HARROW SAFEGUARDING PARTNERSHIP ANNUAL REPORT 2021/2022

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HARROW SAFEGUARDING PARTNERSHIP MANAGER

Contents

1. Introduction

This is the first Harrow Safeguarding Report that has reported on the work to safeguard both adults and children – previously there were 2 separate reports. The move to have a single report reflects the further integration of the support structures and funding for the Partnership as well as the joint work to strengthen awareness and understanding of safeguarding issues as they impact on all members of the family – so that children's services are able to identify and refer safeguarding concerns to adult services and vice versa.

It is much shorter than previous reports. It focuses on the activity of the Partnership carried out through the work of the sub-groups and the work of Board members to deliver Partnership objectives in their own services.

2. Report of the Chair of the Safeguarding Adult Board and Scrutineer for the Safeguarding Children Board

Safeguarding Partners in a Local Authority Area, for the purposes of both safeguarding adults and children (the Partners) are required to publish their arrangements for both sets of safeguarding arrangements (the Arrangements) [1],[2] They are also required to publish at least annually a report on what the Partners have done under the Arrangements and whether they have been effective[3],[4]. This independent scrutiny report is an assessment of how effective the Harrow Safeguarding Partnership has been in 2021-2

Six Areas Assessed

This assessment covers six areas that I consider require to be assessed

- Joint ownership of the Arrangement by the Partners.
- Impact of the Arrangements on service users and their families.
- How the arrangements lead to organisational learning.
- The extent to which the Arrangements are jointly owned and contributed to by other Relevant Agencies.
- Appropriate processes exist for data collection, audit and information sharing.
- Involvement of Service Users in the Arrangements.

Each area is assessed in the following way.

[1] 16G (2) Children Act 2004
[2] Sec 3 Schedule 2 Care Act 2014
[3] 16G (7) Children Act 2004
[4] Section 4 Schedule 2 Care Act 2014

- Good – This indicates that the Partnership provides good evidence of achievement.

- Additional Evidence Required – This indicates that the Partners can provide some evidence of achievement but there is more to be done.

- Much Evidence Required. This indicates that the Partners require to provide more evidence of achievement.

Overall Assessment - Good

The Partnership is a strong one with good evidence of cooperation, mutual understanding and determination to reflect on opportunities for learning and improvement.

Attendance at and contribution to the main boards and the sub-groups are consistent across the Partnership.

Joint Ownership of the Arrangements by the Partners - Additional Evidence Required

Harrow Council assumes a high level of responsibility for the funding, coordination and management of the Arrangements. Given that the ownership of the Arrangements is meant to be equitable across the three Partners, this continues to be something that requires further work.

The chairing of the Harrow Strategic Safeguarding Group, which sits as an advisory and steering group to the two Safeguarding Boards, now sits with the Integrated Care Board. This offers an opportunity to demonstrate equity of ownership
The sub-groups are well populated and are effective but there is not, across them all, a widespread membership from the three main partners.

Impact of the arrangements on service users and their families - Good

The Harrow Partnership is a reflective one and has a plethora of data that demonstrates that safeguarding risks are understood, managed and responded to. The Council has for some time led on a coherent policy for keeping families together and so the numbers of children taken into care is relatively low. The child protection procedures are contributed to by the whole partnership.

Providers of residential and other care services for adults with support needs work cooperatively with the Partners and as a result care home safeguarding alerts remain low. When the subjects of safeguarding cases are asked whether their desired outcomes have been met a very high proportion of respondents (95+%) say they have.

How the Arrangements lead to organisational learning - Good

There is a lot of good evidence that demonstrates how the Partners encourage learning, follow up on review findings and promote development.

This performance year was a busy one for the Partnership with regard to the reviews it conducted. The reporting was clear, the engagement of the wide range of partners was strong and some good lessons have been distilled and acted upon. The response by the Partners led by Harrow Adult Social Care to two Safeguarding Adult Reviews is particularly impressive.

