in specific areas, whether that is related to punctuality, or emotional wellbeing. They put a spotlight on children's learning and progress for three academic terms.

Impact to date:

- NewDAy is made up of a multi-disciplinary team of domestic abuse specialists and advisory teachers who deliver evidence-based direct work with families.
- The majority of children and families accessing NewDAy are on a child protection or child in need plan. The aim is to step down from statutory services and reduce re-referrals.
- NewDAy is sharing knowledge and experience with the wider workforce. Over the last year, they delivered 121 consultations on domestic abuse case work with social workers.
- NewDAy has offered some form of training to 152 social workers and 219 teaching staff.
- NewDAy has a strong governance structure with local partners and subject experts who are very engaged with and interested in the development of the programme.
- NewDAy is being independently evaluated, with a final report being produced in March 2020.

Feedback from families: **"***NewDAy have a totally different approach that helps"*

"If every team was like the one we worked with, it would achieve major change for many families"

"With NewDAy it was better; when we talked to the team… it was explained and understood"

"We want to work with you (NewDAy)… to be better parents"

Police Operation Encompass

In February 2018, Newham joined 25 other police forces across the country that is embedding this innovative joined-up way of working. Operation Encompass is a police, education, early intervention and safeguarding partnership that support children and young people affected by domestic abuse.

It begun with a pilot with 28 schools in West Neighbourhood, followed by 25 schools in the East quadrant in March with a plan to phase in and be fully operational across all Newham schools by the end of the summer term 2018. Over 200 Head Teachers and designated safeguarding leads are expected to complete mandatory training by June 2018.

- Launch date TBC (we are aiming for 03/09/2018) for Central quadrant (22 schools) and South quadrant (25 schools).
- LBN to delegate one person to work in partnership with police (to provide names of children schools)

Feedback, benefits and impact so far:

- Increase in schools attending S47 strategy meetings.
- Unprecedented response from schools wishing to be part of Operation Encompass
- Operation Encompass has been highlighted as good practice approach in the recent JTAI report, HMIC, NAHT and OLAC inspections.
- Co-facilitation of planning and delivery of training by police and CYPS.
- Increase in consistent school approach and intervention for children affected by DVA.
- Upskilling of school workforce to embed ACE / Trauma informed approaches.
- Promotion of NewDAy and HeadStart interventions.
- Increase in schools moving to a **safeguarding@school** email address for referrals and notifications of Amber and Red DVA merlins, enabling management oversight and a coordinated approach to practice to better support children.

2.6 Neglect

INTENDED OUTCOMES
Children who experience parental neglect are identified early, and receive effective and timely interventions and early help which reduce long term harm. The work force understands the lessons from research and serious case reviews and is well trained to assess and intervene effectively

DATA AND PERFORMANCE 2017/18

- Neglect is the highest recorded category type of abuse recorded in contacts to the MASH and accounted for 27% of all contacts

- Neglect was identified as a factor in 665 assessments, an increase of 104 assessments on the previous year. Around two-thirds of these assessment led a statutory plan at the end of that assessment

- Neglect is the most commonly recorded reason for children to have a child protection plan and accounts for 45% of all child protection plans which is same as the previous year

PROGRESS AND IMPACT 2017/18

The main objective for this year was to embed the use of the NSPCC Graded Care Profile 2. 137 staff were trained over the course of the year to use the GCP2. Following this accredited training, Health Visitors, Families First Coaches and Social Workers were expected to use the tool in cases where there are concern about the quality of parental care being provided.

During the year, 17 completed GCP2s were returned to the LSCB. This is a much lower number than was expected and to tackle this this, the LSCB has asked senior leads in Child Health and Children's Social Care to drive up compliance and ensure that first line managers are discussing the use of the tool in supervision. The LSCB will commit further investment in training for 2018/19.

Feedback from practitioners

In dealing with a family where neglect is concerned, using the GCP2 tool was helpful to my analysis and understanding the children's experience.

It helped me to recognize strengths and focus on achievable outcomes and areas to build on

It helped me to have a more open discussion with the family about neglect not only when it is occurring but also when it is not.

The Child Protection Quality Panel (see section 3.3) reviewed the plans of 18 children with child protection plans for neglect and made the following findings.

Summary of Findings

Of the 19 neglect cases, 7 were rated as green, 8 as amber and 3 as red. In the cases rated as red, two involved older teenage boys whose plans did not appear to be effective in improving outcomes for them and these cases were escalated to senior managers. In the third case, the Local Authority had made an application for an interim care order which had been refused by the Court and the children were continuing to live in a neglectful home.

The Public Law Outline was being used in most cases which met the threshold for legal intervention and where there was had been no significant improvement in the children's circumstances. In many of the cases, the neglect related to the children's emotional needs and/or linked to lack of parental supervision rather than neglect of physical needs. Parental substance misuse and/or parental ill-health (mental and physical) were a feature in most of the cases.

In 2 cases where domestic abuse featured, the CP plan had empowered the mothers to protect their children. In nearly all cases, the CP plan had led to improved school attendance for the children

A range of supportive interventions had been provided including parenting programmes and school based support for children,

The Graded Care Profile had not been used in any of the cases reviewed by the panel and social workers were asked to attend this training.

Newham CCG audit of Children not brought for Appointments (DNA)

It is recognised that when children are not brought to their health appointments this denies them their right to access health care (Article 24 United Nations Convention on the Rights of the Child 1989) and is a feature in neglect cases and Serious Case Reviews.

Children not brought for their health appointments has been a standing item of the Joint Health Safeguarding Subgroup meeting. Audit findings have been presented by:

- Bart's Health acute health services
- CAMHs
- ELFT Newham Community children
- LBN School Nursing

The majority (57.8%) of the total number of children and young people were over the age of 5 years and within 2 particular clinic types in Bart's Health. Services in ELFT, for which there are formal key performance indicators for children not brought, were within the targets set. There is a proposal for a wider audit to include:

  - Reason for non-attendance
  - Instigator of cancellation
  - Sharing of information with other professionals

- Services that are generally provided in schools tend to be adversely affected by necessary changes to those arrangements during school holidays.

- ELFT has recently updated the "Was not Brought" (DNA) policy to inform and guide service practice. The Looked after Children Decliner Pathway has been updated to be consistent with best practice (Not Seen, Not Heard, Care Quality Commission, 2016).

- Following the audit, Newham CCG have put in place a structured process of sharing information between school nurses and GPs for over and underweight children.

- Further guidance is being developed to support staff manage cases where parents refuse to give consent for the National Child Measurement Programme

2. 7 Parental Mental Health

INTENDED OUTCOMES
Adult and Childrens' Health and Social Care Services work in partnership to support families where parents have mental health needs. Families are pro-actively helped to access early help services and children are safeguarded from potential harm.

DATA AND PERFORMANCE 2017/18
There is a dearth of data on the number of families living in Newham that have parental mental health needs. Data from Children's Social Care showed that there were 685 assessments carried out over the course of the year where parental mental health was identified as a factor at the end of the assessment. This number is similar to the previous year (647). 51% of these assessments led to statutory intervention which is an increase on the previous year (45%).

PROGRESS AND IMPACT
In the first half of the year, the LSCB worked with safeguarding from Children's Social Care and Adult Mental Services (LBN) and (ELFT) to develop and implement a Joint Protocol for Supporting Families with parental mental health needs. The development of the protocol was informed by a learning review in the previous year and the identified need to improve mutual knowledge and understanding of pathways for referral and intervention.

The protocol was launched at an event attended by 107 staff from across Adult Mental Health and Children's Services. The feedback from the event was extremely positive and attendees said that they valued the opportunity to come together, to share information and to address the challenges of joint working. When asked what they would do differently as a result of the day, improving communication, more joint working and joint visits and seeking out further training were the most frequently recorded responses.

A very informative and problem-solving event in identifying issues around working together. Social Worker, Children's Social Care

I will improve discussion with the team to review families with children to consider early referral for assessment. Team Leader, Adult Mental Health

Since the launch, a series of training events on adult and peri-natal mental health have been delivered by ELFT staff. From spring 2018, the Principal Social Worker for Adult Mental Health (LBN) has been based a day a month in the main Children's Social Care teams and this is helping to nurture improved communication and sign-posting.

The progress and impact of the protocol on partnership working will be tested in 2018/19 with a multi-agency audit of cases. A task and finish group will plan this audit and will lead the continuing work to improve partnership working with families affected by parental mental health.

3. SCRUTINY

The LSCB uses the following mechanisms to scrutinise practice in order to identify areas of strength, areas for improvement and other learning:

- Serious Case reviews
- Local learning reviews
- Multi and joint agency audits
- Child Protection Quality Panel
- Section 11 Assessments of Safeguarding arrangements

3.1 Serious Case Reviews

Child J published November 2017
The learning from this serious case review and the progress in implementing the recommendations are detailed in section 2.3. Due to the unique, identifiable factors in this sad case, the LSCB took the decision not to publish the report in order to protect Child J's sibling from harm.

Child C published January 2018
Newham LSCB was party to the serious case review of Child C, conducted by the London Borough of Barking and Dagenham and published. Child C's parents were found guilty of causing or allowing the death of a child. Among many lessons this case highlights, the difficulties that professionals experience when working with non-compliant, chaotic, mobile and duplicitous families. This family lived at six different addresses (these were the addresses that the professionals knew about), and in four local authority areas, three of which were in London. The mother engaged with the different agencies and professionals on her terms. She often managed to do 'just enough' in terms of attending health appointments to suggest she was complying and trying to keep her appointments. She shared different information with different professionals and was verbally aggressive and abusive; she accused professionals of lying or giving her the wrong appointment times.

