Local Safeguarding Children Board

Annual Report 2012-13

On behalf of Hammersmith and Fulham, Royal Borough of Kensington and Chelsea and Westminster City Council

Local Safeguarding Children Board Annual Report 2012-13

Contents

Essential Information

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1. Foreword

This is the first report of the Local Safeguarding Children Board covering the three boroughs of Hammersmith and Fulham, Kensington and Chelsea and Westminster. This report is produced for a wide readership of the public, children and families, staff in statutory, voluntary and independent agencies, members of Councils, governing bodies and Boards, as well as regulators, central government departments and others. It is an account of the work of the Board in its first year; the three boroughs previously having had three separate Boards. The report contains some data and more technical information but also tries to describe what we have done together – and still have to do – in a way that is accessible for its wider readership.

The approach taken is thematic and descriptive, with analysis of areas of achievement and comments on progress that is still to be made. The report sets some local context but limits this, as other reports (eg Joint Strategic Needs Assessments) give greater detail. It covers the provision of policies, procedures and guidance for the multi-agency arrangements to protect children and to promote their welfare, the training offered and the quality and effectiveness of arrangements and practice. The report describes our approach to Section 11 audit, the work of the Child Death Overview Panel (CDOP), Serious Case and Management Reviews, and the engagement and participation of children, along with issues of diversity and equality.

The LSCB meets quarterly but a number of sub-groups, which report to it, meet more regularly. There are Partnership groups for each of the three boroughs. The Board also commissioned short-life working groups on gangs and sexual

exploitation and on faith and culture. Getting the arrangements right for quality assurance developed significantly later in the year.

A strong and effective LSCB should be reviewing its own contribution and challenge about its own effectiveness. As a very large Board this had been a thread throughout our work together and we are conscious of the improvements that can always be made to both analysis and challenge – and we have sufficient seniority on the Board to step up on this too. The opportunity has been taken to use the advantages of the merging of the management of the three boroughs' children's services and to benchmark what works in protecting children and promoting their welfare. Early Help is an example here. There has been learning from this during the year.

Other learning from the work together is set out in the report.

Working Together 2013, published as our first year ended, and the new inspection arrangements for children in need of help and protection, will be underpinning our work going forward.

The LSCB is served by a small team in Children's Services with a contribution from Health into the CDOP. During a year of such change within both Health and the local authorities, the support to the Board has been managed with stretched resources. I want to thank those staff who, have worked extremely hard to get the right arrangements in place. The greatest thanks go though to staff in the full range of agencies who work together to protect children and to promote their welfare. Their tireless work on behalf of children underpins everything that we achieve.

Jean Daintith

Independent Chair

2. Introduction

2.1 Working Together 2013 requires each LSCB to publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area. This report aims to provide a rigorous assessment of the performance of local safeguarding services and to show how any areas of weakness will be addressed. It will be submitted to the Chief Executive, Leaders of the three Councils, the local Police and Crime Commissioner and the Chairs of the three Health and Wellbeing Boards.

2.2 In order to establish the effectiveness of local safeguarding arrangements and of the LSCB itself, the report will evaluate standing work of the Board such as training, case reviews and safeguarding of priority groups. It will also measure progress against the LSCB priorities for 2012-13: early help and prevention of harm; better outcomes for children subject to child protection plans and those looked after; practice areas to compare, contrast and improve together; continuous improvement in a changing landscape. The details of these priorities are set out in Appendix 1.

2.3 LSCB Annual Report 2012/13 Executive Summary

The 2012/13 Annual Report of the LSCB for Hammersmith and Fulham, Kensington and Chelsea and Westminster is the first such report for the Board which was established in April 2012. The report aims to provide a rigorous assessment of the performance of local safeguarding services and of the effectiveness of the LSCB itself.

The report details a number of achievements and strengths of the local arrangements including:

- Compliance with LSCB statutory responsibilities
- Maintenance of effective and good safeguarding partnerships through inaugural year and an effective governance structure to co-ordinate the work of statutory partners
- Strengthening links to local communities through the appointment of lay members and creation of posts for better engagement with community groups, children and young people
- A developing quality assurance framework to support the Board's scrutiny role and identification of and advice on areas for improvement
- Successful delivery of a multi-agency safeguarding Leaning and Development programme aligned to the Board's priorities, regularly monitored with new courses commissioned in response to need
- Establishment of case review subgroup to proactively consider and disseminate lessons learnt both locally and nationally in order to improve practice
- Improved visibility of outcomes for those children and young people who are looked after across the three boroughs, including those looked after because they are remanded
- Establishing a direction of travel to improve safeguarding of children and young people across cultures and faiths and agreed resources to lead the required inter-agency improvements
- The use of compare and contrast activity to learn from local best practice relating to young people involved in serious youth violence and gang related sexual exploitation

The annual report also identifies areas for attention and further development by the constituent agencies of the LSCB. These include:

- Improved engagement and representation of schools in the work of the Board
- Strengthening the role of a rapidly changing Metropolitan Police Service in operational and strategic safeguarding activity
- Improved sharing of quality assurance material particularly by the Police, Probation and Housing services, the more systematic use of inspection findings across agencies and strengthened scrutiny and challenge by the Board
- A need to develop accessible resources and communication channels via a single LSCB website
- Influencing commissioning and priority setting across other strategic partnerships
- The need to extend the capacity of the LSCB support team within the local authorities
- Ensuring all lessons learnt reach front line practitioners within a wider Learning and Development Framework
- Wider dissemination of the multi-agency learning and development programme across more sectors and development of evaluation to ensure that activity is making an impact on children and young people becoming safer
- Improved engagement with children and young people
- Extending the LSCB's oversight of how effectively agencies engage with diverse communities
- Increasing the LSCB's understanding of the effectiveness of early help services
- Specific strengthening of local responses to children who go missing from home and care

The first annual report provides an important opportunity to reflect across agencies the difference being made to the safety of children and young people in Hammersmith and Fulham, Kensington and Chelsea and Westminster.

3. Local background and context

3.1 The boroughs of Kensington and Chelsea (RBKC), Hammersmith and Fulham (LBHF) and Westminster (WCC) created a tri-borough children's service in 2012 under one Director of Children's Services. This led to the formation of a single LSCB. This report therefore looks at safeguarding services across the tri-borough area.

3.2 Keeping children safe and ensuring that they are not at risk of harm is one of the strategic priorities of the tri-borough Children's Services business plan. The strategic priorities of each of the Children's Trust Boards also include safeguarding as a key priority area, thereby ensuring that safeguarding is high on the agenda of all partners.

3.3 The three areas are located in the centre of London where there is a diverse population with extremes of poverty and wealth. Recent inspections of safeguarding and look after children services have been either good or outstanding. Below are key characteristics of the area:

- Between the 2001 and the 2011 Census the population of Hammersmith & Fulham and Westminster has risen. The population of Kensington and Chelsea has declined. The population is LBHF: 182,500 (+10%), RBKC: 158,600 (-0.2%), WCC: 219,400 (+21%).
- Kensington & Chelsea is the country's second most densely populated area (Islington is the most densely populated) Hammersmith & Fulham is sixth and Westminster is seventh.
- The population turnover (churn) is high in all three boroughs: Westminster is the highest in London, Hammersmith and Fulham is the fourth and Kensington and Chelsea is the sixth.
- In Hammersmith & Fulham 20% of the population are aged 0 to 19 years, 19% in Kensington and Chelsea and Westminster.
- An estimated 86,600 children under 16 in the tri-borough: LBHF (+9%), RBKC (-2%), WCC (+33%).
- 23% of all households in LBHF contain dependent children; 19.5% in RBKC and 19% in WCC.
- 15,000 (46%) children in LBHF are from Black and Minority Ethnic (BAME) group; 10,300 (38%) in RBKC and 20,500 (57%) in WCC.
- WCC has seen a 73% increase in the non-Christian under 16s population; 41% in LBHF and 2% in RBKC.
- 17% of LBHF children have other (non-British) national identities; 28% in RBKC and 23% in WCC.
- Foreign-born children made up 14% of all children in LBHF; 21% in RBKC and 19% in WCC.
- All three boroughs have a higher percentage of lone parents not in employment than national (40.5%) and London (47.8%) rates with Westminster ranked second highest nationally (Tower Hamlets has the highest percentage).

3.4 The table below sets out the numbers of children on a Child Protection Plan and the rate per 10,000 for the 2012/13 year. During 2013/14 the LSCB and the

Quality Assurance (QA) sub-group will be examining further the trends and rates as well as auditing cases. Children in Need numbers in the final part of the table reflect the significant number of children being helped. The figures below are for reference for this Report. Each LSCB meeting receives more detailed reports and the QA subgroup interrogates the quality issues as well as undertaking quantitative analysis.

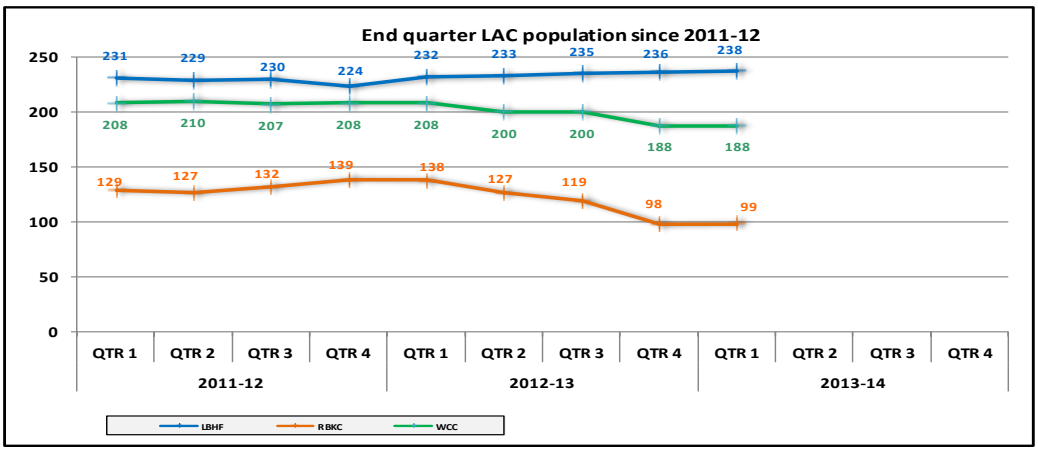
2012-2013	LBHF	RBKC	WCC
Number of Child Protection Plans started in year April 2012 to March 2013	165	100	108
Number of Child Protection Plans ended in year April 2012 to March 2013	159	106	110
Number open at 31st March 2013	142	73	94

Rate per 10,000	LBHF	RBKC	WCC
Number of Child Protection Plans started in year April 2012 to March 2013	46	34	26
Number of Child Protection Plans ended in year April 2012 to March 2013	44	36	27
Number open at 31st March 2013	39	25	23

Children 2012-2013	LBHF	RBKC	WCC
Number of episodes open at 31st March 2013	1555	998	1899