The system leadership shown by the ICB in commissioning ICON[5] training across North West London is also a good example of lessons learned leading to performance improvement.

The extent to which the Arrangements are jointly owned and contributed to by other Relevant Agencies - Good.

The involvement of schools and colleges is well described in the partnership arrangements. The Designated School Leads gathering is well organised and well attended as is the involvement of schools in the Significant Incident Group. The strategic contribution of schools to the Partnership is less well evidenced.

The voluntary sector is well represented, particularly with the safeguarding adults' agenda and the work that they do across the safeguarding function is a strong addition to the Partnership.

Several Health Provider Trusts, the London Fire Brigade, The Department of Work and Pensions and the National Probation Service all contribute to the main board and to the various sub-group activities.

Appropriate processes exist for data collection, audit and information sharing

- Data Collection Additional Evidence Required
- Audit Good
- Information Sharing Additional Evidence Required
-

The data that the Partnership scrutinises is wide ranging and well analysed. However, despite it being an issue for some time there is still no Metropolitan Police Data Set, which can be effectively analysed against other partner data.

[5] This is training designed to help professionals advise assist parents who are stressed by their of babies' crying and poor feeding routines

Notwithstanding the incomplete nature of the Partner data set the quality of analysis and review of what data is available is very good.

The quality of multi-agency audit is good, particularly in relation to child safeguarding. There is still some work to do on developing the same audit function for adult safeguarding.

My brief report on information sharing at section 2 of this report explains how there is more work to do in relation to the workforce having confidence about why they can and should share information particularly in child welfare cases.

Involvement of Service Users in the Arrangements - Good

The work that Harrow partners have done with the Young Harrow Foundation on commissioning the survey of Harrow children and young people is excellent. There is a strong user voice representation in adult safeguarding through the involvement of representative groups.

Both these engagement processes demonstrate a commitment from the Partners to involve service users in the safeguarding agenda in Harrow.

Chris Miller

Independent Scrutineer
October 2022

3. Scrutiny

Review of Independent Scrutiny

In 2021, the HSP commissioned a review of its arrangements for independent scrutiny. The purpose was to provide assurance of the effectiveness of multi-agency arrangements to safeguard and promote the welfare of all children – including arrangements to identify and reviews serious child safeguarding cases.

Whilst the decision on how best to implement a robust system of independent scrutiny is to be made locally, safeguarding partners should ensure that the scrutiny is objective, acts as a constructive critical friend and promotes reflection to drive continuous improvement. To support this requirement the HSP and Harrow Safeguarding Children Board undertook a review of its current arrangements for independent scrutiny and, having considered the report, decided to continue with the current arrangement.

Summary of Harrow Safeguarding Partnership's Arrangements for Independent Scrutiny September 2019 to September 2021

Function required by WT 2018	Evidence
The role of independent scrutiny is to provide assurance in judging the effectiveness of multi-agency arrangements	In the HSP/HSCB's Annual Report for both 2020 and 2021 the Independent Chair/Scrutineer provided his evaluation of the Partnership's performance against 8 key standards: • Response to Covid-19 • 3 Partners actively involved in strategic planning and implementation • Involvement of wider safeguarding partners • Learning from reviews and incidents • Enquiry and challenge • Information sharing • Working with other strategic partnerships • Children, young people and families aware and involved with plans for safeguarding children The Independent Chair/Scrutineer's evaluations were presented for discussion and debate at the Business Development Days. Areas of achievement and development were explicitly identified
Identify and review serious safeguarding cases	• The Independent Chair/Scrutineer has considered the recommendations of the Case Review Subgroup and identified a CSPR and three Learned Lesson's Reviews to be conducted. • The Independent Chair/Scrutineer has also identified two SARs to be conducted – both of which were conducted jointly