There was concern about the care of Child C and her sibling by the mother, and in particular her transient lifestyle, avoidance of engaging with services and failing to put the needs of her children first. But there was no specific evidence that Child C would experience serious physical harm. In these circumstances, it is reasonable to say neither Child C's death nor her injuries could have been predicted. However, there was a constellation of factors both in the history of Child C and the older sibling that presented a cumulative picture of risk, neglect and poor understanding of the mother's wish or capacity to care for Child C. The issue of the father was a singularly significant factor in the risks to both children.

The SCR contained 9 recommendations for both the LSCB's involved with the family. Newham have completed 5 of these recommendations and 5 are in progress. In view of the broad nature of the recommendations for practice – covering professional curiosity, supervision, quality of assessments and working with avoidant families, the LSCB and its partner agencies will be carrying out further testing of these areas of practice in 2019.

Child M
This SCR was started in December 2017 and is due to published in autumn 2018.
This review concerns a disabled child who suffered a potentially life changing injury as a result of an accident with equipment in the home when she was unsupervised.

Chris SCR
This SCR was started in September 2017 following the murder of Chris aged 14 years and is due to be published in autumn 2018. The emerging learning from this SCR is reported in section 3.4.

3.2 Local Learning reviews
The LSCB completed 5 local learning reviews this year in cases that did not meet Working Together threshold for a serious case review but where the partnership identified that there were lessons to be learnt for local practice.

Child B – June 2017
This case highlighted the need to strengthen multi-agency assessment and improve joint working by Children's Social Care and Adult Mental Health services with families where the parent has mental health needs. A joint protocol was developed as a result of this learning review and the LSCB has provided training on suspected Fabricated and Induced Illness. Adult mental health staff from the East London Foundation Trust (ELFT) now provides the LSCB training on adult mental health and peri-natal mental health.

Family D June 2017
This case highlighted the importance of direct work with children and their parents in households where there is domestic abuse; and a professional recognition that the risk of physical abuse to children increases in households where there is domestic abuse. The learning from this case has been disseminated through safeguarding leads and is used in LSCB training courses on domestic abuse.

Three Learning Reviews 2017 involving disabled children
While the lives and circumstances of the three individual children were unique, three key themes in common and areas for improvement were identified:

- Access to independent advocacy for disabled children
- Professional escalation when there are concerns about the provision of care and services
- Care co-ordination by a lead health professional for children with complex health needs

In response to the findings, the Newham Clinical Commissioning Group (CCG) has revised local guidance on the lead professional role; the LSCB has reissued its guidance on how to escalate concerns; the local authority has communicated information about Newham Children's Rights service more widely to all staff.

3.3 Quality Assurance
The LSCB has carried out a number of activities over the period 2017-18 on specific themes to evaluate the effectiveness of practice and drive improvement, using the following mechanisms:

- Multi-agency and Joint Agency audits
- Child Protection Panel Quality panel to review the cases of children subject to a child protection plan for 12 months +

3.3.1 Multi-agency and Joint Agency Audits

Children at risk of child sexual abuse (Q1 and Q4)

Purpose Two audits were carried out during the course of the year in order to assess the response to referrals of child sexual abuse in response to a recommendation from the KA serious case review (May 2017). Audit findings are reported in section 3.1

Children who attempt suicide and self harm of 5 cases Q4

Purpose: to review the implementation of learning from the two local Serious Case Reviews for children who tragically committed suicide. In particular to:

- Ensure referrals are being picked up at the earliest point and preventing further harm
- Review the quality of assessments
- Seek reassurance the discharge planning process is working effectively
- Seek reassurance strategy meetings are happening and are multi agency
- Meet actions arising from recent SCR recommendations

These audit finding are reported in section 2.3

Child Sexual Exploitation audit of 33 open cases December 2017

An annual multi-agency audit of live and recently closed cases was conducted in December 2017. In total, 33 cases were audited and the panel consisted of children's social care, police (Sergeant from both local CSE police team and the central Sexual Exploitation Team), CAMHS and was at time supplemented by the Designated Nurse for Safeguarding Children (CCG) and the NSPCC.

Purpose To obtain an overview of cases with a CSE risk including risk management, safety planning and the voice of the child/family; evidence multi-agency collaborative working to help mitigate the CSE risk and evidence accurate record keeping and management oversight

Findings

Areas of Strength:

- Escalation procedures – the majority of practitioners exhibited a good understanding of how to identify and respond to CSE vulnerabilities and initiating the CSE process.

- Use of student social workers – in a number of cases, student social workers were able to build strong working relationships with young people, by having weekly sessions/contact and exploring issues around CSE (i.e. healthy relationships and consent). This can also be particularly useful if the social worker is a different gender to the child/young person and the student social worker is the same gender as this can create a safe space for the young person to engage in conversations around sex and relationships.
- Partnership working with police – for those cases that are open to the Newham CSE police team there was consistent evidence of strong partnership working, from sharing information to attendance and participation at strategy meetings. Officers from the Newham CSE police team also built good working relationships with young people and had an understanding of their thoughts and wishes.

Areas for Improvement:

- Risk assessment – there were a number of different risk assessments currently being utilised. It had previously been advised that practitioners use the risk framework within the pan-London CSE Protocol; however it was agreed that this could be expanded upon and disseminated for consistency.
- Strategy meetings – though there has been improvement in the frequency of strategy meetings, health partners are not consistently being invited, with school nurses almost always being overlooked and not invited to such meetings.
- Record keeping and management oversight – minutes of meetings and evidence of safety plans were not consistently uploaded onto Azeus and there were a number of cases that lacked management oversight and grip.
- Closure of CSE cases (particularly by the police Sexual Exploitation Team (SET)) – there was a consistent finding relating to CSE cases open to the SET team (category 2 and 3 CSE risk), in which the police would close the case without prior consultation with the professional network. Decisions such as these should always be made within a strategy meeting, to ensure that all professionals are aware and in agreement.
- Voice of child – young people and/or their parents was not, in the vast majority of cases, invited to attend strategy meetings. Young people/parents/carers should, where appropriate, be invited to attend strategy meetings to have their views and wishes heard and input to the safeguarding plan. Social workers and managers were unsure of how to split the agenda to allow children and families to be part of the meeting but to also allow for confidential conversation. It was agreed by the panel that a template agenda for this would be a useful tool.

Recommendations to improve practice

- Update the CSE risk assessment tool
- Attendance of Youth Offending and Health staff at Strategy meetings; (attendance of CAMHS staff had significantly improved since the previous year's audit)
- Sexual Exploitation police to ensure that any case closures are a multi-agency decision made within a strategy meeting
- Better mapping of cases to identify criminal exploitation and harmful sexual behaviour

- Use of MASE as an escalation procedure where there are significant barriers to the progress of the safeguarding plan. MASE should also be used to feed in any hotspots or themes that practitioners are aware of, so that a strategic plan for disruption can be agreed.
- Follow-up audit of Return Home Interviews
- Provision of reflective supervision to support staff to reflect on cases and the impact of CSE on the wider family, as well as ensuring case files are kept up-to-date.
- Develop a Directory of CSE support services including in the Voluntary and Community Sector
- Awareness raising and training of key stakeholders

These recommendations have been encapsulated within the improvement plan for complex exploitation that has been developed following a system wide review at the beginning of 2018.

<u>Newham Secondary Schools Child Sexual Exploitation Audit Report</u>

This audit took place in April-July 2017 in 20 Newham secondary schools including 4 Independent schools. The purpose of the audit was to inform the CSE/Missing Subgroup of the LSCB what secondary schools are doing well to effectively intervene and safeguard young people at risk of or experiencing sexual exploitation and to highlight areas for improvement.

Audit Process

This audit tool consisted of four main areas:

1. To review procedures to identify, refer and support students
2. To get feedback from students about what they have learnt about CSE and how the school protects them and supports them
3. To get feedback on how confident staff feel to teach about CSE, identify at risk/vulnerable students and refer
4. To review what is in the curriculum about CSE and how it is taught

Feedback from the students:

The greatest area of understanding was around online safety and this could be partly due to the topic being addressed in IT lessons as well as safeguarding.

88 % of students were able to identify an unhealthy relationship although 38 % of students were unable to articulate what this meant. Comments were made that this focused more on the negative side of relationships and it would be nice to learn more about positive relationships.

91 % of students were able to explain how they would help someone if they were worried about them being sexually exploited, despite not understanding the term fully. Responses included speaking to staff, the Safeguarding Team, an adult, ChildLine, family member, another friend and the police. They also would encourage them to tell their parents.

Students agreed the school had helped them stay safe from exploitation and named the following ways they had done this; phone ban, online information, appointments with seniors, assemblies, booklets, posters, flyers, cards with phone numbers on, teachers to talk to and workshops on staying safe.

96 % of all students stated they were not involved in shaping the curriculum on CSE although at several schools, students had expressed a desire to take more ownership of their learning in this area. 47% of students were

critical of the depth and detail of information provided by their school. 57% of schools are already developing ideas for students to be involved in developing their own curriculum. Suggestions from students include peer-led presentations, assemblies and campaigns and also real-life case studies.