LAC numbers	2011-12				2012-13				2013-14			
	QTR 1	QTR 2	QTR 3	QTR 4	QTR 1	QTR 2	QTR 3	QTR 4	QTR 1	QTR 2	QTR 3	QTR 4
LBHF	231	229	230	224	232	233	235	236	238			
RBKC	129	127	132	139	138	127	119	98	99			
WCC	208	210	207	208	208	200	200	188	188			

LAC numbers (per 10k)	2011-12				2012-13				2013-14			
	QTR 1	QTR 2	QTR 3	QTR 4	QTR 1	QTR 2	QTR 3	QTR 4	QTR 1	QTR 2	QTR 3	QTR 4
England 2011-12	59	59	59	59	59	59	59	59	59	59	59	59
London 2011-12	56	56	56	56	56	56	56	56	56	56	56	56
LBHF	71	70	71	69	71	72	72	73	73			
RBKC	48	48	49	52	52	48	45	37	37			
WCC	58	58	58	58	58	56	56	53	52			



Governance and Accountability

4.1 The new tri-borough LSCB, serviced by a single team, commenced work in April 2012 with an agreed set of subgroups and activities. An Independent Chair was appointed and membership agreed, ensuring representation across agencies in the three boroughs. The purpose, function and membership of the tri-borough LSCB can be found in Appendix 2: Terms of Reference, to be read in conjunction with Appendix 3: Roles and Responsibilities Guidance:

4.2 Effective governance has been achieved as a result of meaningful representation from across the three boroughs. Members bring learning and information from other roles or subgroups to which they belong ensuring strategic direction is aligned for example:

- The Family Services Directors oversee safeguarding practice across the Local Authorities and lead on tri-borough service reviews (e.g. Early Help, Children in Need and Children Protection). They are also members of the three local Safeguarding Partnership Groups, who update the full Board on a quarterly basis and enable members to communicate any current, local areas of concern e.g. closer working with Adults' Safeguarding.
- The Director of Children's Services has close linkages with Cabinet Members and is a member of both the Children's Trust Boards and the Health and Wellbeing Boards.
- The Head of Combined Safeguarding, Review and Quality Assurance Service brings information directly from safeguarding and review teams and is a member of the Children's Services Senior Leadership Team.

- The Designated Nurse and Doctors are key members, as recommended in Working Together 2013.
- The Designated Nurse is the Chair of the Health Network where it is her role to advise providers as a commissioner (CCG) and take forward LSCB matters. Members of the Health Network are all directors and this encourages ownership of safeguarding issues at a senior level.
- LSCB members chair each of the LSCB sub-groups (Quality Assurance, Training and Development, Child Death Overview, Serious Case Review and Short Life Working Groups) to take forward specific LSCB programmes of work.
- Several member agencies attended two or three of the previous boards so the new arrangement has consolidated the position.

4.3 The composition of the Board is in line with statutory partners listed in Working Together 2013. At a local level NHS England is developing a proposal regarding how it can be represented on the Board; but is already liaising with the Independent Chair. Representation by Health at LSCB sub-groups may need to be reviewed in respect of seniority; ideally Health sub-group members should also be attendees of local safeguarding partnership groups in order to make useful links. One of the Directors of Family Services manages the Head of the Youth Offending Service (YOS) and therefore has oversight of this area and in addition, the Head of YOS attends the LSCB annually to present the YOS annual report as well as other relevant items.

4.4 2012/13 has been a year of transition for member agencies and the LSCB has succeeded in continuing partnerships across the various agencies and agreeing governance arrangements. It has been a challenge to maintain links with all parts of the education sector given the LA's shifting relationship with schools. It has not been possible to have continuity of representation across the three boroughs at both primary and secondary level and this is a challenge for the next year. However, the Director for Schools is a member of the Board and a new tri-borough Safeguarding in Schools and Education Officer has been appointed and will be a valuable resource to the board. There are plans to establish a Tri-borough Designated Teacher Network to share good practice and highlight emerging needs for further advice / guidance / training. A priority is to improve school representation across phases and sectors.

4.5 There have been a lot of changes at Borough level for the Police and this has contributed to a lack of consistent LSCB representation. One of the Borough Commanders now represents all three Borough Commands at Board level. It is hoped that the new model of policing will enable more connectivity

with the front line and links with Safer Neighbourhood Teams. The LSCB will be focusing on encouraging the strategic and operational value that the police can bring.

4.6 Feedback indicates that membership could be reviewed as we move into the second year as the group is large, meaning that the Board agenda remains at a high level. Members of the Board are keen to make a real difference to practice and to ensure the 'added value' from working together.

4.7 In response to the statutory requirements of Working Together 2013 the LSCB has recruited four lay members to the LSCB. They are local residents who have good links with the community .They have also been successful in many different walks of life. Each lay member has a 'buddy, a representative of the LSCB, and has received a supportive induction. The lay members attend the main board, the local partnership boards, as well as subgroups and short life practice improvement groups .It has been important for the different LSCB groups to be clear about how lay members can best be involved to ensure their time is well spent and that they contribute to making a difference.

The lay members have shown a strong commitment to supporting local safeguarding. It is anticipated that in the coming year their contribution will be reflected in a more effective LSCB that has stronger links with the community it serves.

4. Quality and Effectiveness

5.1 In addition to taking forward governance arrangements, the first year of the tri-borough LSCB has provided an opportunity to develop the Quality Assurance (QA) systems which were previously an area of weakness in the three individual LSCBs. The merging of three boroughs required a safeguarding stock-take with partners at the end of 2011 to provide a foundation for the identification and agreement of shared strategic safeguarding priorities for 2012/13, as set out in Appendix 1. This has informed the LSCB's programme of work and the formation of short-life working groups.

5.2 In the last year, the LSCB Quality Assurance sub group has developed processes for pulling together robust information to support focused discussion and decisions resulting in tangible improvements to safeguarding services. Data, audit and survey findings are key components of this. Based on the London Councils' framework, the dataset is comprised of a range of data providing information on the impact and outcomes of multi-agency working

across the three boroughs. Where data is captured on a single agency basis, comparison of that data with information obtained from other partners supports the identification of patterns, trends and anomalies and the exploration of themes and challenge.

5.3 Data sources are set out in the diagram on page [10*].

[* diagram]

5.4 QA developments have so far focused on establishing reporting mechanisms. The intention is for the information to incorporate quantitative data, information about the quality of services, and information about outcomes for children (i.e. how much, how good, what difference). The Board wishes to push forward on its scrutiny of information.

5.5 However, this QA process has already driven some areas of development:

- It is using it to understand the 2012-13 priorities of effectiveness of early help, improving scrutiny of outcomes for LAC and care leavers and maintaining focus on children affected by domestic violence, parental mental ill health or substance misuse.
- Exception reports are now influencing the agendas of Local Safeguarding Partnership Group. Thematic QA reports, such as

Domestic Violence, have supported proposals for practice development and data recording.

- The inclusion of learning from Child Death Overview Panels (CDOP) and Serious Case Reviews (SCRs) has led to a focus on suicide prevention in 2013/14.

5.6 Details of the QA process are set out below:

A number of "**data owners**" have been identified who are tasked with collating data from their own and other associated organisations to populate the dataset. All are members of the QA subgroup. **Data owners** take responsibility to ensure that data is collated and reported within timescales to **ensure scrutiny at the QA subgroup in advance of LSCB** meetings. Our identification of data owners is aimed at ensuring the co-ordination of data requests to individual organisations.

The **3B Children's Commissioning Business Analysis Team (CCBAT)** receive the data supplied by the data owner on a standardised template according to agreed timescales. This will include indications of possible exceptions/highlights for reporting to the Board with an accompanying narrative.

The **CCBAT will collate the dataset** and **liaise with the LSCB Manager** around gaps in returns and themes/issues emerging from the returns. The LSCB Manager will lead on partnership discussions relating to emerging themes and gaps in returns so that a "shortlist" of exceptions/highlights can be prepared by the CCBAT for the QA subgroup to discuss and consider. The populated dataset will be available as a background document to the QA Subgroup.

The **LSCB Manager** will consider whether there are relevant findings from various **audits and surveys** completed during the quarter for feedback to the LSCB.

The **QA subgroup** will consider the **exceptions report shortlist**, discuss the issues relating to the exceptions and agree the content of the final report to the Board.

The **LSCB** will receive a **quarterly exceptions report** for discussion. The full dataset will not be provided as a matter of course. Any data contained within the data report should have been considered by individual organisations in advance of publication to the LSCB. The focus of the discussion at the Board will then be on how particular issues can be addressed by the partnership to improve safeguarding outcomes for

5.7 Each of the three Councils has developed QA systems in the last year for child protection. This includes Westminster's case auditing of selected cases and examining the quality of practitioner analysis. Any feedback is reported to the practitioner and recommendations shared with safeguarding colleagues. RBKC has coordinated a frontline week and LBHF has undertaken local peer auditing.

5.8 Due to high numbers of children subject to a child protection plan (CPP) in RBKC for the second or subsequent time, cases were audited to assess the underlying reasons. The findings of this audit are being addressed and the same process is being undertaken in WCC. There is also now a routine multi-agency audit of all cases where a child has been the subject of a CPP for more than 12 months, with systems put in place for additional scrutiny. The real effects of this work will be seen over the next year, but there are indications that children are already spending less time on CPPs and the number of children on CPPs are declining overall.

5.9 Findings from external inspections are also reported to the LSCB as part of this QA process and any recommendations are taken forward by the LSCB. In the last year, the three borough Councils underwent the following:

- a Fostering Inspection, where the overall judgement was 'Outstanding' for Overall Effectiveness, with no significant recommendations.
- the OFSTED thematic inspection in WCC of safeguarding in relation to missing young people highlighted some problems with the accuracy of data gathered. This issue will be considered in the LSCB's short life working group on missing children in 2013/14 (see section 8).
- an internal audit of key child protection processes across all three Family Services Directorates by Internal Audit at RBKC. The focus was to review the completion and accuracy of key processes within the child protection system. It recommended a review of visit recording across all three boroughs to ensure consistency and efficiency of recordkeeping, which will be taken forward by a task group. It also recommended a review of the internal case auditing processes with a view to introducing one common tri-borough system which will be tested this year.

Currently the LSCB only looks at findings from Local Authority inspections and there is no systematic collation of inspection information from partner agencies. The LSCB needs to strengthen this area and, in particular, utilise the new tri-borough Safeguarding in Schools and Education Officer to inform the LSCB regarding on-going school inspections.

5.10 Each Clinical Commissioning Group (CCG) monitors the quality of service provision within the providers it commissions, including safeguarding activity. During the year the CCG Safeguarding Team has worked with providers to develop an outcomes framework for improving safeguarding children within health settings, which is aligned with and fed into the QA process of the LSCB. This framework enables providers to demonstrate how their structures and processes are functioning, as well as the effectiveness of their systems to improve outcomes. The framework is set around seven standards which take into account systems for the early identification of risk, such as non-attendance at appointments in maternity units, as well as the role the organisation plays in working with other agencies to protect children subject to a child protection plan or looked after. Audits were undertaken with GPs, dentists, pharmacists and optometrists to establish their compliance and further work is required to include them in the outcomes framework.