	with the HSCB because of their relevance to the learning for both children and adult services • The Overview Author for the CSPR was a separate Scrutineer with extensive review experience • The Overview Author for the two SARs was Harrow's existing Independent Chair/Scrutineer • The Independent Chair/Scrutineer sits on the Review Panels for Learned Lessons Reviews
Scrutiny is objective, acts as a constructive critical friend and promotes reflection to drive continuous improvement.	The Independent Chair/Scrutineer: • is not in the employment or affiliated with any local organisation in Harrow. • influences the agenda and areas to be scrutinised at both the HSP and HSCB meetings. Areas of good practice are actively sought to help identify good practice both locally and externally (e.g. via lead roles in TASP and the London Safeguarding Board. Challenges by the Independent chair are clearly recorded • is a regular attendee and participant at the Quality Assurance Sub-group – actively involved in the scrutiny of all data and information reports • holds separate/single agency meetings with strategic leads where required e.g. regularly attends the LA's Quarterly Safeguarding Meeting with Senior Officers and Lead Members
Independent Scrutiny of Annual Report	• Versions 2019 to 2020 & 2020 to 2021 examined for accuracy and evidence of impact by the Independent Chair • Annual reports are submitted to the National Review Panel, What Works for Social Work Project • Annual reports are submitted to the H&WB • Annual reports are published on the relevant websites
Business Development	At the HSCB's 2021 Business Development Day members were surveyed about their views on the effectiveness of their arrangements for independent scrutiny. Positive feedback was received, and this review process is an extension of that verification/challenge
Additional Independent Scrutiny	
Expansion of Lay Membership	The HSCB continued with its inclusion of the existing Lay Representative due to the high standard of contribution and challenge provided. This Lay Member is also the Vice Chair for the HSCB. The model has been extended during 2021(supported by the Independent Chair/Scrutineer) – increasing the membership (shared with the HSAB) to 3 Lay members. As well as attending

	the HSCB meetings, they attend subgroups and participate in the scrutiny of audits and case reviews.
Business Development	Young people have been consulted on topics such as exploitation, the presentation of the HSCB website. Following the findings of the 'How are You' Survey, steps will be taken to expand consultation with children, young people and families.

Independent Scrutineer's review of: Workforce understanding of the legal basis to share information

The introduction of the General Data Protection Regulations in 2018 clarified and in many ways simplified the responsibilities of public sector workers in relation to information sharing concerning the welfare and protection of children. The Information Commissioner has made it clear that employees of public bodies should not seek to rely on parental (or other) consent when it comes to sharing or otherwise processing personal data. They should instead share information because they have a legitimate public task. They should, other than in exceptional cases, inform parents and other data subjects that their data has been shared, with whom and why. But this is not the same thing as obtaining prior consent.

For many years the children's workforce developed an understanding that generally they should not share information about a child or their family unless they had parental consent.

Many serious case reviews have revealed a failure to share information as being significant contributors to harm suffered by children. This was a finding in the two most recent Child Safeguarding Practice Review Panel publications into a) non accidental injuries to children under one and b) the deaths of Star Hobson and Arthur Labinjo-Hughes. While not exclusively responsible for this non- sharing of information workforce misunderstanding and misapplication of "rules" on parental consent play a part.

I observed this misunderstanding of the need for parental consent across agencies and at a variety of grades of staff. I concluded that it may be detrimental to the partnership's effectiveness in its safeguarding role and could put children at risk.

<u>The Scrutiny</u>

I decided to conduct some initial scrutiny of the extent of the workforce's understanding of the role of parental consent in information sharing. This involved a short questionnaire, which was responded to by 157 staff. It took place between February and May 2022.

Initial Findings

Staff are good at knowing the theory of information sharing concerning safeguarding. They are much less sure about information sharing in relation to child welfare. When confronted with some relatively realistic scenarios their practical knowledge was seemingly much less good than it should be.

Next steps

GDPR and the new data Protection Act are now four years old. There is a stickiness in the system, that means that custom and practice in relation to information sharing has not moved on.