Areas of strength:

- 100% of schools have systems in place to support students who are victims of CSE or vulnerable to CSE. Some schools demonstrate good in-house practice such as safeguarding teams, mentoring, using school nurse, monitoring and reviewing attendance. Schools also liaise with statutory and none-statutory external partners such as the Police, Social Care, CAMHS, SHINE, NSPCC. 100% of schools stated they had systems and procedures in place to identify and refer students at risk or vulnerable to CSE. Some schools explained their procedures in more detail that others
- 100% of schools stated their students were encouraged and enabled to report concern and some schools explained the systems in place
- 100% of schools have given their staff CP training
- 58% of settings who had involvement with SHINE and/or drama and theatre sessions appear to have a good understanding of CSE
- Students are generally aware of online safety, the use of mobile technology and social networking sites as this is a topic covered in IT lessons as well as PSHE and assemblies
- Students at most schools could identify a range of examples where the school had helped them to stay safe from exploitation
- Some schools have excellent relationships with external agencies, both statutory and none-statutory
- Some schools are engaged in multi-agency work
- Many schools have a good variety of guest speakers for school assembly
- Some schools are pro-active in developing ideas to improve practice such as sharing knowledge and ideas with other schools

Areas for improvement:

- Achieving good practice consistently across all schools
- Some schools identified good practice in supporting the families of victims of CSE. However, some schools have identified this as an area they could improve on. From the responses given, it is clear that some schools are failing to connect with parents of students at their school and this means they are unable to provide information and support to them about CSE.
- Although all schools have given their staff training, some felt that this could be more focused on CSE, particularly developing awareness of terminology
- Generally, student understanding of CSE is not secure. There appears to be confusion with the acronym CSE, differences between CSE and child abuse, terminology and understanding between year groups

- Students in some schools are able to identify their learning but this is not consistent across all schools with some students stating they do not know as much as teachers think they do
- When asked about unhealthy relationships, not all students were able to articulate what this meant. Some schools felt there was too much focus on unhealthy relationships at the expense of healthy relationships.
- Only 8% of schools currently involve students in shaping the curriculum on CSE. Some schools receive feedback from students on the school council. Students at one school expressed the desire to take more ownership of their learning in this area. Other schools were developing ideas to include students in shaping the curriculum. However, at some schools, students were not involved at all.
- Staff at some schools are well-trained in CSE and feel confident in identifying a child at risk of exploitation and reporting this. However, 38 % of schools had staff that were not confident in this area and spoke about needing more training.
- Assessment of students' learning about CSE is an area that most schools are aware they need to develop
- 100% of schools address CSE through PSHE lessons. Some schools include use external agencies such as SHINE to speak to students in assembly or by providing workshops.
- Some schools could develop their relationships with external agencies, both statutory and none-statutory

The following next steps were identified:

- Better communication across the Local Authority and LSCB and all schools is required especially where there is dispute about threshold or risk or plans too limited
- Schools need to be better informed about thresholds, and local processes post referral
- Better understanding of the systems of support available
- Directory of services and main contacts
- Encouraging parents into the school to inform them of CSE
- Involvement of students in shaping the curriculum on CSE
- Use of theatre and drama to teach and involve students about CSE
- Although all settings reported systems in place to support a pupil who is the victim of CSE or who is vulnerable to CSE there is no consistency in the approach and this should be addressed.
- Schools supported by the LA to ensure balance: Information about CSE supported by the building of resilience so that young people can identify and want healthy relationships
- Qualitative examination of CSE responses, qualitative interviews with parents and young people to better understand their perceptions.
- Qualitative audit of impact of interventions
- Linking CSE to awareness of gang activity within schools
- To hold a local CSE 'Raising awareness event' for all schools (Summer term 2018)

3.3.2 The Child Protection Quality Panel

The function of this multi-agency panel is to assure the quality and effectiveness of child protection plans for children. The panel meets regularly over the year and reviews four cases each month. This activity is carried out by reading the child protection plan, minutes of the last conference and core group and by questions to the allocated social worker who attends the panel with their line manager.

The discussion is recorded on a template and a RAG rating system is used to record case progress and current level of risk and sent to the Practice Leader and Service Manager. Red cases are escalated to the Head of Service. A check is made back by the panel on action taken.

During the last 12 months, the panel reviewed the case of 19 children with child protection plans for **neglect** (18) and 7 children with child protection plans for **sexual abuse,** as these are current NSCB's safeguarding priorities. These findings are reported in section 3. And section 3.1

The panel found that were there are delays in achieving the outcomes set out in child protection plans, this appears to be due to a change of social worker in the case, or because improvements in parenting had not been sustained.

3.4 Section 11 Reports 2017/18

Section 11 of the Children Act 2004 places duties on local authorities, the NHS and a range of other organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

Section 11 audits were carried out this year by commissioned services providing placements and support for Looked After Children; services providing positive activities for children and young people; by schools and by early years providers. The findings are presented to the LSCB Executive Board and then progress in implementing the audit action plans are monitored by the Performance and Quality Assurance sub-group.

Training needs are particularly highlighted in the first two section 11 audits and the LSCB is monitoring to check that the individual agencies book onto relevant training in 2018.

3.4.1 Placements and Support for Looked After Children

The self assessment questionnaire was emailed to organisations commissioned for semi Independent accommodation and support for looked after children making their transition into independent living and are unregulated by Ofsted. 13 out of 18 in current use by the local authority at the end of March returned their self-assessment by the due date and are included in the analysis.

Areas of strength:

- All organisations have identifiable leads for safeguarding

- All organisations report that their staff and volunteers know their safeguarding lead and how to report safeguarding concerns
- All organisations have at least one staff member trained in safer recruitment and their recruitment comply with Safer Recruitment guidelines
- All organisations provide opportunities for young people to give their views.

Areas for improvement:

- 8 out of 13 organisations reported that their staff are not aware of the findings from Local Learning and Serious Care Reviews
- 7/13 of their safeguarding policies do not address Female Genital Mutilation or Radicalisation
- 7/13 organisations have not met the LADO in the last 12 months
- 8/13 do not have young people's version of their safeguarding policies
- 7/13 reported that all staff have not had received training in Radicalisation
- 9/13 organisations requested that the NSCB could support them by providing updates about training opportunities.

The lead commissioner has responded to the areas for improvement by providing information on training and resources to support improvements and is tracking progress through the commissioning monitoring process.

3.4.2 Neighbourhood Based Positive Activities

Eight providers took part in this section 11 audit using a section 11 template designed by the NSPCC for voluntary organisations. These services are commissioned by LBN from internal and external providers and offer a range of activities and development opportunities to local young people.

While the 8 organisations met most of the audit standards, it was clear from the self assessments that there were gaps in some organisations' knowledge in relation to learning and serious case reviews. There was also a need for some organisations to review and strengthen their policies, specifically around child sexual exploitation, e-safety, radicalisation and female genital mutilation, and this process has presented an opportunity for them to do this.

Action plans for each agency have been put in place and are being monitored by the lead commissioner and information provided on how to access LSCB training and the role of the CSE and Missing Co-ordinator.

3.4.3 Best Start in Life Section 11 Safeguarding Returns for 2016/17

A request was sent to all commissioned early years services, (77 Private Voluntary Independent (PVI) settings; 224 Child-minders (CM) and 20 independent after school clubs with a response rate of 87% from the PVI sector and 70% from Child Minders. Only 2 After School clubs submitted a return and these are included in the PVI data.

The data from maintained nurseries and nursery provision within schools is reported as part of the schools return in section 3.2.2.

A total of 21 settings were moderated as part of the section 11 audit. These were chosen because they were new settings, had an OFSTED grade of Requires Improvement or Inadequate, or were a setting which had a LADO referral. 90% of self-assessments moderated demonstrated accurate information. Managers of the settings that were moderated gave feedback that they found the section 11 process useful and helped them to identify areas to improve.

3.4.4 Section 11 Audits for Schools 2016/17

A total of 104 schools responded and there was a good response this year from the maintained and non-maintained sectors. The collated data was gathered from 85 schools as some schools used different audit tool to submit their return.

As the schools and Early Years audits were completed using the same template the findings are shown together in the table below.

Headlines

The response from Newham schools demonstrates a good understanding and commitment to safeguarding children and to early help. Schools are also increasingly making use of the Early Help Pathways which suggests that these processes are becoming more effective. This year's audit shows that schools have strengthened their policies in relation to leads for CSE, E-safety and Prevent and their letting arrangements. The section 11 audit for Early Years Providers shows a more mixed picture with some strengths and areas for improvement. Schools and EYP services all need to improve their recruitment practice with volunteers.

The Designated Safeguarding Leads for Schools and Early Years have put in place robust action plans to address each of the areas for improvement identified. The reports have been presented to the LSCB Executive Board and progress will be monitored by the Performance and Quality Assurance sub-group.