5.11 Over the past year the LSCB has strengthened its quality assurance framework to include scrutinising Section 11 reports to show how effectively organisations work with the LSCB to ensure they have in place their safeguarding functions (accountability, procedures, training, whistle blowing, etc). A standardised Section 11 template has been used across London so that reports can be used for organisations that cover a large geographical area. The initial findings of the QA subgroup are that a significant number of Section 11 reports require further multi-agency follow up. In most reports there has been no link between agency activity and learning from the LSCB. Reports have been largely descriptive and lacked analysis of the effectiveness of their services. The reports often focus on what is expected within an agency rather than what is local practice. Agencies have emphasised the processes that their organisations employ using expressions such as 'in process of review' or that the safeguarding issue is 'regularly reviewed'. The QA group therefore plans to question agencies further to ascertain levels of safeguarding practice and action plans to address any short fall.

5.12 An LSCB Development Day was held in December 2012 which was opened up to Borough Partnership Groups, voluntary sector representatives and operational staff. The aim was to encourage networking across safeguarding agencies and to plan for the proposed multi-agency inspection framework (subsequently revised) and to use that framework as a basis for understanding the effectiveness of local safeguarding arrangements. Input from the day has been used to form the LSCB's QA mechanisms and has initiated a useful model for delivery of board meetings which involves presentations followed by workshops to discuss particular issues in more detail, leading to agreed next steps. Moreover, these presentations now have a more multi-agency focus

rather than solely children's social care. For instance, a presentation from Housing regarding the impact of benefit caps was a useful way of promoting knowledge of early intervention. The work in small groups also highlighted the need for mutual challenge at the Board and to communicate learning from case reviews, as discussed further in this report.

5.13 The LSCB has recognised that management representatives from agencies need to be connected to front line staff so that they know which areas are working well and which areas are not. This is particularly in light of new methodologies considering the child's journey as a measure of the differences being made. The LSCB will be implementing an approach to address this, such as a SCIE questionnaire or a dip sample across front line staff, reporting on their experiences and feedback from key gatekeeping points across agencies and a report on their experiences produced. As part of this, the RBKC 'Frontline Week' looked at 90 cases, undertook 20 observations and spoke to 20 parents. Learning points are being presented to the LSCB.

5.14 As a further way of assessing safeguarding, the LSCB has now cleared a slot on their agenda where members can bring areas of concern for discussion. Where themes are identified, they will inform future priorities or short life working groups.

5.15 LSCB members feel that the above steps show significant progress in enabling them to assess local safeguarding arrangements. It has, however, been suggested that LSCB meetings do not provide sufficient challenge to partners to make a real difference to practice. This Annual Report is a step in identifying areas for such improvement, along with further development of quality assurance and data sharing. More work is required to improve data sharing from Police, Probation and Housing. The Police are willing to take this forward by providing an analyst to work with a Local Authority and Housing analyst to share data and produce a Strategic Assessment which highlights tri-borough trends and locality needs. This could be used by the LSCB to develop protocols and policies which address compliance with agreed processes, making a real difference to safeguarding practice.

5.16 The LSCB receives high levels of QA support from the Tri-borough Business Development and Performance Team. However, to improve further the functioning and effectiveness of the LSCB, it needs to review its resourcing for ongoing business development. The one LSCB Manager post (1FTE) and Business Support Officer (0.4FTE) provide only limited capacity to carry out the level of awareness raising, communications activities, co-ordination of case reviews and policy development that is required.

6. Standing Work of the LSCB

6.1 Communication and Awareness Raising

6.1.1 As part of the requirement for LSCBs to promote the welfare of children, the LSCB is agreed that a multi-agency website is needed, covering all three boroughs' multi-agency work. There is currently an LSCB web page on each Borough website but it is not well sign posted, does not have a distinctive identity and does not bring together all the necessary information. The LSCB is working with the Councils to develop a multi-agency website which can be the repository of all agreed policies and protocols relating to safeguarding and can be useful for the public, parents and children and young people. As part of this work, a tri-borough LSCB logo must be agreed, which can be used on LSCB documents such as Serious Case Reviews. This will help to give the LSCB a clearer identity and emphasise the partnership working that is undertaken through such reviews. There are plans for the website to have a "schools page" to promote ready access to key information including a model Child Protection Policy and Safeguarding and Child Protection Audit Tool.

6.1.2 There is a range of 'sovereign' documents in place across the three boroughs regarding referrals, assessment and thresholds. The LSCB has taken on board the requirement to publish these and evaluate their effectiveness and therefore, over the next six months, the LSCB will be mapping existing policies and procedures to identify those which require revision and updating in the context of recent changes at a national and local level. Following the publication of Working Together 2013, the publication of revised London Child Protection Procedures by the London SCB is awaited and local protocols will be adapted as required and published on the LSCB website. This report also commits to the development of a number of LSCB strategies in the next year, such as the Faith and Culture Strategy described in section 7 which will also be published on the LSCB website.

6.1.3 LADO (Local Authority Designated Officer) arrangements have been secured for each of the three boroughs. The LSCB has written to all partner agencies to advise them of the new arrangement to report all allegations to the LADO with 24 hours. It will also be necessary to improve signposting to information regarding the three LADOs, through the website and newsletters.

6.2 Training

6.2.1 The LSCB training programme has the flexibility to respond to the priorities of the Board and learning from serious case reviews. The programme is reviewed every year. For instance it has started to focus on cultural practice training and working with young people. It has also developed enhanced programmes. The national changes to Health and particularly the new arrangements for GPs have increased demand for multi-agency safeguarding and protection training. The LSCB training group has successfully responded to this and increased the number of courses. We are also piloting 'bite-size' learning, to suit practitioners' availability, where trainers visit team meetings and provide links to resources.

6.2.2 The LSCB training programme continues to be overseen by the LSCB Learning and Development (L&D) Subgroup. The programme aims to use the expertise of professionals working within the tri -borough area, however, at times we have externally commissioned providers. By using local knowledge, it is possible to provide tailor made packages for the professionals within the area. However, there continue to be difficulties with this model as there are insufficient offers of co-facilitation from some partner agencies. Without sufficient partner co-operation there is a vulnerability to the programme as it over-relies on delivery via one individual i.e. the LSCB Trainer.

6.2.3 Multi-agency training offered between April 2012 and April 2013 is as follows:

- Introduction to Safeguarding
- Multi-Agency Safeguarding and Child Protection Training Level 3
- Working with Domestic Violence in Relation to Safeguarding Children Level 3
- Parental Substance Misuse and Safeguarding Children Level 3
- Parental Mental Health and Safeguarding Children Level 3
- Awareness of Cultural Practices Level 3
- Abuse and Young People's Relationships Level 3
- Safeguarding Children who might be involved in Gangs Level 3
- Fabricated and Induced Illness
- Safeguarding Children with Special Needs
- Supervision in Relation to Safeguarding Children Level 6
- Safer Recruitment Level 6
- Sexual Exploitation: identify the needs and risks of children and young people in relation to safeguarding
- Be Wise to Sexual Exploitation

6.2.4 Expectations of capacity and attendance were exceeded. Courses are running on average at 86.6% capacity and 83.45% attendance. In this training year a decision was made not to run several courses due to low application numbers. We now target advertising and communications in relation to the more bespoke/specialist courses.

6.2.5 It remains concerning that some sectors appear to have low attendance at LSCB Learning and Development events. These agencies include Police, Probation and Adult Social Care. It is understood that a lower percentage of these agencies should be attending than of the Children's Workforce; however, some work needs to be done to establish whether these practitioners are receiving safeguarding training elsewhere and to evaluate its content. The Borough Commander has committed to making safeguarding training compulsory for all Safer Neighbourhood and Response officers and take-up will now be reviewed quarterly, although ongoing restructuring within the Metropolitan Police continues to impact on Borough Officers being identified to attend LSCB courses.

6.2.6 The course evaluations are extremely positive with only a small proportion of candidates stating that objectives were only partially met or not met (0.5%). In relation to the evaluations of the trainers' skills, there is positive feedback. Over all the courses, 78.5% participants have evaluated the trainer's knowledge of the subject as excellent. We continue to look at how we balance training methods between input from the trainer and group work.

6.2.7 It has not been possible to offer a LSCB eLearning package as part of the L&D programme since the licenses for the previous programme expired in October 2012. There is a plan for a new eLearning programme to be established on the L&D booking system so that all L&D resources will be available at one place. Content is being devised and there should be a new eLearning programme up and running in autumn 2013. We plan to use it to complement other aspects of the directly delivered L&D programme.

6.2.8 The booking arrangements for the LSCB programme have been transferred successfully to an electronic system provided by the Royal Borough of Kensington and Chelsea. The booking system has been streamlined and can now be accessed across the children's workforce .

6.2.9 In addition to this formal LSCB training, there is a need for increased skills development, such as shadowing opportunities and signposting to information. It is hoped that a new website could address this.

The LSCB has collected helpful information from participants about its training courses, but has not secured an effective training needs analysis across all agencies of all the gaps in safeguarding training of local professionals. More robust scrutiny of member agencies' section 11 reports will assist the LSCB in identifying weaknesses in agencies' safeguarding performance to support the direction of either single or multiagency safeguarding training in the future.

6.2.10 Single agency training delivered this year, to address issues specific to practitioners in individual organisations, includes:

- Barnado's training commissioned by the CCG on the impact of DV on children
- In house training delivered by Central London Community Healthcare on FGM
- Updated Safeguarding training by West London Mental Health Trust, in line with the UK Core Skills Training Framework.
- Increased level 2 and level 3 training to hospital staff by Chelsea and Westminster NHS Foundation Trust. A police session has been integrated into the level 3 training to broaden multi-agency focus and has been well received. The number of referrals to Social Care has increased to reflect improved awareness. The Trust also held its first DV Champion course this year to enable staff to raise awareness.
- A training event for tri-borough Child Protection Advisors, based on learning from the Strengthening Families approach and hosted by WCC to build on the quality of CP plans and connect them to the experience of the child. Learning from this has been built into an action learning set.
- Imperial College Healthcare Trust has redesigned training to focus on risk factors so that assessments are robust and information sharing improved. The maternity department will now be incorporating level 3 training into their mandatory and statutory training.
- A comprehensive yearly training programme by the Child Abuse Investigation Team, including SUDI training and the Multi-Agency Critical Incident Exercise which the LSCB engages in. This model has been included within the Munro review as best practice.
- 6 weekly training to all Home-start Volunteers by WCC to improve the quality of Safeguarding in early help cases
- BUPA Cromwell Hospital has increased participation in Level 1 and Level 3 safeguarding training including GPs who have Level 3.