Management oversight of safeguarding arrangements	Schools	PVI	CM
There is designated lead for safeguarding and this person is part of the senior leadership team	100%	97%	75%
Comment In one school the DSL role was filled by a social worker who was not part of the school SLT			
There is a nominated lead for Prevent	100%	89%	94%
FGM	100%	90%	95%
On-line safety	100%	95%	88%
CSE	100%	93%	86%
Training	Schools	PVI	CM
DSL has completed safeguarding training in last 2 years	82%	86%	70%
Whole setting safeguarding training has been provided	100%	90%	20%
Comment: 80% of child minders are lone workers. Of those that work with assistance, 80% had received whole team training. Since April 2017, Level 1 safeguarding training became an on-line course to provide			

practitioners with continuous access. All schools confirmed that whole school training happens at least annually and many provide termly updates			
There is a named person responsible for safeguarding induction and this training is signed off	Schools 100%	PVI Not completed	CM Not completed
Comment: one school did not confirm there was sign off			
Safeguarding information and awareness raising on "Keeping Children Safe" is provided to parents/carers during the year	Schools 97%	PVI 96%	CM 89%
Safe Recruitment	Schools	PVI	CM
Leaders/managers have attended safe recruitment training	98.8%	80%	13%
Safer recruitment procedures are followed for paid staff and volunteers	100% paid staff Gaps in the recruitment process for volunteers	90% Gaps in the recruitment process for volunteers	59% Gaps in the recruitment process for volunteers
Comments: regarding volunteers - 98% of schools had carried out ID checks; 51% had take up 2 or more references 73% of schools confirmed that DBS checks had been carried – although all schools also confirmed that volunteers were supervised at all times; and 72% had confirmed Right to Work. In the Early Years settings compliance fell much shorter with procedures only followed for volunteers and students in 55% of cases. In April 2017, Safer Recruitment training was offered as an on-line course to improve access.			
A single central record is used and maintained	Schools 100%	PVI 90%	CM 88%
Comment: 84% of schools reported that the Link Governor for Safeguarding had checked the register during the academic year. While it is not a requirement for Early Years providers to have a single central record, it is good practice and the Best Start in Life team is encouraging setting to have one.			
Site Safety	Schools	PVI	CM
A signing in and out procedure is in place	100%	92%	40%
There is a Premises letting Agreement in place which covers safeguarding and child protection	100%	72%	n/a
Policies and Procedures	Schools	PVI	CM
The setting has a current policy in relation to Early Help, Safeguarding and Child Protection	100%	95%	76%
And includes reference to other specified safeguarding areas: **CSE**	 100% 100%		

FGM **Peer on Peer Abuse** **Prevent** **Setting has completed or reviewed the Prevent Duty Risk assessment**	80% 89% 88%	74%	60%
Comment: The reported gap in polices and procedures for the Early Help providers was immediately addressed by the DSL			
Written guidance has been provided to staff and volunteers on safer working practices	Schools 95%	PVI 63%	CM 59%
Comment: 99% of schools, 75% of PVIs and 70% of child minders had a Code of Conduct that gave guidance on staff behaviour.			
Safeguarding is embedded into the curriculum and there is a culture of listening to children and taking account of their wishes and feelings	Schools 100%	PVI	Child minders
Comment: this section was poorly completed by most of the EYP. Schools provided examples of how they support pupils to identify risk and keep themselves safe. *PHSE lessons, resilience teaching, assembles, letters, pastoral teaching, NSPCC speak out and keep safe, PANTS campaign, circle time, WRAP sessions, learning mentor support, Peer mediators, school council, online safety sessions, anti-bullying sessions, stranger danger, self-esteem groups, helpline numbers and talks from local PCSO.*			
Allegations against staff	Schools	PVI	CM
Comment: Newham schools reported that they had 98 allegations against staff across 45 schools and sought advice from the LADO on 88 allegations. PVI settings reported 28 allegations against 19 settings while child minders reported no LADO referrals. However, data obtained from the LADO identified that 8 referrals were made.			
Positive Handling Incidents involving children	Schools	PVI	CM
Comment: EYP reported 23 incidents of positive handling across all providers but not details were provided of the circumstances. In comparison, schools reported that positive handling had been required on 1,679 occasions across 42 settings and identified that this approach was required for the following reasons: to prevent a child from hurting themselves and others; trying to leave the school site; kicking, spitting, slapping and hitting members of staff; fighting in the playground; child with complex needs and challenging behaviour			
	Schools	PVI	CM
Child protection records are scored securely **Early Help records are stored securely**	100% 100%	60% 63%	72% 25%
Comment: Many schools reported using Safeguard software to support their written case work notes, alongside the Early Help record and plan. It is believed that the low response rate from EYP relates to the use of the Early Help record being at an early stage. 60% of PVIs and 41% of CMs said that they securely transfer CP records to a new setting. Most CMs do this in person rather than electronically.80% of PVIs and 38% of CMs keep copies of original files.			
Settings have a record of requests made to CYPS Triage for support or protection	Schools	PVI	CM
Comment: All settings provided information on the referrals they had made to Triage and details of the			

support being provided to children e.g. EH, Families First and Statutory plans. The number of referrals from EYP to Triage was low 34 from PVI and 20 from CM while schools reported making 689 requests.

Schools reported that 798 children were identified in need of early help support across 74 schools. 230 Early Help records (EHR) and plans were used for a single agency approach to address needs across 53 schools. 107 HER were use to share information with other agencies across 43 schools. 94 HER and plans were in place where another agency were the lead agency. 63 families consented to a transition from a statutory plan to school being the lead agency in an EH Family plan while 71 families consented to transition from Families First to EHFP.

In contrast, EHP had completed just 7 EHR. It was also noted that very few PVIs had a designated person for Looked After Children.

There is management oversight to support staff in carrying out their early help and safeguarding responsibilities	Schools	PVI 98%	CM 33%

Comment: EYP identified supervision meetings, annual appraisal, staff meetings and spot checking of knowledge as activities linked to management oversight. Schools identified the following mechanisms:

"Supervision meetings are held with the Head teacher or pastoral lead"
"The DSL has undertaken supervision studies training with Christ Church University Canterbury"
"Fortnightly case management meetings with line manager for Safeguarding Team members"
"External consultant used"
"DSL and SLT Team work together to ensure that staff understand their responsibilities within safeguarding and early help"
"Annual whole school safeguarding training takes place in September. All staff have regular reminders of new guidance and statutory requirements"
"School Home Support worker meets weekly with the DSL to discuss caseload, review progress and identify any students that may require more intensive support"
"School staff receive termly supervision; our family support worker receives monthly supervision and our outreach workers receive half-termly supervision"
"No official supervision however we meet weekly as a safeguarding team and discuss cases amongst the team"
Schools were also asked to confirm the number of occasions the Head teacher or DSL met with the Safeguarding Link Governor throughout the year. Most schools had met over and above the minimum of 3 occasions. There were 27 schools that reported below 3 which were followed up by the SLE.

3.5 Child Death Overview Panel (CDOP) 2017/18

The CDOP current operates as a statutory formal sub-committee of the Newham LSCB. This will change in 2019 when the CDOP will become the joint responsibility of the local authority and Department of Health and initial plans are already in place for this transition.

The Newham CDOP is effective and met all the standards for the review of child deaths in Working Together 2015. Newham CDOP was the first in London to implement the E-CDOP and this has improved the quality of information and increased efficiencies. 77% of deaths were reviewed within 0-6 months compared to 32% England average.

There were 38 child deaths in Newham and 30 were reviewed by the CDOP. The outstanding reviews were as a result of serious case reviews, homicide investigations or inquests and will be reviewed by CDOP once these processes are concluded. 10 of the deaths were unexpected and 7 of the reviews identified modifiable factors. This is in line with the England average and higher last year (15.6%) which indicates that the Newham CDOP is now more effective in its scrutiny role. There were no modifiable factors in the expected deaths. Neo-

natal deaths accounted for just over a quarter of all deaths which is slightly lower than the England average of one-third.

Neo-natal themed CDOPs have been established this year to improve the scrutiny of neo-natal deaths in line with "Safe Maternity", Department of Health and to ensure that any modifiable factors relating to maternity care are identified.

The CDOP annual report 2017/18 has been presented to the LSCB Executive Board but is not for Publication to the General Public due to small numbers and risk of data protection breech.

Emerging Trends

A priority that has been raised across London and in Newham is the care of children and young people with asthma, deaths due to suicide and infant deaths due to SIDS or SUDI where they might have been preventable. Newham has responded to this.

This year has seen an increase in deaths reported from violent crimes and suicides across East London including Newham. Newham in collaboration with other London Boroughs is responding to this.

Recommendations for the Prevention and Reduction of Child Deaths

1. A greater emphasis is placed on educating parents about the risks of SIDS and SUDI as well as recognising the signs of deterioration in a child with sepsis.
2. CDOP continue to ensure that deaths due to group A streptococcus infection are notified to Public Health
3. Interpreters are always used when giving important relevant safe sleep and child health information to parents and family members to ensure that health information is fully understood
4. Health Visitors and Community staff are reminded of the importance of communication with other professionals when following up children's health and in particular test results after admission to hospital
5. Asthma care remains a priority for all Child Health professionals in Newham to ensure that deaths due to asthma in children are reduced
6. Safeguarding Partners to work together to ensure that a robust suicide strategy is in place on Newham including risks of self harm in school safeguarding procedures.
7. Prevention strategies on youth violence and deaths from trauma are addressed in Newham
8. Ongoing training and awareness of learning from child deaths and serious case reviews.

The CDOP Co-ordinator is a member of the Joint Health Safeguarding Sub-group and delivers awareness training to partnership staff, attended by 53 partnership staff in the last 12 months.

CDOP have worked in partnership with Learning Disabilities Mortality Review Programme (LeDeR) in ensuring that the deaths of children with disabilities are reviewed and registered on LeDeR database led by University of Bristol.

Newham CDOP has contributed to a small study led by Warwick University on Sudden and Unexpected Deaths in Infancy, Sudden Infant Death Syndrome (SUDI and SIDS) and how this is classified by CDOPs. The results are expected to be published late 2018.

Newham CDOP has also contributed to a review of CDOP information that is available from the Lullaby Trust.

3.6 Private Fostering 2017/18

While Newham's performance is low in comparison to national figures it is comparable with other London local authorities. It is positive to note that the number of private fostering cases held by the local authority has increased this year to 14 in April 2018, from 6 in April 2017. The number of confirmed new private fostering arrangements has also increased in the same period from 4 to 13. The number of cases closed remains around the same, with 4 this year compared to 5 in 2016/17.

The Private Fostering team have provided awareness raising training to partnership staff and key safeguarding mechanisms such as the National Referral Mechanism for Trafficking now form part of the Private Fostering scrutiny and assessment process. The team report that there has been an increase in the number of telephone enquires for advice and information from Children's Social Care and Education and each of these receive initial scrutiny and oversight by the Private Fostering Lead Social Worker and Supervisor.

Cases are regularly audited to ensure that they are compliant with statutory guidance and address permanent planning for individual children. The cases that have been audited have identified the need to improve the assessment and timely grip of cases. Not all cases have been scrutinised from the point of referral and relevant information obtained about family relationships and Home Office checks. To address this, a Private Fostering Social Worker now attends all initial visits to cases in assessment, following a PF notification and confirmation of a PF arrangement. Before closing a case, the Assessment social worker is now required to discuss the case with the Private Fostering team.

3.7 Local Authority Designated Officer

The LADO threshold is well established, and understood in Newham, with wide ranging use of LADO procedures across agencies. The LADO is proactive and effective in training the whole partnership, and has made significant progress in improving awareness.

"Management of allegations of abuse and poor practice against staff who work with children in effective and characterised by robust and timely decision-making". Ofsted Focussed Visit, Feb 18.

There were 321 LADO enquiries this year and the slight decrease from last year, can be explained by the implementation of new guidance on 'concerns' and 'allegations' that was implemented in October 2017.

Period	LB Newham LADO Enquiries
2017/2018	321

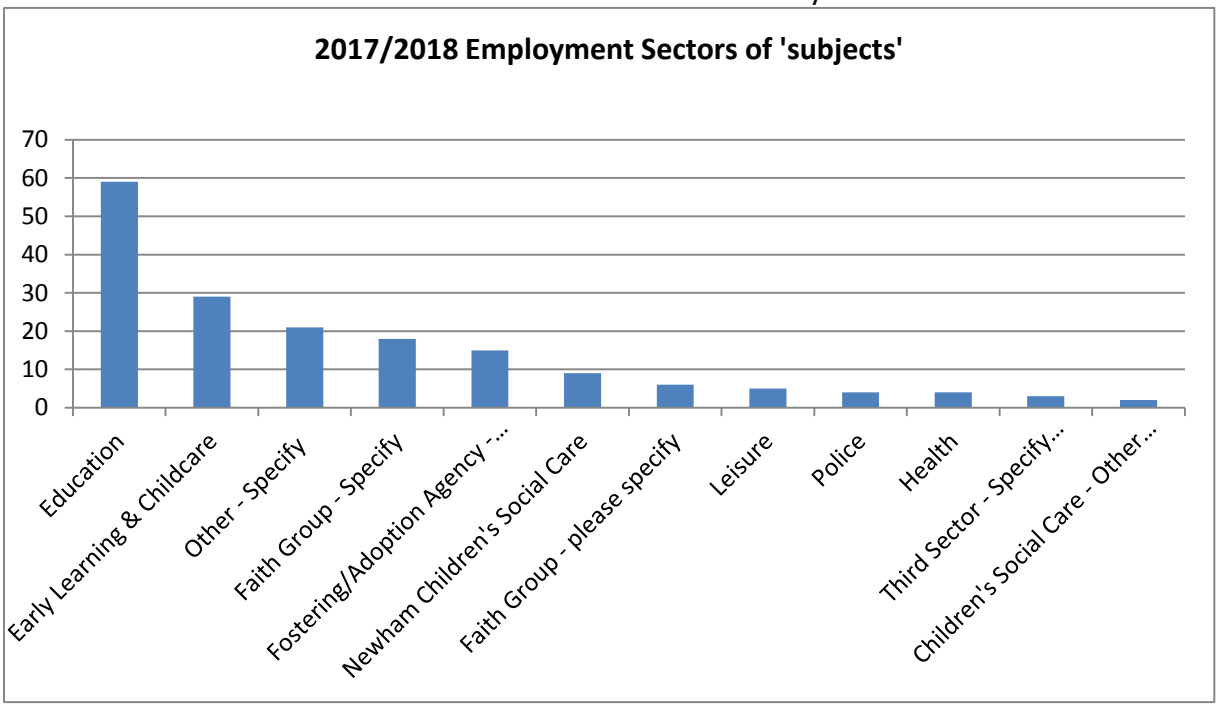
2016/2017	354
2015/2016	211
2014/2015	176
2013/2014	147

The majority of dealt with in a timely way but there were 18 cases that took 60-120 days to resolve due to on-going police investigations.

As was the case last year, the majority of the referrals were for physical abuse 65%. Sexual abuse allegations accounted for 25 % of referral which was an increase of 16% on the previous year. The LADO has overseen a number of complex/organised abuse cases which may be a contributing factor. Emotional abuse accounted for 6% of referrals and neglect for 7%.

Subjects of referrals by Sector

The following table shows the employing agencies of the individuals who were the subjects of allegations in this period. The education sector (schools and colleges) represents the overwhelming majority of subjects of allegations, with the remaining subjects spread across a very broad range of agencies, including Social Care, Health, Fostering agencies, Early Years and the voluntary sector.

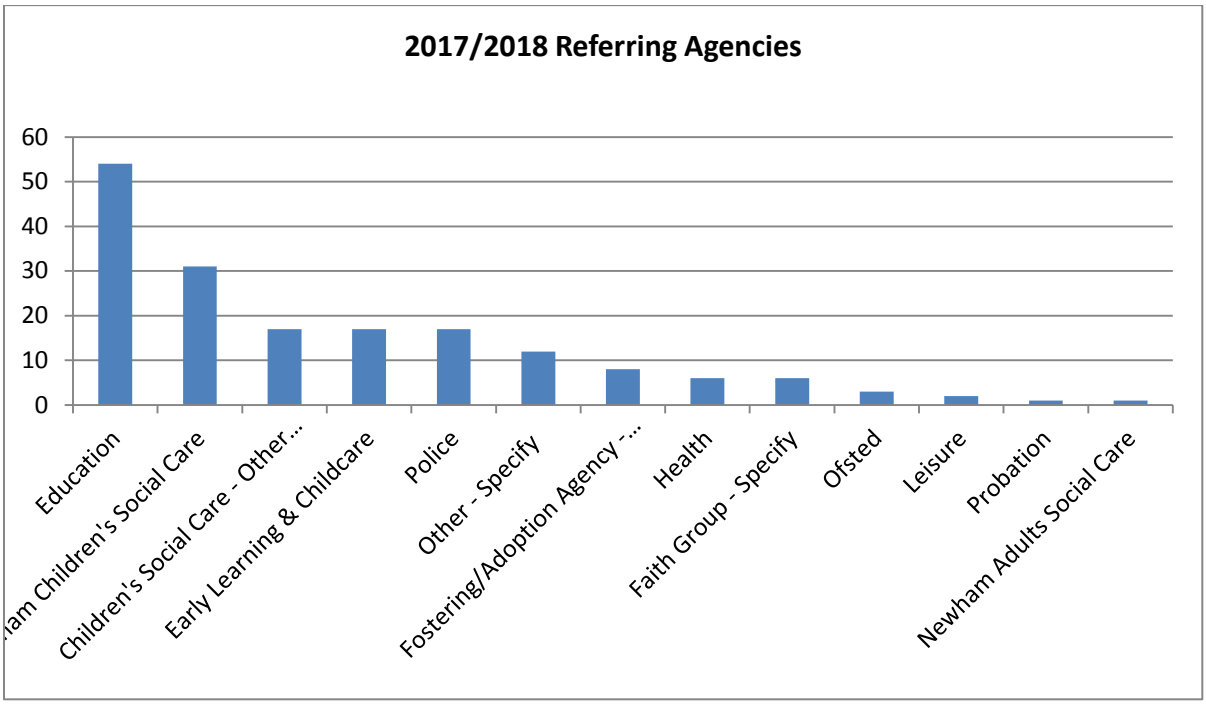


This data enables the forward planning of outreach and training.