- London Probation Trust hosted a multi-agency conference on child sex exploitation aimed at increasing awareness and developing best practice.
- All CAIT supervisors undergo training so that they can take over sensitively from uniform colleagues when called to deal with Sudden Unexpected Deaths in Infancy whilst remaining focused on their role as investigators.
- Delivery of training by Local Authority to schools including Bi Borough Safeguarding and Child and Protection Training for Designated Teachers, with increased take up from independent schools.
- Tri-Borough Local Authority training to schools for chaperones working with children involved in Entertainment issued with Licenses**.**

6.3 Case Reviews and Child Death Overview Panel

6.3.1 The learning opportunities and recommendations arising from Serious Case Reviews (SCR) and Child Death Overview Panels (CDOP) have been significantly strengthened this year. The Designated Nurse is the Chair of CDOP and the Director of Family Services in LBHF is the Chair of the SCR. The Chair of the CDOP always attends the SCR and this has improved communication between the two processes. For instance, even if a death is not preventable, the two groups can look at the circumstances and context for the child and this forms part of the learning. Both panels have good representation across agencies, including Police, Health (Designated Nurse and Doctor, Consultant Paediatrician) and LA Safeguarding. The London Probation Trust has also requested membership. Arrangements to support the CDOP are under review in order to support further its administration.

6.3.2 CDOP information is published in an annual report and, since the three boroughs merged, there are more cases to review, which provides more information with which to establish common themes and lessons and tailor training accordingly. It will also be necessary this year to publish SCRs on the LSCB website.

6.3.3 SCR and CDOP is a standing item on the LSCB agenda and influences future safeguarding practice. For instance, the recent small increase in suicides has led to the set up of a short-life working group on this area in 2013/14.

6.3.4 CDOP has also improved its multi-agency working. Recent CDOPs have been attended by social care representatives for cases of sudden deaths in infants (SUDI) due to co-sleeping, in houses where there were already

safeguarding concerns. These were previously Health-focused reviews but this new way of working is helping to share safeguarding lessons.

6.3.5 The Case Review sub group has highlighted that although Health Visitors, Midwives and paediatricians do attend Child Protection Conferences, there is no guarantee on the quality of the information they provide. The Group is therefore leading on an audit to look at the quality of contributions from these practitioners. It will be necessary to work with social care partners to achieve this, looking at all contributions regarding the same child.

6.3.6 The LSCB case review sub group has reflected on the local case reviews conducted over the year and national lessons and has summarized the key findings in the following 5 key messages:

- Setting the right culture, in schools and other agencies, is crucial to effective response to safeguarding concerns. Some SCRs showed that cases were dismissed because the issue raised about a member of staff did not correlate with their good reputation. Alternatively, the issue was recognised and dealt with internally and therefore not referred on / shared with Children's Services. Cases should be thoroughly investigated and the new Safeguarding in Education and Schools lead is following up these issues with school Heads
- Self harm / suicide or putting themselves at risk through 'risky' behaviour. Individual cases highlight issues around:
  - Care planning limbo that a looked after child felt.
  - Lack of professional awareness of the impact of suicide websites. This is being picked up by the LSCB multi-agency training and the short life working group.
  - School providing extensive support to a learner and family but not communicating with local Social Care services. This issue will be taken to the tri-borough Heads' Executive meeting.
- In terms of death and serious injury the children who came to the attention of the sub group reflect the recent OfSTED report "Ages of Concern" which highlighted equally serious but different vulnerabilities of children under one and over 14
- Information Sharing. One review highlighted the difficulty of information sharing when there is discontinuity of participants in the key child protection meetings i.e. case conferences and core group meeting. In addition case conference minutes were not sufficient as a vehicle for passing on information. In future, it will be requested that in cases where individual agencies have developed an action plan in response to specific recommendations, then the proposed

action/solution should be shared with other agencies. There should also be opportunities for 'professionals only' (without parents) meetings so that professionals can be open and transparent.

- Working with families who hide the truth i.e. parents who undermine the ability of the worker to get to the truth and work effectively either because of threats / rejections or because parents are co-operative and have the power to distract the worker from what is really happening. This is being highlighted in multi-agency Safeguarding and Child Protection Level 3 Training which is held five times a month.
- Domestic violence issues. There is a need to review practices in this area given the potential for family members to be silenced or subject to further violence, particularly where the perpetrator attends case conferences. The same review report raised another issue regarding case conferences: "Current local policies of Police and MARAC, about disclosure of DV and risks to a victim in CP Conferences, have the effect of prioritising confidentiality over information sharing". The current serious case review is exploring this area further. The Learning and Development Group has identified an ongoing training need on information sharing and has developed a "bite-sized" learning tool for frontline practitioners

6.3.6 Key messages and lessons were shared with the LSCB and will be published on the LSCB website. In addition, the sub group has been asked to focus on testing out the decisions made in universal services when a potential safeguarding concern has been raised in that agency and the decision has been not to refer on. Learning will be published in key messages on the LSCB website and in an LSCB newsletter.

6.3.7 Westminster has commissioned independent case reviews following the death of a care leaver which will be informing this year's short life working group regarding self harm; this highlighted the need to ensure the assessment of a young person who presents as homeless contains an appropriate analysis. Consideration should be given to further defining the skill-set required to work with older teenagers presenting as homeless, both in terms of Housing and Children's Services and to determine where, within this pathway, this service is best provided. Further work is to be undertaken in relation to transitional arrangements between children and adult services.

6.3.8 Entry to care for babies has been higher than previously which suggests communication of lessons regarding Ages of Concern has been disseminated effectively, as per the LSCB priority this year. Overall the LSCB has made significant progress in developing its case review function. However, its role

could be strengthened in terms of making more improvements at practice level, following on from lessons learned, such as information sharing.

6.3.10 Following on from Working Together 2013, the LSCB is developing a Learning and Improvement Framework and this will be developed by the Case Review Sub group for agreement by the Board. The Learning and Improvement framework will also set out a process for the co-ordination and analysis of case reviews which the LSCB has highlighted as an area for development. Agency actions following a case review will be agreed, recorded and monitored by the case review group.

6.4 Engagement and participation with children and young people

6.4.1 It is a current priority of the LSCB to promote the engagement of children, young people and families with the work of the Board as this area had not been given attention prior to the tri-borough Board. In the last year, the Chair and the Manager of the LSCB have attended the tri-borough youth council and individual youth boards of the three boroughs, including Children in Care Councils. They described the work of the Board and consulted the young people on what issues currently concern them and what their priorities are. These included bullying, e-safety, gangs, street lighting, having places to go and knowing who to talk to. Some of these issues will need to be explored through closer working with Safer Neighbourhoods. The LSCB will also need to share this information and maintain ongoing dialogue with children, young people and families and signpost them to advice and guidance. This will be taken forward by the new LSCB Community Development Worker who is employed two days a week to focus on engagement of children and young people including priority groups such as care leavers.

6.4.2 The LSCB also commissioned one of the Children's Forums (8-11 year olds) to agree a top ten set of tips to keep themselves safe and this will be circulated to schools and published by the LSCB as a leaflet for children. Over the next year, the LSCB will look at reserving an agenda item for a representative group of young people to attend some Board meetings to share safeguarding themes.

6.4.3 A variety of methods are used to capture feedback and the views of service users across the boroughs although work on identifying and embedding the most effective of these mechanisms is required. In RBKC, the EU funded Involved By Right Project concluded with a dissemination conference feeding back the impact of the advocacy for children and young people involved in the child protection process. The project was a runner up in the London

Safeguarding Children Board awards and advocacy to children in RBKC involved in child protection processes continues into 2013.

6.4.4 In Westminster, the implementation of the Strengthening Families approach to case conferences has contributed to a steady decline in numbers of children subject to plans overall. As part of the Strengthening Families evaluation a sample of parents were consulted to ascertain their views. A focus group with young people was also undertaken. A project is currently being taking forward regarding child participation in the child protection process which includes making a film with young people to help them to understand the conference process.

6.5 Equality and Diversity

6.5.1 A tri-borough LSCB priority is to improve engagement with BME families and communities to increase access to early help and safeguarding responses across cultures and faiths. Equality and diversity is routinely considered by the LSCB when setting out terms of reference for case reviews or working groups and when thinking about issues as they impact on families. However, the LSCB itself is not a particularly diverse group and it will need to think more about how to engage with diverse communities, including a stronger focus on disability.

6.5.2 A Community Development Worker has recently been appointed to focus on BME communities. The work plan includes work with the voluntary sector on statutory responsibilities. The Chairs of the Safeguarding Partnership Boards in each borough and the LSCB are also currently reviewing representation from the voluntary sector.

7 Priority Groups

7.1 Early Help

7.1.1 A priority of the tri-borough LSCB is to provide a clear assessment of early help (EH) services and minimise the impact of reductions to funding on these services. Over the last two years, structures have moved to an early intervention model because of evidence which shows that it is an effective way of addressing need before serious problems escalate. The focus is now on improved targeting of early help to those who most need it.

7.1.2 The 'Team Around' approach in Westminster has been developed to include health colleagues and there has been progress in making better use of existing data to support early identification of children with additional needs. The transfer of three Education Welfare Officer posts to the Early Help Service has enhanced capacity for addressing concerns regarding attendance and/or punctuality.

7.1.3 Westminster's Family Recovery has been extended to a larger group of families as well as developing the provision across the tri-borough, including a "lighter" model for more families. The Family Coaching Service will focus particularly on families where anti-social behaviour, youth offending and attendance and behaviour at school are the key issues.

7.1.4 The Westminster Multi- Agency Safeguarding Hub (MASH) has been launched and will be extended across all three boroughs in 2013. This involves the co-location of Police's Public Protection Desk (PPD) and partners from Children's Services and NHS, within a secure office. It enables partners to share information in order to quickly identify and assess risk. This ensures the social care decision makers within the MASH are able to make necessary and proportionate intervention decisions based on the best possible information available at a given time. It will be necessary for the LSCB to review the progress of MASH and for MASH members, such as Health, to develop the most appropriate contribution.

7.1.5 The Integrated Gangs Unit in Westminster is working in partnership with the Safeguarding Unit to identify cases where girls may be at risk of sexual exploitation through gang or group related activity. The LSCB has used this learning to form recommendations for its short life working group on gang related youth violence (see section 7). The Child Protection Adviser in Westminster who leads in relation to Child Sex Exploitation (CSE) keeps a spreadsheet up to date to help to monitor these cases. She is also convening a CSE forum to increase awareness of changes and the new Police approach to working with these cases.

7.1.6 In 2013, Central London Community Health implemented a version of Rio (electronic records) which is shared across the tri-borough and links up children's services. There is a robust system on flagging and placing an alert on records, where there are known vulnerabilities such as disability, child in need, domestic violence or CPP.

7.1.7 Imperial College Healthcare NHS Trust (ICHT) has conducted an audit of postnatal discharge documentation. As a result, the discharge checklist will be changed to become more specific for safeguarding cases. A safeguarding

discharge summary sheet with key information and contacts will in addition be sent to GPs, Health Visitors and Community Midwives from June 2013. At Chelsea and Westminster NHS Foundation Trust, an audit of discharge summaries in Paediatric A&E, Paediatric Wards, Outpatients and Neonatal and Midwifery Departments showed that summaries sent by medical staff to GPs required further information regarding safeguarding concerns which led to delays. This is being addressed at a new doctor induction and consultant supervision. An audit was also completed to review the quality of information passed on to Social Care when safeguarding concerns are shared. An observation made was that no feedback was received regarding referrals unless followed up by Named Professionals in the Safeguarding team. The LSCB will need to look into this and agree how to provide guidance on this.