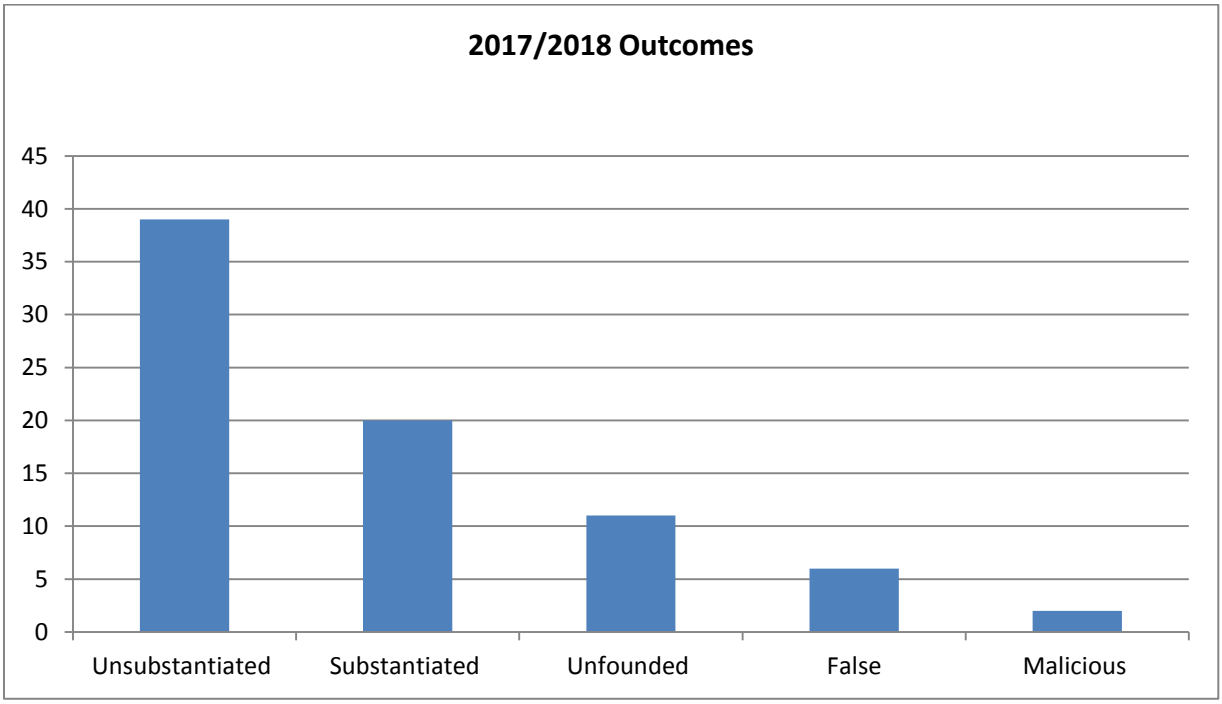
Referring Sectors

It is important to look at the sectors that make referrals to the LADO, this enables the LADO to identify on the one hand where gaps exist and where there may be limited awareness/knowledge about the role of the LADO, it also enables the LADO to consider how well organisations are educating and supporting their workforce about safer professional

practice. A positive development is that referrals from the faith sector are improving year on year following outreach.



The figure below outlines the outcomes of cases that have met LADO threshold that have been concluded during this period. There are a remaining 20 cases from this period pending an outcome.



Outreach activity

Education

All identified non-referring School settings (including maintained, independent and faith Schools) have now been contacted and personally visited by LADO to explore referral rates and general engagement. There has been very positive feedback and subsequent engagement in the majority of these settings both in terms of consultation and attendance at LSCB and DSL (Designated Safeguarding Lead) training. Monitoring will now be implemented on an annual basis to ensure that the Local Authority continues to push to prevent isolation of settings and to support them to meet their statutory requirements and Regulatory expectation.

Through joint working with Early Help, LADO training continues to be embedded within the monthly Designated Safeguarding Lead training rotating around schools in the borough. These have been very popular with 200 DSLs having been trained in LADO Process in the past year. Qualitative feedback forms from the sessions have frequently noted the LADO training as a highlight from participants.

There has also been positive liaison with schools that have been subject to Ofsted inspection. Where safeguarding concerns have been raised, Ofsted inspectors have made direct contact with the LADO and supportive visits have been completed as an immediate response to assist schools with integrating with the LSCB and training on offer. This immediacy of response has been met with appreciation from those schools affected.

Police

Good partnership working continues between LADO and the Police. The facilitated training over the past year (also covering this period) to all Police departments and PCSOs has seen a better understanding of LADO process and increased liaison and consultation. This is supported by a consistency of expectation from senior officers within the Police force covering Newham.

There have been a number of high profile cases where positive working has been cited by SLT and employers on both sides.

Faith Sector

Continued outreach to the faith sector is ongoing. The data above outlines the improvement in engagement with referrals being made to LADO on 6 occasions. Previous years saw one referral in 2016/2017 and none prior to this period.

Health

Health continues to be a statistically low referral sector and this is mirrored both regionally and nationally. Discussion has taken place with the Designated Doctor for Safeguarding Children at NHS Newham CCG around this issue to seek support in this area.

Regionally, the LADO group has invited representatives from NHS England who attended the group in May. The issue of referrals to LADO has been a longstanding one.
It is understood that a review of this process and LADO engagement generally by NHS England staff is being considered by their Head of Quality and Safeguarding in the coming months.

Early Years

Training has been provided across the sector, both via the NSCB training portfolio and more directly when concerns arise. Newham LADO has completed presentations at local Early Education Practitioner's networks over the year to childminders in the area. Feedback has been received to indicate the positive benefit to childminders.

Unregulated Provision

There has been an increase in concerns/allegations raised in unregulated provision. As a result of this, the LADO has been raising awareness amongst Safeguarding Colleagues and these sectors to identify ways of how to combat some of these issues.

There are also plans to support the faith sector with managing concerns around 'rogue' private tutors via their own internal mechanisms. It is hoped that the forthcoming year will outline and implement more solutions to these complex issues faced on a national level.

A further consultation from DfE with a view to regulation. This would support access and improvements to safeguarding practice which are currently difficult to address from a LADO perspective.

LADO Training

Joined up working with the NSCB saw 3 bespoke LADO training sessions throughout the course of the previous year in addition to the 'Creating Safer Organisations' training which is bi-annually. Demand for bespoke training around the completion of LADO internal investigations and reactionary risk assessment relating to staff at the time an allegation has been made has been high and received well. This training is unique to Newham with both regional and national interest into the course material and outcomes.

For the 2018/2019 period, 2 additional courses have been requested to meet demand.

This combined with the DSL Training and bespoke sector training provides a comprehensive package across the local authority to support organisations providing services to children in the area.

4. LSCB TRAINING 2017/18

A comprehensive multi-agency training offer was made available to the Partnership, focussing on LSCB priorities. The training programme is developed on the basis of a training needs analysis which draws from LSCB priorities as well as learning from reviews, audits, and national guidance.

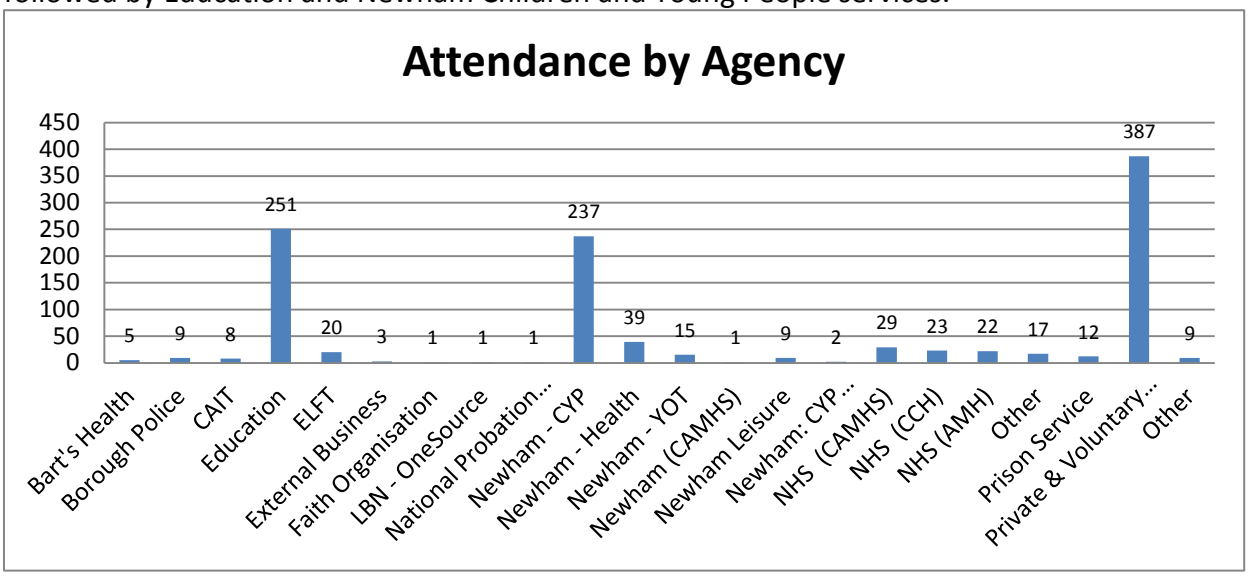
In 17/18 the programme covered 32 courses and a total of 116 sessions with the capacity to reach just under 3,000 delegates. While applications have increased on last year, 25% of delegates did not attend their booked session. Course capacity has now been increased from 20 to 25 places to ensure that spaces are not wasted.