7.1.8 A 'did not attend' (DNA) audit demonstrated the paediatric outpatients department at St Mary's Hospital required an action plan to reduce the DNA rate. A process mapping exercise has been undertaken to improve the systems and processes as part of this. An audit on the referral processes and the sharing of information between agencies highlighted training issues for staff mainly on identifying risk. As a result, training was implemented to address the learning needs. Working closely with an LSCB representative, ICHT has continued the design work of a Trust wide electronic clinical record system to record details on whether patients have children at home and to assess that they are being cared for and to support the implementation of a Trust-wide flagging system for north west London children with a child protection plan.

7.1.9 A team of specialist midwives within ICHT maternity services provide a service for women subjected to female genital mutilation (FGM) and will work with the safeguarding team to incorporate key findings into staff training and reporting. The safeguarding team and specialist Midwife for FGM are currently part of a multi-agency tri-borough working group to look at the process of identifying and referring women with FGM who are either pregnant or have a child.

7.1.10 An independent case review of an early intervention case was commissioned in Westminster in order to review the way that the Early Help system operates particularly where there are children and young people of different ages and a complex network. It concluded that more attention needed to be directed to developing a whole family approach to work with families. This work in now underway and will include a refresh of the Lead Professional role and training for some groups on working with parents. This case also highlighted the need to consider how services reach out to minority ethnic groups, in terms of future service development.

7.1.11 Arrangements are in place as part of the extended "Munro pilot" to remove the distinction between initial and core assessment, replaced by ongoing assessment of need. The evaluation of this has been agreed with the Department for Education (DfE) and is also part of the LSCB's QA reporting.

7.1.12 A Homeless Outreach Programme steering group has been set up in Westminster to deliver presentations and workshops to Schools/Colleges/Youth Centres which aims to inform young people about the barriers of accessing the City Council's housing stock and to provide advice about the process, dispelling some of the myths around housing at an early stage.

7.1.13 The LADO is now in place, with one in each borough, as per the LSCB early help priority last year regarding securing arrangements for safer recruitment and allegations management across agencies. There has been learning drawn from LADO activity which includes the need for organisations to adhere continuously and rigorously to good safer recruitment and safer organisation practices, particularly in the context of reduced legislatory requirements. The Board has received reports on LADO activity; and the need for specialist resources in this complex area is clear, as are strong professional relationships with Human Resources colleagues. The LSCB will also need to focus on providing LADO advice on its website and also on communicating changes around the disclosing and barring service. In addition, the LSCB has had 'safer recruitment' and 'safer organisations' discussions at Board meetings. In October 2013, the Board will be receiving a lessons-learnt report regarding a number of cases where allegations have been made against staff or volunteers working with children and young people. Government has just ended a consultation on scaling back requirements for school staff on safer recruitment but our child protection and safeguarding offer to schools (delivered by the tri-borough Safeguarding in Schools and Education Officer) will aim to promote best practice across the local school network on safer recruitment. We continue to run a course for staff from all agencies as part of the L&D programme. The QA sub group will also be picking up on any issues identified in Section 11 reports regarding safer recruitment policies and practices.

7.1.14 As demonstrated, there is a wide range of early help services and projects currently in place. However, the LSCB has not yet been sufficiently involved in testing out processes for early help, assessing impact and informing future commissioning. Further QA work and information sharing initiatives such as the MASH will assist in this. Furthermore, the LSCB will utilise the findings of the tri-borough early help review, which is currently underway, to feed into any future remodeling. The Director of Family Services in WCC is the sponsor of the review and will have ongoing input as a member of the LSCB. The work on

'Front Doors', included in the review, will also enable the LSCB to agree with partners the levels for the different types of assessment and services to be commissioned and delivered. An early help outcomes framework is also in development and will be linked to the LSCB's QA system for ongoing assessment of services. The LSCB could also explore links with Utility Companies who might signpost the need to assess families for help at an early stage.

7.2 Children Subject to Protection Plan and Looked After Children

7.2.1 A priority for the LSCB in 2012/13 was to ensure better outcomes for children subject to child protection plans and those looked after. Part of this is to improve the scrutiny of the safeguarding needs of looked after children and care leavers. A case review for a care leaver increased the focus on looked after children in QA work.

Looked After Children

7.2.2 The tri-borough Care Proceedings Pilot took place year with the aim of improving outcomes for children in care by significantly reducing the time care proceedings take. This has ensured that decisions about a child's future are taken more quickly and reduces the length of time children are waiting to know where and with whom they will be living in the future.

7.2.3 The tri-borough Fostering and Adoption Service was co-located and launched in June 2012 enabling: use of a shared tri-borough database of carers and adopters; access to all Boroughs' Integrated Children's Systems; harmonised carer fees, allowances and payment processes; and use of tri-borough duty emails to request placements, recruit and support carers and adopters. As a result, the Service has enabled foster placements to be shared across the three boroughs, avoiding the additional cost of having to use independent fostering agency placements. This has already helped to place a number of children with good local matches, which will deliver the desired outcomes. An improved service for 'friends and family' carers has also been provided through a dedicated team in the Fostering and Adoption Service.

7.2.4 The development of a Safeguarding Adults team at Central London Community Healthcare (CLCH) is co-located and works closely with the CLCH Safeguarding Children's teams and CLCH LAC teams to support the identification and assessment of issues related to the transition from Children to Adult services and also offers support and advice in cases where the parent is an adult at risk. The LSCB recognises that transition to Adult Services is an area for development and in 2013/14 there will be joint work on this with the new

Safeguarding Adults Executive Board (tri-borough). The Chair of the Children's LSCB and the Adults Safeguarding Board are now focusing on making links between the two Boards and will attend each other's Board annually. There are plans for joint work on issues such as domestic violence and mental health. The CAMHS Service has undertaken a co-production piece of work in Hammersmith and Fulham regarding care pathways and transition for Care Leavers and this will be valuable learning for the LSCB.

7.2.5 CNWL CAMHS has been commissioned to deliver a Multi-Systemic Therapy pilot for 11-17 year olds on the edge of care or custody. The implementation of the service was a multi-agency project across Social Care, Health and the YOT and the evaluation of outcomes for this cohort will be shared and used to inform service delivery.

7.2.6 To ensure children and young people have access to suitable housing, Westminster Housing Services attend a bi-monthly liaison meeting with Westminster Accommodation on Leaving Care (WALC) team to consider the housing needs of this cohort and a number of re-housings have been achieved. Housing has continued to work jointly with Children's Services to identify households where housing issues are impacting on the efficacy of a Child Protection or Child In Need Plan. The Children Act Accommodation Panel, comprising of senior officers from Children's Services and Housing, considers the full range of housing options available to such households and manages an annual quota of properties to be allocated to those in the greatest need.

Children Subject to Child Protection Plans

7.2.7 Outcomes for children subject to Child Protection Plans are good. This section describes some of the processes about information sharing and scrutiny that are used across the LSCB.

7.2.8 Information is shared at the MARAC (Multi-Agency-Risk-Assessment-Conference) on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors, in order to agree an action plan for the victim and the family involved. Feedback indicates that attendance at MARAC by Children's Services social care needs to be more consistent and this will be looked into by the LSCB, working with MARAC leads. It is also necessary to address the communication gap between the DV MARAC process where children have come to the notice of the Child Abuse Investigation Team (CAIT).

7.2.9 The housing representatives on MARAC acts as a point of contact for Independent Domestic Violence Advocacy seeking advice and support for their cases making homeless applications. Housing has also completed a mapping exercise that identifies the most appropriate referral pathways for DV clients with various risk levels seeking support, which includes generic floating support services as well as specialist DV services. The Maternity Unit at ICHT has an independent domestic violence advisor who is available to the MARAC for risk assessment, support and advice to women together with being a source of advice for staff.

7.2.10 The Domestic Violence Partnership in Hammersmith and Fulham is a key mechanism for managing and monitoring multi-agency performance specific to domestic violence. It is led by the charity, Standing Together, who are also represented on the LSCB and the Crime and Disorder Reduction Partnership. This partnership could be commissioned to provide analysis in this area to contribute to the LSCB QA function because an LSCB priority is to ensure we maintain focus young people affected by DV. Standing Together also lead on The Maternity Project which identifies women at a high risk of DV; a significant number has been identified and referred to the MARAC. These cases are identified through close working of the midwife, social worker, IDVA and health visitor. Children subject to CPP or CIN are discussed at MARAC. This is in addition to health visitor meetings with GPs to share information on vulnerable families and children.

7.2.11 This year, Standing Together, coordinated an independent researcher to complete a "survivor consultation" with local survivors in H&F. The results have been distributed widely among local services, the Local Authority and the Children and Health Operation Group.

7.2.12 The Exchange Project at Central North West London Mental Health Trust (CNWL) between a social worker and mental health staff ensures joint understanding of perspectives, roles and responsibilities and increases joint working with families where both agencies are involved.

7.2.13 London Ambulance NHS Trust shares information via Child at Risk/in Need report form completion. These referrals are made by frontline crews detailing their concerns about children who may be at risk of abuse or neglect which are faxed to Children's Services for action.

7.2.14 The CAIT, which works across the three boroughs (and five other boroughs), has worked closely with partners to deliver safeguarding in 2012/2013 against increased demand despite no growth of staff numbers. Detection rates have also increased. Additional funding and posts have been secured for CSE

investigations.. Project Topaz has been implemented by the CAIT to work with partner agencies to safeguard and protect children who are subject to a child protection plan. Referral staff are required to identify every occasion a child subject to a CPP becomes the subject of a new allegation. The Continuous Improvement Team reviews these incidents and includes them in their Daily 'Grip and Pace' meeting. This ensures that enhanced protection for children subject to a child protection plan is reviewed by the Senior Management Team, and actions are identified and prioritised. Child Protection Plan information is now shared through Project Topaz where the Safer Neighbourhood Teams are informed of children on Plans in their area.

7.2.15 The Police have invested significant resources into ensuring efficient and effective information sharing practices through the development of new risk based approaches and enhanced referral desk capacity. CAIT Command has collated information that shows these new practices have identified victims and allowed for safeguarding interventions which may have been missed previously.

7.2.16 Development and implementation of a tri-borough MASH will see the tri - borough CAIT piloting all referrals through the MASH with a number of CAIT staff seconded into the hub to support this process. This will improve timeliness and quality of initial information exchange and the pilot will enable the CAIT to review quality of decision making, risk management and demand data amongst other key issues.

7.2.17 CAIT CSE teams will have in excess of an additional 100 posts created in the coming months which will be dedicated to the investigation of CSE. CSE teams will be working with CAIT Metropolitan Police Borough colleagues to identify vulnerable children who may be at risk of CSE and detecting/disrupting CSE activity which includes oversight of missing children.

7.2.18 The London Probation Trust has commissioned a Research Fellow to undertake an audit of its child protection systems and decision making processes. A sample of cases has been randomly selected to evaluate the effectiveness of its safeguarding children practice. Learning from this will be shared with the LSCB.

7.2.19 Skills development has been suggested as an area of development for staff where exchange days and shadowing opportunities between agencies, such as Probation Officers and Social Workers, would help in raising awareness for both agencies about roles, managing expectations and developing multi-agency working. The Training and Development Sub Group will be considering this over the next year. This aims to resolve issues around multi-agency working, for

instance where Probation Officers are not invited to Child Protection Conferences and therefore not informed about key decisions.

7.2.20 In 2013/14 the Hammersmith and Fulham Safeguarding Group is creating a sub-group focused on improving the response to FGM and learning from this sub-group will come to the LSCB.

7.2.21 Following the audit of children subject to CPP for the second or subsequent time, actions need to be taken forward by the LSCB based on the findings of the underlying reasons. There is also an identified need to improve involvement of children who are looked after and this will be a priority area within Children's Services in 2013/14 for the Independent Reviewing Officer (IRO) teams to improve the contributions made by parents, as well as children, to the looked after children review process.

7.2.22 The LSCB is aware of the wide range of initiatives that exist across the tri-borough to improve outcomes for children subject to child protection plan and those looked after. The Board hopes that the QA system will be developed further to allow improved scrutiny of the safeguarding needs of this group. In the coming year, there will also be a review of children in need and child protection services as detailed in the Children's Services Business Plan and the recommendations that come from this will be brought to the LSCB. Under the new Legal Aid Sentencing and Punishment of Offenders Act (LASPO) all young people who are remanded to secure accommodation become looked after which will strengthen safeguarding arrangements for this group. However, those on sentence pose a greater challenge and there are real concerns about the experiences of young people, particularly following the recent report on Feltham. We are working with the Youth Offending Service to improve the data we capture and review as part of the LSCB dataset on young people in the secure estate and this will be considered as themed audit topics so we get a sense of the qualitative issues.

7.3 Faith and Culture

7.3.1 This year, the LSCB agreed that multi-agency short life working groups should be established to focus on safeguarding in two priority groups. These were expected to meet no more than monthly for a maximum of 6 months and provide recommendations to the LSCB on how safeguarding practice could be improved. Each group has a responsibility to map out the response of services to particular issues and to identify how practice can be strengthened and good practice lessons shared. One group focused on faith groups and culture, in line with the LSCB priority.

7.3.2 Initial bench-marking indicated that other Boroughs across London have specialist posts and teams devoted to working in this area. It was established that there was a need for a development worker to enable the LSCB to be more outward facing. The Community Development Worker is now in post and will develop sustainable initiatives on behalf of the LSCB, working in partnership with and enhancing existing examples of good practice, as well as creating new links and relationships in order to improve Safeguarding arrangements.

7.3.3 As well as a demographic review of the tri-borough population, an assessment of current strengths and weaknesses was undertaken, leading to practical recommendations to be taken forward, as follows:

- The group identified a need to improve the focus on understanding race, culture, religion and language as a crucial part of the front-line task of assessing family circumstances. This is believed to be very variable, with some group members commenting that under the pressure of completing assessments that there is not time to explore this aspect of family functioning. Take up of the LSCB training in relation to Faith and Culture has been low. There is a need to consider how staff cultivate a "global perspective" to inform their work so that faith and culture are not seen as separate categories of activity. This is important for every level of the organisation.
- The group considered it a priority for the LSCB to lead on ensuring a multi-agency strategy is devised and implemented for the prevention and early identification of:
    - Female Genital Mutilation (FGM was considered to be the top priority as it is believed to be hidden and there were no-known cases across the tri-borough)
    - Accusations of Witchcraft and Spirit Possession
    - So-called Honour Based Violence
    - Forced Marriage
    - Trafficking
- Whilst there are clear policies for dealing with identified cases in these categories, identification rates are low and often anecdotal. The first step would be to convene a "think tank" style workshop for each area to include representatives from voluntary agencies such as AFRUCA, IKWROW and Forward, and any identified members of the local community. One Child Protection Adviser could lead on these issues for each of the three Boroughs in order to assist with promoting good practice at the front-line and to champion the issues within each Borough.
- A key part of the new development role will be to spend time engaging local Faith and Community Leaders. An offer of training would form part of this approach; it is proposed that the new development worker can link in

with existing projects across London to adapt them on behalf of the tri-borough. The LSCB could create a place for a senior representative of a Faith Organisation to join the Board to support this work.

- One recurring theme in discussion was that families may perceive statutory services to be more punitive and powerful than they really are, deterring them from asking for or accepting offers of early help. A further common theme was the difficulties in working with interpreters that can also prevent families from seeking help. The group proposed that the LSCB initiates a qualitative piece of work that reviews the quality of interpreting services and provides a framework for basic minimum standards and good practice when working with interpreters. This could lead on to a more creative use of interpreters, drawing on their local and cultural knowledge in order to bridge gaps between family and organisational understanding and expectations.

  The LSCB could convene an annual conference to show-case examples of good local practice and learning across the three Boroughs.

7.3.4 The LSCB has agreed that there is so much work to be done in this important area that it is necessary for the LSCB to support the work of the development post for a further 12 months, and to monitor the progress and impact of the changes proposed.

7.4 Young people involved in gang related serious youth violence and sexual exploitation

7.4.1 The second short life working group focused on young people involved in gang related violence and sexual exploitation, which was a LSCB priority. Local drivers of this project included recent fatal stabbings, lack of a coherent strategy across the three boroughs, a need to review local practice and learn from best practice and look at links with other safeguarding streams such as substance misuse and self-harming behaviour. The aim was to improve integrated working, strengthen partnerships and identify gaps in service provision.

7.4.2 The group felt strongly that it is important to be conscious of the fact that change itself is an intrinsic characteristic of gangs as they adapt and change quickly, partly in order to evade being understood or engaged with by professionals. This key understanding needs to be incorporated into tri-borough work in this domain.

7.4.3 The report identified three key strands that will promote a reduction in youth violence and sexual exploitation in the tri-borough area. These strands

need to be considered alongside other related work streams such as children who go missing and children at risk of self-harm. Successful work with young people at risk of being involved with youth violence needs timely sharing of information prior to serious incidents arising. Housing, Education, Health, via-Accident and Emergency departments, and Adult Social Care are important agencies who may be in a good position to identify risk issues at an early stage. Good outcomes depend on effective multi-agency referral pathways and arrangements. This is reflected in the new guidelines drawn up by the London Safeguarding Board:

- There is a need for improved preventive work through the engagement of schools and local community and therefore the LSCB should improve the early identification of young people who are at risk of becoming involved in youth violence. Actions are:
  - New LSCB Education Safeguarding lead to work directly with schools around improving engagement of schools in early identification and referral of young people at risk of becoming involved in youth violence.
  - New LSCB Development worker to promote stronger engagement of the voluntary sector and local community groups with existing preventive services.
- Improved multi-agency partnership working is required around youth violence and sexual exploitation and therefore all agencies within each borough to establish a single point of contact (SPOC) role (Youth Violence and Sexual Exploitation). Actions are:
  - Development of a SPOC role and responsibility within each agency. This person will promote good communication and practice around sexual exploitation and youth violence on behalf of their agency.
  - Roles and responsibilities of SPOC to be clarified and reviewed.
- The wider framework for agencies working together should be improved by promoting further learning from the Westminster pilot and introducing the London protocol for working with young people at risk of sexual exploitation and youth violence. Actions are:
  - Ensure each agency reviews its service delivery in the context of the new London protocol
  - Roles and responsibilities of SPOC to be clarified and reviewed
  - Introduce the new London protocol within each borough by October 2013

7.4.4 In addition to these substantive recommendations the working group has identified a number of other areas that need further attention. Each borough is at a different stage in considering local partner arrangements. In Westminster

there is a well-established multi-agency team, whereas in the other two boroughs this is more a virtual arrangement with recent plans for agencies to meet on a regular basis.

8 Future priorities 2013/14

8.1 A number of areas of improvement have been highlighted in this report which the LSCB will be addressing. In terms of its priorities, there is still a lot of work to do and therefore it is agreed that they remain: early help and better outcomes for children subject to child protection plan and those looked after. We will continue comparing and contrasting practice areas and responding to an ever changing safeguarding landscape. The LSCB will also continue the life of the Faith and Culture working group in order to monitor its recommendations. In addition to these, the LSCB has agreed 'Missing Children' and 'Prevention of Suicide' as the two short life improvement groups for 2013/14. They will deliver reports to the LSCB in October 2013 and January 2014.

8.2 The Missing Children sub group will cover those who go missing from home, from care and those who are care leavers. This was highlighted by the Police as a significant safeguarding concern that requires multi-agency policy development and a costing exercise to show how resources could be used differently to prevent it. The Group will report on what we know and what we need to know and provide a detailed short action plan to improve multi-agency practice in respect of missing children. Its starting point will be to draw upon the work of the OfSTED thematic inspection of Westminster and the National Report on Missing Children (February 2013). The report will identify 3 key actions that will lead to improvements in practice and reductions in the numbers of children who go missing.

8.3 The focus of the Prevention of Suicide group will be on children and young people who are at risk of self-harming behaviour. It has a responsibility to produce a multi-agency strategy and action plan to improve practice in respect of children at risk of self-harming behaviour. An important consideration for the group will be a distinction between those young people who are at risk on account of suicide ideation and depression, as well as those who may be at risk on account of risky behaviours. There is a particular need to take into account the risks for 18 year plus care leavers. The group will need to consider the impact of issues such as bullying, self image, and internet safety on assessment of risk. The group should draw upon the findings of the biennial review of SCRs as well as local reviews of children where there has been a focus on self harm.

9 Formal Summary Statement.

9.1 As a new Tri-borough Board in its first year, the inclusion of partners previously attending three separate LSCBs was secured early on. In addition, there is now new membership of lay people and the beginnings of a connecting agenda with children and young people so they can influence the Board. The Board is numerically large but commitment to attendance has been generally high, particularly from Health. NHS leaders have ensured there is strong representation from Commissioning and CCGs have established specific accountabilities for safeguarding.

9.2 The Head Teacher representation has changed and cannot yet provide added value, though there are now new plans to broaden and deepen the input from Education in the next six months. We recognised that additional resources were needed to maintain links between the LSCB partners and schools in terms of quality assurance, support, challenge and training, and the new Safeguarding Education lead is bringing forward plans to address this.

9.3 Changes in policing and new leadership means that closer working with the Borough Commands ought to be possible in the next year and work with the Child Abuse Investigation Team is already strong.