Course Name	Sessions offered in 17-18
Child Health and Safety: CDOP, Safety and Public Health	2
Child Sexual Exploitation and Missing	6
Child Trafficking and Modern Day Slavery	3
Children and Young People who Display Sexually Harmful Behaviour	2
Children Missing from Education	1
Children's Rights and Meaningful Practice	1
Core Groups and Case Conferences	4
CP Refresher training	9
Creating a Safer Organisation	2
Domestic Abuse and Young People	2
Domestic Abuse: Intervention and Ways of Working	4
Early Help Framework and Team Around the Family (Commissioned by EH)	6
Effective Engagement with Families	3
Female Genital Mutilation	6
Harmful Practices and Protecting Children and Young People	2
Impact of Parental Mental Health on Children and Young People	2
Impact of Parental Substance Misuse on Children and Young People	2
Introduction into Child Sexual Abuse	3
Introduction into Safeguarding	8
LADO	3
Learning from Serious Case Reviews (and Learning Reviews)	2
Multi-Agency Safeguarding Leads	4
Neglect and Assessing the Quality of Parental Care	2
Private Fostering	3
Protecting Children from Harm	7
Protecting Disabled Children	3
Recognising and Responding to Domestic Abuse	4
Supporting the Needs of Young Carers	2
Triage and Early Help	4
Understanding Gangs and Youth Violence	4
Understanding the Impact of Children Exposed to Extremism	4
WRAP Workshops	4
Young People and Self-Harm	6
Total	**116**

The LSCB self-booking service website is now fully operating and this has led to improved administrative efficiency. All training data is now available to be downloaded directly from the website which reduces the margin of errors in the data reported. Further development to the website is required to accommodate data collection, as well as to enhance the use of the automated communication for sharing training information

Attendance by Agency April 17- Feb 18

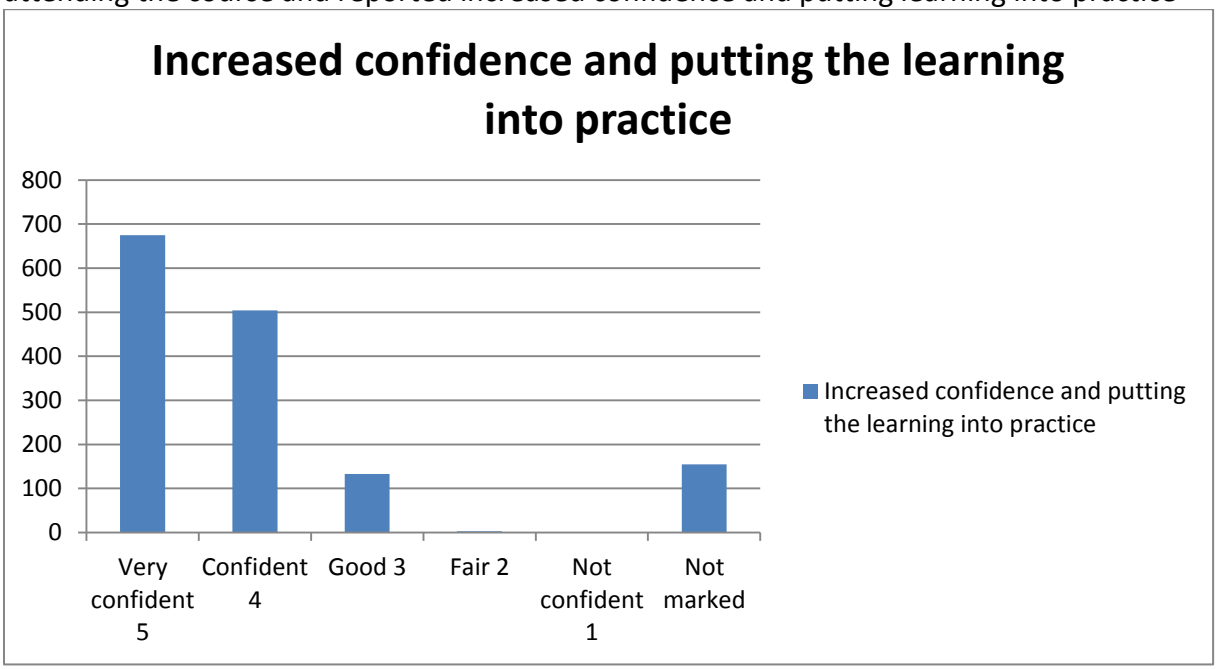
Staff from the Private, Voluntary and Independent sector is the largest group of attenders followed by Education and Newham Children and Young People services.



Quality Assurance and Evaluation

Arrangements are in place to ensure that each training course is of good quality and delivered in accordance with the specification e.g. learning outcomes, assessment methods, legislation and guidance.

Feedback was received from 59% of participants who highlighted that there is very good delivery of the course objectives - participants reported improved learning in the areas of safeguarding and referrals, substance misuse, domestic violence and assessments and the legal framework. Most evaluations recorded very good or good in terms of meeting the learning outcomes and none were graded as fair or poor. In terms of meeting learning outcomes, **90%** of participants stated their learning of the subject had increased after attending the course and reported increased confidence and putting learning into practice



Delegates were asked how useful the training is in their work.

- *"It has helped me to identify risks and the different levels of need and which services I could refer to. I am also aware of the process involved when deciding the level of need."*
- *"As a new staff I attended the safeguarding level 1-3 and this has helped me greatly I was able to identify what I need to look out for when assessing the children."*
- *"It will support me in analysing risks and I have gained productive knowledge for when working with families with substance misuse. By using this I will be able to allocate what support and intervention is needed."*
- *"I have learned the importance of going deeper in my interview skills."*
- *"Assessing sexually abused young mothers and drawing up a risk management plan for them."*
- *"I feel much more able to carry out a comprehensive assessment and risk assessment."*
- *"Improve practice and identify indicators for DV issues. Improved awareness."*
- *"Being more confident in challenging when we feel something else / more needs to be done."*
- *"It will support my practice, knowledge and skills when attending reviews and conferences and to be practical about what I bring."*
- *"Very simply as a foster carer it is useful to know how to put parental controls on mobiles and games."*
- *During my visits having the knowledge on how to ask questions and making good assessments..."*

Post course impact

A small number of delegates (28) responded to the survey and of these just over half said they had already been using the training in their day to day work and provided examples of how this.

I have a number of families I am currently supporting, who have domestic abuse situations at home and the information provided within the training has given me a greater confidence when support these families, as I have a greater understanding of the impact on all, also how to support them to move forward. *To consider the different areas and forms neglect can occurs* *In my day to day role , I have applied this training in my day to day role I was able to help a young women get moved into a refuge after finding out she was in a abusive relationship , Update my policy, reflect on my practice, use as staff training.* *I was able to work with a colleague to set up a school safeguarding account and also decide if one particular case would have met the criteria for a triage referral , Supporting staff to complete EHR* *Listen to the full stories of families, not making judgements. To find solution that helps all. Having Knowledge and tools how to protect young people and children from sexual harm, able to apply this in my practice of my placement and future career.*
What are you doing differently now as a result of this course?
I have more awareness, more vigilant of the dangers to disabled children, I attended the FGM 1/2 day course to increase my understanding in this area and the signs and the services involved. *I'm thinking outside of the box and assessing situations differently as I'm aware of the fact people minimise the abuse due to fear , keeping up with the latest legislation and guidance.* *I now have more knowledge around the area and how to respond and who to refer to.* *More open and mindful about how life is like for the SEN children that I assess.*

5. ASSESSMENT OF SAFEGUARDING IN NEWHAM

Based on the data, the serious case reviews and learning reviews last year, audits, parents and child feedback an assessment of safeguarding can be drawn. Key messages from this are as follows:

Areas of Strength

- Thresholds for referral remain appropriate and improvements noted last year in the MASH have been sustained
- Multi-agency contributions to child protection strategy meetings from Health and Education show an improvement at year end
- The improvements noted last year in the police response to children at risk of gangs, sexual exploitation and abuse needs have been sustained, and there is good intelligence gathering and use of intelligence to prevent exploitation.
- There is better recognition of the risk associated with self-harming behaviour and the number of such referrals leading to a CSC assessment has risen from 124 to 206
- There has been an increase in the number of referrals of young people to CSC and to the Chanel Panel – indicating better identification of young people at risk of extremism
- Joint working arrangements between CSC and Adult Mental Health services in ELFT and LBN have been strengthened
- The LADO arrangements in Newham remain well embedded and robust and there are some excellent examples of outreach work with local faith groups
- New ways of working with families (NewDAy and Operation Encompass) are creating better opportunities to prevent repeat domestic abuse in families; referrals to the MARAC have increased by 34%
- There schools section 11 audit and schools CSE audit evidences good understanding and engagement from schools section in early help, child protection and tackling child exploitation

Areas for Development:

- The absence of data on early help across the partnership make it difficult to assess the effectiveness of the current system
- While progress has been made, strategy group meetings are not yet consistently multiagency, and we do not have sufficient assurance of the quality of discussion and planning in these key meetings
- There is evidence that the lack of a clear lead professional is having an impact on children and families, and this has been raised as a contributing factor in a number of learning reviews
- We have not yet made sufficient progress in embedding the use of GCP2 in assessments, despite considerable investment by Childrens Social Care and LSCB and the relatively strong evidence base for this intervention as compared to many other programmes
- While we have made progress on protecting children at risk of criminal exploitation, the high level of youth violence, and in particular the high incidence of knife attacks,

including fatal incidents illustrates that there much more work is required to effectively protect Newham children

- Several audits and learning reviews have highlighted a failure to listen to the voice of children, young people and their families and this is not acceptable
- The section 11 audit process for commissioned services has highlighted unmet training needs and where organisational arrangements need strengthening; and in particular clear policy guidance about the use of volunteers in schools and other settings
- Partners are engaging in learning events associated with SCRs and audits, and often reflecting changes in process, but this is not always reaching practitioner level and some follow up audits identify the same practice weaknesses.
- Further information and an analysis of ethnicity and case progression from referral onwards is required to assure the LSCB that the safeguarding partnership is providing an effective and safe service to all children and families

A Health Perspective of Safeguarding Arrangements in Newham
(Extract from the Newham CCG Safeguarding Children and Looked After Children ANNUAL REPORT 2017/18).