9.4 Each of the three Housing Departments have worked with the Board to monitor the impact of housing reforms and welfare benefits and to offer opportunities for intervention in cases where children are subject to plan or who have other significant needs. In 2012/13 a specialist homelessness caseworker was recruited to work with families affected by the benefit caps.

9.5 The Board meetings now include a workshop on relevant issues providing an opportunity for working together in the meeting. Whilst there might be greater challenge across the table at meetings, participation is high and challenge is increasing after the first four meetings. Getting the involvement of all Board members in business items, development agendas, analysis and challenge at the Board meeting has been a big task and one which will continue to be a high priority for how we work together.

9.6 A strong legacy of commitment to the priorities from the three previous Boards has shaped the work this year and the agenda has been progressed successfully through active short life working groups and sub groups of the Board. Borough-based partnerships include a proper focus on local activities and there are developing relationships with the three Children's Trusts and Health and Well-Being Boards. Work on early help, domestic violence and welfare reforms from a Housing perspective have been evident in this first year.

9.7 Children are protected by the plans made in each of the Boroughs and there are now stronger audit arrangements of front-line work. This progresses the quality assurance that the Board is seeking; and also shows areas where improvements can be made. The QA function is now getting the correct steer. All partners are needing to look at how data can be used by the Board in a meaningful way.

9.8 High profile child abuse and exploitation in other parts of the country alert us to the need to be aware of opportunities for local children and young people to be similarly exploited or harmed. Our short life groups this year and next year mean we are looking at this in more detail. The standard of children's services work in all three boroughs is good.

9.9 Arrangements for workforce learning and development have meant there has been a responsiveness to new as well as more established child protection activities. The Child Death Overview Panel has published its annual report. Learning from different types of case review is formalised. There is one Serious Case Review underway on a child who died in 2010, prior to the establishment of the new Board.

9.10 Compliance with Working Together 2013 has been tested and policy and practice developments are underway so that there is full compliance by the Board with the Statutory Guidance. Practice development is already embedded in the Board's priorities. The involvement of both Chief Executives is secured and the Chair reports to one of the Chief Executives as part of this new governance.

9.11 The Board is supported by a very small, dedicated team and resources to the team may need to be reviewed this next year. The Board does not yet have its own logo or website, instead relying on the Councils' three websites rather than having a multi-agency identity. This must be rectified in the next year. Information for children, families and the public is still provided on a single agency basis and this does not do justice to the strong working together that exists on the ground and the strategic partnership work of the Board.

9.12 The Board will continue to focus on the four priority themes it has adopted. I am confident that strong leaders in each of the agencies and their commitment to the LSCB will strengthen it further in its second year of operation. I will continue as the Independent Chair.

Jean Daintith

Appendix 1

Tri-borough LSCB priority areas for 2012-13

(revised 15 June 2012 and grouped)

1. ***Early help and prevention of harm***
   - 1.1 Minimise impact of reductions to funding and/or changes to funding priorities on early help services and clear assessment of the effectiveness of early help services
   - 1.2 Secure arrangements for safer recruitment and allegations management across agencies

2. ***Better outcomes for children subject to child protection plans and those looked after***
   - 2.1 Promote the engagement of children, young people, families and frontline practitioners with the work of the Board and their increased participation in safeguarding practice
   - 2.2 Improve the scrutiny of the safeguarding needs of looked after children and care leavers
   - 2.3 Increase the effectiveness of safeguarding arrangements and improved outcomes for children subject to child protection plans (through initiatives such as Project Topaz and Strengthening Families) ensuring we maintain a focus on children and young people affected by domestic violence, parental mental ill health or substance misuse.

3. ***Practice areas to compare, contrast and improve together***
   - 3.1 Improve the engagement with BME families and communities to increase access to early help and strengthen safeguarding responses across cultures and faiths
   - 3.2 Improve the safeguarding of young people involved in gang related serious youth violence and sexual exploitation

4. ***Continuous improvement in a changing landscape***
   - 4.1 Identify and respond to the safeguarding implications of the housing benefit and wider welfare benefit changes
   - 4.2 Establish and respond to changes in the safeguarding arrangements during the NHS reforms as well as during transitional periods for other partners including tri-borough developments

4.3 Establish and respond to the implications for safeguarding in schools, given the changing educational landscape and role of the local authority in quality assurance, support, challenge and training

4.4 Establish and address the practice implications arising from Ages of concern: learning lessons from serious case reviews (Ofsted, October 2011) particularly with respect to scrutiny of local systems for transfer of cases between midwifery, health visiting and GP services

Appendix 2

Tri Borough Local Safeguarding Children Board (LSCB)

Terms of Reference

1. Introduction

1.1 These are terms of reference that apply to the tri-borough LSCB of London Borough of Hammersmith and Fulham, Royal Borough of Kensington and Chelsea and Westminster City Council and its multi-agency partnership. The three local authorities discharge their respective duties as a combined tri-borough LSCB under Section 13 (8) of the Children Act 2004.

2. Purpose

2.1 The overall purpose of the tri-borough LSCB is to ensure that local multi-agency safeguarding functions are discharged for the purposes of safeguarding and promoting the welfare of children under Section 11 of the Children Act 2004. The Local Safeguarding Children Regulations 2006 accompany the primary legislation.

2.2 The core objective is to coordinate the actions of all agencies represented on the Board, and to fulfill the duty to ensure the effectiveness of these actions in line with the guidance set out in Working Together to Safeguard Children (2010).

3. Functions

3.1 The functions and procedure of the LSCB are established under Section 13 of the Children Act 2004 and in relation to the deaths of children under Section 6 of the Local Safeguarding Children Regulations 2006. Chapter 3 of Working Together (2010) sets out the functions and operational arrangements of the LSCB.

3.2 The tri-borough LSCB functions can be broadly defined as falling into the following seven areas:

I. Communication and awareness raising;
II. Promoting good practice and deliver multi-agency training;
III. Setting quality standards and outcomes;
IV. Monitoring and evaluation;
V. Ensuring voices of children are heard;
VI. Planning and commissioning;
VII. Undertaking child deaths and serious case reviews.

3.3 To execute its functions, the tri-borough LSCB will adopt the following steering instruments:

- A three year strategy to set the long-term strategic direction for the LSCB;
- A business plan to set objectives and targets, and monitor the implementation of LSCB priorities;
- A LSCB dataset with a range of performance indicators from partners of the LSCB to make improvement recommendations to individual agencies, and provide partnership solutions to achieve aspirational objectives;
- A quality assurance and risk management framework to demonstrate accountability of statutory functions;
- A communication strategy to coordinate communication priorities, and ensure effective communication to the public, professionals and targeted groups of service users;
- A training strategy to lead on safer working practices and plan effective learning and development programmes.

4. Governance

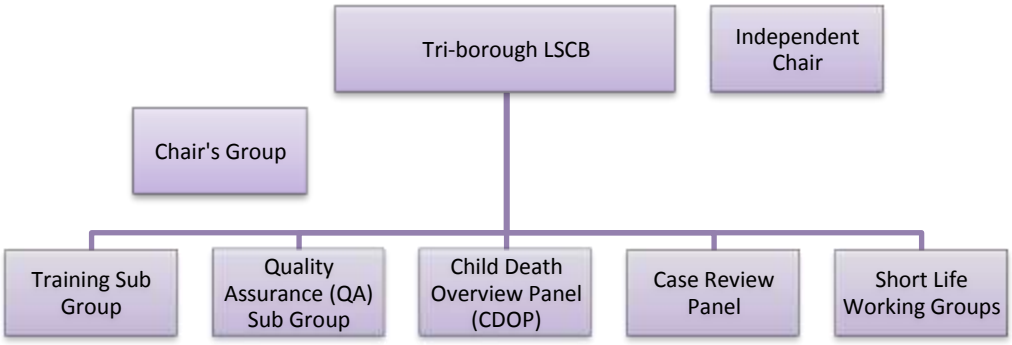
4.1 Effective governance is achieved by the Board setting the strategic direction and providing the impetus for continuous safeguarding improvements. The positive confirmation of a strong LSCB governance structure is that quality and outcome standards are adopted by partnership agencies, and fully understood by staff at all levels of member organisations.

4.2 The composition of the LSCB is set out in Section 3 of the Local Safeguarding Children Regulations 2006, and reflected in the membership list in Annex 1. The terms of reference and membership is reviewed on an annual basis.

4.3 The constitution of the Board and arrangements for the appointment of the Chair are in line with the Local Safeguarding Children Regulations 2006. The LSCB is established under the Tri-borough Executive Director of Children's Services, and the appointment of the Independent Chair is made in consultation with Board partners.

4.4 The LSCB Chair is also the Chair of the Chairs' subgroup which is part of the delivery arm of the Board, see structure overleaf.

Figure 1: Tri-borough LSCB structure



4.5 There are ongoing and direct relationships between the tri-borough LSCB and the relevant Cabinet Members for Children and Young People, the Chief Executives, the Health and Wellbeing Boards, the Adult Safeguarding Board and Community Safety Partnerships to ensure synergy between policies, plans, strategies, service improvement and practice developments.

5. Confidentiality and Information Sharing

5.1 Information is being shared among Board members in the public interest for the purpose set out in Working Together to Safeguard Children (2010), and is bound by legislation on data protection. Before joining the Board, each Member will be asked to sign a document to not disclose any information regarding LSCB business other than pursuant to the mandated agency responsibilities of that individual.

5.2 Reports submitted to the LSCB and its subgroups which contain case details will be anonymised to ensure that personal information cannot be identified.

6. Planning and Reporting arrangements

6.1 The tri-borough LSCB will identify safeguarding priorities and develop a three year strategy and an annual business plan. An issue log and risk register will be used to mitigate risks, and provide solutions that draw on the strengths of the LSCB partnership.

6.2 The tri-borough LSCB Business Plan is agreed and published annually. It includes information pertaining to the tri-borough Board's budget and funding contributions as well as detailing the agreed safeguarding priorities for the coming year, including those relating to looked after children and young people leaving care. At the end of the financial year, the LSCB will publish an annual report of its business which includes a financial statement.

6.3 The Chairs of the subgroups will submit quarterly reports of its business to the Chairs' group. The Chair of each subgroup will contribute to the LSCB's annual report, and provide recommendations for next year's business plan.

7. Administration

7.1 The tri-borough LSCB meets quarterly for a three hour meeting in a venue which alternates between the three boroughs. The meetings are recorded by the LSCB team's business support officer and the minutes are distributed within 5 working days. The agenda and papers are circulated to members at least 5 working days before the meeting. Reports and papers should be submitted at least 10 days before the meeting.

8. Performance monitoring

8.1 The Board is expected to demonstrate effective communication, training delivery, business and financial management through a scrutiny process driven by its broad range of steering instruments.

8.2 The LSCB Independent Chair makes the decision about referring matters from the Chair's Group for the attention and scrutiny of the tri-borough LSCB.

8.3 Members' attendance at meetings is monitored and evaluated to ensure that designated roles and responsibilities are carried out on behalf of each organisation. Each LSCB member will be asked to sign a roles and responsibility agreement to demonstrate its commitment to the Board.

8.4 The LSCB will use appropriate research tools and resources to undertake evaluation of its own effectiveness.

Approved by the tri-borough LSCB on 13/04/2012

Membership of the Tri Borough LSCB

Name	Position	Organisation
Jean Daintith	Independent Chair	n/a
Andrew Christie	Executive Director	Tri-borough Children's Services
	Executive Director	Tri-borough Adults Services
Helen Binmore, Elizabeth Campbell, Danny Chalkley or Deputy Heather Acton	Elected Member	RBKC, LBHF or WCC
Clare Chamberlain	Director of Family Services	Royal Borough of Kensington and Chelsea
Steve Miley	Director of Family Services	Hammersmith & Fulham
James Thomas	Director of Family Services	Westminster City Council
Kate Singleton	Head of Combined Safeguarding, Review and Quality Assurance Service	Tri-borough Children's Services
Tim Deacon	LSCB Manager	Tri-borough Children's Services
Will Jones	Assistant Chief Officer	London Probation Trust
Paul Monk	Detective Superintendant	Metropolitan Police CAIT
TBC	Primary Headteacher	Vacancy
Sally Whyte Headteacher	Secondary Headteacher	Lady Margaret Secondary School

Name	Position	Organisation
Ian Heggs	Director for Schools, Quality and Standards	Tri-Borough Children's Services
Mike England/Greg Roberts	Housing Services	Hammersmith and Fulham, Westminster Housing
Lucy D'Orsi	Borough Commander	Metropolitan Police
Jillian Aldridge	Head of Service	CAFCASS
Dr Ike Anya	Consultant, Public Health Medicine	(Moving to Westminster City Council)
Nicky Brownjohn	Designated Nurse for Safeguarding Children, Westminster and Hammersmith and Fulham	CWHH CCG Collaborative
Kathryn Jones	Deputy Director of Nursing	Imperial Healthcare NHS Trust
Therese Davies	Director of Nursing	Chelsea and Westminster NHS Trust
Andrea Goddard/Paul Hargreaves	Designated Doctors	St Mary's Hospital, Chelsea and Westminster Hospital
Louise Ashley	Director of Nursing and Quality Assurance	Central London Community Healthcare Trust
Catherine Knights	Associate Director of Operations	Central North-West London Mental Health Trust
Johan Redelinghuys	Director of Safeguarding	West London Mental Health Trust
Sally Jackson	Voluntary sector representative	Standing Together
Steve Lennox	Director of Health Promotion and Quality	London Ambulance Service
Elizabeth Virgo,Tola Dehinde, Poppy Plumber:Andrya Andreou	Lay Members	n/a
Jonathan Webster	Director of Quality, Patient Safety and Nursing,	CWHH CCG Collaborative
Adela Kacsprzak	Assistant Chief Officer	London Probation Trust

Appendix 3

Tri-borough Local Safeguarding Children Board (LSCB)

Roles and Responsibilities Guidance and Agreement

1. Introduction

1.1 The roles and responsibilities guidance should be read in conjunction with the LSCB Terms of Reference which sets out the purpose and functions of the Board in accordance with Section 12 (8) of the Children Act 2004.

1.2 The purpose of the roles and responsibilities agreement, provided at the end of the document, is to clarify the expectations of each individual LSCB member. Each member will be asked to sign the agreement, on behalf of its organisation, within one month of joining the Board.

1.3 Working Together Chapter 2 explains the roles, responsibilities and duties of the different people and organisations that work directly with, and whose work affects, children and young people. Working Together Chapter 3 explains the role, functions, governance and operation of Local Safeguarding Children Boards.

2. Roles and Responsibilities

2.1 The overall LSCB role falls into three categories:

i. To engage in activities that safeguard all children and aim to identify and prevent maltreatment, or impairment of health or development, and to ensure that children are growing up in circumstances consistent with safe and effective care;

ii. To lead and co-ordinate proactive work that aims to target particular groups;

iii. To lead and co-ordinate arrangements for responsive work to protect children who are suffering, or likely to suffer, significant harm.

2.2 The functions of each member is defined in Working Together 2010 Section 3.63 which states:

‘Members should be people with a strategic role in relation to safeguarding and promoting welfare of children within their organisation. Members should be able to:

- Speak for their organisation with authority;

- Commit their organisation on policy and practice matters; and
- Hold their organisation to account.'

2.3 The individual members of LSCBs have a duty as members to contribute to the effective work of the LSCB and in recommending or deciding upon the necessary steps to put right any problems. This should take precedence, if necessary, over their role as a representative of their organisation.

Overall responsibilities

2.4 The main responsibilities of each LSCB member is:

a) To promote the aims of the Board within their own agency and to be accountable for their agency's contribution to those aims;
b) To hold managers and staff within their agency or organisation to account for that agency's contribution to safeguarding, and to oversee the development of safeguarding policy and practice;
c) To represent the views and take decisions on behalf of their agency or organisation at LSCB meetings and/or provide a representative view from their profession, discipline or sector;
d) To receive and provide briefings, and to consult staff and disseminate information on safeguarding matters within their own organisation;
e) To ensure that processes are in place within their own agency or organisation for the implementation of learning points and new policy changes arising out of LSCB work

Governance and Business management responsibilities

2.5 The following responsibilities are about fulfilling Board roles and responsibilities in relation to governance and effective business management:

a) To attend and contribute to meetings of the LSCB regularly and consistently, having read papers in advance and prepared to make a full contribution, including requesting that specific items are placed on the agenda;
b) Where members are unable to attend a meeting, they should send apologies in advance and send a named, well-briefed substitute who may be a more senior colleague or manager

c) To attend and participate in LSCB subgroups and task group meetings, as appropriate;
d) To produce or ensure the production of reports to and from their agency or organisation, as required;
e) To nominate members to LSCB subgroups and short life working groups from within their organisation;
f) To maintain liaison with the subgroup representative, and to brief the Board on aspects that relate to the expertise of the organisation as necessary;
g) To contribute and examine regular updates and audits, data collection and analysis on individual and joint agency safeguarding children performance indicators as requested by the Chair;

Workforce, training and organisational learning and development

2.6 The following responsibilities are about compliance with relevant safeguarding legislation in relation to the workforce, staff training, organisational learning and developments:

h) To ensure that the agency or organisation have procedures about how to safeguard and promote the welfare of young people in order to clarify people's individual responsibilities;
i) To ensure that there are systems in the agency or organisation to check that there are no known reasons or information available that would prevent staff and volunteers from working with children and young people;
j) That there are procedure for dealing with allegations of abuse against members of staff and volunteers;
k) There are agreements about working with other organisations to promote and ensure partnership working, which include provision about confidentiality and information sharing;
l) To undertake training and personal development activity as required to fulfil Board functions;
m) To identify any child protection and safeguarding training needs within their agency and draw these to the attention of the LSCB;
n) To ensure that all staff are trained in safeguarding to an appropriate level by:

- supporting attendance at multi-agency training courses to those within their agency;
- maintaining up-to-date knowledge of safeguarding issues;

- contribute to or nominate staff who can contribute to the multi-agency training programme

Confidentiality and information sharing

2.7 The following responsibilities are in relation to ensuring confidentially and information sharing:

o) The decision to share or not to share information about a child should always be based on professional judgment, supported by the cross-Government *Information Sharing: Guidance for practitioners and managers* (published by DfE in April 2008) and informed by training;

p) The role of the Board member is to ensure that there are systems in place to support practitioners and build their confidence in making information sharing decisions to safeguard and promote the welfare of the child;

q) LSCB members are responsible for ensuring that there are safe systems in place within the agency or organisation to securely share, transfer and store LSCB information and data.

Tri-Borough Local Safeguarding Children Board

Membership Agreement

□ I have reviewed the above document.

□ I accept the document's contents and sign it off.

□ I accept the document's contents and sign it off, subject to the attached comments.

□ I do not accept the document's content and cannot sign it off.

……

Signature

……

Name and Title

……

Organisation

……

Date

A copy of this agreement will each be held by the LSCB Manager, and the signatory.

Appendix 4

Financial Statement

LOCAL SAFEGUARDING CHILDREN BOARD – TRI-BOROUGH BUDGET STATEMENT 1/4/2013 TO 31/3/2014							
CR		**£**	**£**		**DR**	**£**	**£**
Bal b/f 1/4/2013	WCC	167,635					
	LBHF	72,672					
	RBKC	67,371					
			307,678				
				Budgeted Expenditure			
Contributions Due 13/14				**13/14**			
Metropolitan				**Salary**			
Police			15,000	**Expenditure**		247,800	
Probation			6,000				
CAFCASS			1,650				
					Total Salary		
PCT (HEALTH)			91,200		cost		247,800
Local Authority Income							
				Non Salaries			
	WCC	51,900		**Costs**			
				Independent			
	LBHF	56,000		Chair		17,100	
	RBKC	49,600		Training		20,000	
			157,500	Case Reviews		26,500	
				multi agency			
				auditing		15,000	
					Total Non		
					Salary cost		78,600
				Bal c/f			
				31/3/2013			252,628
total funds							
available			579,028				579,028
Bal b/f 1/4/2013			252,628				

The attached table indicates the financial contributions received from partner agencies, detail the reserves carried forward from the former Boards and outline expenditure, for 12/13.

The table shows that considerable reserves (totaling £167,635) were carried forward at the end of 2011/12 from the Kensington and Chelsea and Westminster Boards with a previous agreement that these funds should be used to resource case reviews and, where sufficient funds exist in the respective reserves, cross borough LSCB projects. The Children's Workforce Development Council provided additional funding as a one off in 2011/12 to LSCBs which led to £46,700 of additional funds being available – these "Munro money" funds were carried forward from Westminster and Hammersmith into 2012/13 but will not be recurring sources of income.

Further reserves have been accrued in 2012/13 and these have been used to fund the Community Development Worker post in 2013/14 to take forward engagement with local community groups and the recommended actions from the Short Life Working Group on safeguarding across cultures and faiths. In addition, the LSCB will be resourcing multi-agency LSCB audits and funding a number of case reviews which are underway in the current financial year, including a Hammersmith SCR.

The financial contribution made by Health to the LSCB in 2012/13 reduced by 20% on the previous year contributions to all three Boards to £91,200. MPS, Probation and CAFCASS contributions remained at London wide agreed levels per local authority area, making a combined total of £22,650.

2012/13 expenditure relates largely to salary costs for the LSCB Manager, Training Officer and business support staff. A number of other local authority resources have been provided "in kind" and have not been charged to the LSCB accounts e.g. support from Children's Services Workforce Development Team, business analysis and policy staff, Heads of Safeguarding, etc.. Member agencies provide chairs of subgroups, etc. "in kind".

Training costs (non-salary) totalled £18,872 for 2012/13 and income from training was received totaling £15,100. Case review costs relating to the final activity on a Westminster case and inquest and the Hammersmith & Fulham SCIE review totalled £16,715. Costs relating to the independent chairing of the LSCB were £17,100 and general running costs were £3,176 for the year.