Safeguarding practice has been strengthened through a number of approaches including:
• Mapping of non CCG commissioned health care providers registered with Care Quality Commission and shared findings with the LSCB to request Section 11 audits
• Writing to primary care providers with details on how to contact designated professionals and access multi-agency safeguarding training
• Sharing learning with contractual team in respect of delays and issues with children getting wheelchairs and contributed to the revised service specification
• Contributing to the procurement of the 111, urgent care treatment and Tower Hamlet's school nursing procurement
• Sought assurance around children not brought practice across the health care providers.
• Ensured the Looked After Children Decliner Pathway is consistent with best practice (Not Seen, Not Heard, Care Quality Commission, 2016)
• Supporting the setup of the North East London Child Sexual Assault Hub to provide an integrated response to children and young people presenting with sexual assault and additional emotional therapy
• Contributing to the revision of safeguarding policies across the partnership.
• Contributing to health care provider site assurance visits
• Refreshing the Looked After Children Service Specification to ensure it incorporates the 2017 NHS England guidance for Looked After Children
• Contributing to Working Together and Safeguarding Roles and Responsibilities Intercollegiate Consultations

6. LSCB GOVERNANCE

In anticipation of changes to Working Together in July 2018 and to take account of the revised arrangements for LSCBs set out in the Children and Social Work Act 2017, the LSCB Executive Board agreed a revised set of governance arrangements in September 2017 which

received royal assent in April 2017. A final set of safeguarding arrangements will be published in early 2019.

Executive Board

Executive Board will lead the scrutiny work of the LSCB. The membership of Executive Board will be streamlined to enable deeper engagement with the adequacy of safeguarding arrangements across Newham.

This represents a significant reduction in membership, which in no way reflects on the calibre of input to date by Executive Board members. Rather, it is a recognition that working in a smaller group will encourage greater ownership and challenge, both of which are critical to good scrutiny.

Executive Board membership:

- Director for Bart's Health Trust (Newham)
- Director of People for Newham
- Director of Operations for CSC and Safeguarding (LBN)
- Director for Newham CCG
- Director Newham Mental Health (ELFT)
- NASH and NAPH Head Teacher leads
- Newham Police Borough Commander
  Newham Acting Detective Super Intendant

And to be compliant with Working Together 2015

- Head of Youth Offending Team
- CAFCASS
- Two lay members representing the local community *
- National Probation Service
- Community Rehabilitation Companies
- Local Further Education Institution – Newham College
- Lead Member for Children's Services

Standing items for Executive Board

The Executive Board will scrutinise, amend and where appropriate sign off the following:

- Serious Cases Reviews, Learning Reviews and improvement plans
- Multi-agency audits and improvement plans
- Single agency safeguarding audits on a rolling basis
- Section 11 reports

The Board will also discuss any significant organisation issues with an impact on safeguarding practice and delivery, whether referred to it by the Business Management Group or any of the partner agencies.

In addition, the Executive Board will have oversight of:

- LSCB Performance Report
- LSCB Budget
- LSCB Business Plan
- LSCB Annual Report
- Child Death Overview Panel Annual Reports
- Local Authority Designated Officer Annual Reports
- Private Fostering Annual Reports
- Serious Case Review recommendations and Action plans
- Child Sexual Exploitation and Missing Children Strategy and Action plans

Frequency
Quarterly for 2.5 hours

Business Management Group

BMG will lead on practice improvement and innovation, taking reports from each of the subgroups and escalating matters to Executive Board as required.

BMG will have the following governance structure for 2017/18.

i) Standing sub-groups
- Child Death Overview Panel
- CSE, Missing and Trafficking*
- Joint Health Safeguarding Group
- Performance and Quality Assurance
- Serious Case Reviews
- Community Engagement (with Adults Board)
- Extremism*

*We will keep under review whether CSE, Missing and Trafficking and Extremism are best run as standing subgroups rather than a task and finish group.

ii) Task and Finish groups

- Adults and Children
  This will be constituted in partnership with the Adult Safeguarding Board. The proposed co-chairs will be the Borough Director for ELFT and Head of Child Protection, LBN. The focus of the group will be to deliver the roll-out and then audit the impact of the protocol for joint working with families affected by parental mental ill health.
- Child Sexual Abuse (new) CSC QA Manager and Police to jointly chair
- Multi-agency Inspection Group (new) chaired by Head of SW Improvement

The distinction between a standing subgroup and a task and finish group is that the former is required to deliver against the ongoing statutory functions of the LSCB, and the latter are set up to deliver practice improvements identified as part of the work of the LSCB, with the

expectation that they close down once improvements are embedded in business as usual practices.

Engagement
Three strands of engagement work will report directly into LSCB BMG

- Community Engagement (jointly with the Adults Board)
- Training and Development – with oversight by PQA sub-group
- Children and Young People's engagement – led by the Group Manager for the Youth Service

BMG Membership:

- Chairs and Leads for all the above
- Safeguarding Leads for Bart's (Maternity and Children)' CCG; ELFT; GP's; School Nursing and Health Visiting; CSC Practice Manager for Hospital Liaison; Police; CSC Quality Assurance
- LBN Senior Officer for School Improvement
- Principal Child and Family Social Worker
- Director of Public Health
- Group Managers for YOS and Youth Services
- Police Partnership Board
- NewDay Programme Board
- Neglect Strategy.

Standing items for BMG

- Development and delivery of the business plan (including reports from all sub-groups and task and finish groups)
- Scrutiny of training plan and delivery
- Scrutiny of LSCB performance report for Exec Board
- Sign off for LSCB protocols/procedures
- Practice sharing

SCRs, Learning Reviews and Audits will be circulated to BMG members for information in order to enable comment prior to scrutiny at Executive Board.

Frequency
Quarterly for 2.5 hours

3. LSCB Performance report
Will be streamlined and contain:

- Core safeguarding data collected by CSC
- Police data on domestic abuse, use of police protection, offences against children
- Data collected by the Newham CCG, ELFT, Bart's Health Trust and the YOS linked to the LSCB priorities
- Other data directly linked to LSCB priorities, including programme delivery updates.

The narrative summary will focus on child and young person *outcomes, with themes arising from these core areas. Wider data will be appended for information

Attendance at the LSCB Executive Board 2017/18

Agency	No of seats at Board	% attended
Independent Chair	1	100
Children & YP Services	2	100
LSCB Team	2	100
Secondary Schools	1	75
Primary Schools	1	75
Police - Child Abuse Investigation Team (CAIT)	1	75
Police – Borough	1	100
Newham CCG	1	100
Barts Health NHS Trust	2	100
East London Foundation Trust (ELFT)	2	100
Community Rehabilitation Company	1	0
National Probation Service	1	100
Adult Services	1	25
YOT	1	75
Housing	1	0
Children and Family Court Advisory and Support Service (CAFCASS)	1	75
Lay Member/PVI sector - resigned	1	25
Lead Member for Children	1	50

LSCB Team

The LSCB was supported by a team consisting of:

- Board Manager (full time)
- Business Support Officer (full time)
- Learning and Development Officer (18 hours)
- Partnership and Development Manager (18 hours).

In May 2017, the CSE Co-ordinator post moved from the LSCB to the CSC Triage Service in order to strengthen operational service delivery and the salary for this post became the responsibility of LBN.

LSCB Budget for 2017/18

Partner Agency Contributions	2017/18
Newham CCG	£150,000
LBN CYPS	£139,000
LBN Housing	£11,000
London Fire Brigade	£500
Police	£5,000
CAFCASS	£550
National Probation Service	£1000
Community Rehabilitation Company	£1000
Total	**£308,050**
Carry forward underspend from previous yr	£40,730

Budget Expenditure	2017/18 budget	Budget out-turn	Comment
Salaries for LSCB staff & Independent Chair	195,00	192,028	
Redundancy costs (BS review)	0.00	16,813	one-off cost
Training and memberships	38,000	34,474	
Premises hire, catering	10,000	11,497	
Printing, stationary, publicity	3,000	2,798	
Fees for professional services, consultancy, serious case reviews	32,000	37,214	SCR costs accounted for £23,975
ICT software	8,500	18,508	Website fees for 16/17 & 17/18 and cost of ECDOP at 5,700
Total expenditure	**337,239**	**313,332**	

7. LSCB PRIORITIES FOR 2018/19

The new priorities are based on the findings of completed and on-going serious case reviews and audits, data on Newham's current risk profile and feedback from across the wider partnership at a development day in May 2018. These priorities will be reflected in the LSCB's plans for training, section 11, quality assurance and the data set report. The Board's new priorities for practice development in 2018/19 are:

1. Criminal Exploitation of Children and Young People
2. Supporting and Safeguarding Children Affected by Parental Mental Health
3. Child Neglect

In addition to the above, the LSCB will closely scrutinise the areas for practice improvement identified in its recent serious case reviews:

4. Suicide and Self-harm
5. Child Sexual Abuse