Some strong messaging on behalf of the Safeguarding Partners is required to improve the situation.

The Learning and Development will take the oversight of this task on using a range of communication methods among which will be

- Leadership statements
- Podcasts
- Bite size lunch time learning events
- Integrating into all applicable training courses.

The safeguarding partners and HSCB need the understanding of this issue among our workforce to improve.

Conclusion

This knowledge gap is not unique to Harrow. This short scrutiny exercise shows that there is still work to be done and that there is a gap between what people purport to know and what they need to do.

A review of progress will be conducted in 8-12 months' time

Chris Miller
Independent Scrutineer
March 2022

4. Learning from reviews

Safeguarding Adults Reviews

SAR A

SAR A highlighted the need for learning in relation to the response to hoarding; working with resistant service users [or involuntary clients]; elective home education; young carers and perplexing presentations. Actions from the plan for SAR A continued to be progressed in 2021/22 including:

- Multi-agency training on self-neglect and hoarding
- Multi-agency training on perplexing presentations [previously referred to as Fabricated and Induced Illness]

SAR B

SAR B highlighted the need for learning in regard to professionals understanding of the Mental Capacity Act and the impact of adverse childhood experiences on carers. Actions resulting from SAR B include:

- The development of the Harrow Self-Neglect Policy and Protocol which requires that each case is taken to the Risk Enablement Panel where the care and medical refusal poses a significant risk to health, has a current mental capacity assessment.
- The setting up of a dedicated team in Adult Social Care to work with people who self-neglect and hoard.

Central London Community Healthcare Trust [CLCH]

- An audit into self-neglect was completed which considered Harrow specific cases. The audit findings demonstrated an increased awareness of self-neglect and staff contacting the safeguarding team when they had concerns.
- CLCH delivered 2 cohorts of the Safeguarding Champions programme, focusing on self-neglect and hoarding.

SAR C

Whilst SAR C was not concluded in 2021/22, agencies started to address some of the emerging issues form the case and particularly the concerns regarding exploitation and ‘cuckooing’:

- CLCH recognised that whilst contextual safeguarding is often considered in relation to children, adults are also subject to cuckooing and exploitation, hence, cuckooing and exploitation of adults and children is included in all levels of safeguarding training.

Child Safeguarding Practice Review [CSPR]

A CSPR was carried out into the case of Child "M" [published June 2021]. This review identified important learning in relation to managing complex needs for children with disabilities; practice in relation to thresholds; and the use of restraint.

Actions arising from this review continue to be implemented including:

- The drafting and publication of a multi-agency protocol providing child-centred guidance on the meaning and application of 'mechanical' and 'physiological / medical' restraint to children living in the community (other than in regulated environments) who are additionally vulnerable by virtue of physical / learning disabilities

- Relevant health agencies reminded professionals of the 'Was Not Brought' policies and importance of complying with those polices. Professionals were also reminded of the associated training programmes.

- Changes to practice which ensure more timely access to dental screening for children with disabilities.

- Improved tracking and education placement planning.

- Lunchtime learning events were held for professionals – these covered
    - Hearing the voice of a non-verbal child
    - Low attendance at school and at health appointments
    - Use of mechanical restraint
    - Managing complex needs

Rapid Reviews

Three rapid reviews were undertaken. None progressed to a full Child Safeguarding Practice Review as it was agreed that the process followed for the Rapid Reviews had been sufficiently rigorous and identified the learning and action required to achieve improvement.

- In the case of a 'shaken baby' case Harrow has worked with the Integrated Care Board to commission ICON Training for health visitors and midwives.

- In a number of cases the lack of consistency in managing and understanding "Was Not Brought" events was highlighted and, as a result, the relevant Board members took steps to publicise organisational 'Was Not Bought policies.[6]

[6] "A was not brought event" is an occasion when a child is not taken to a prearranged medical appointment.

Learning Lessons Reviews

The HSP initiated 3 Learning Lessons Reviews and continued implementing the learning from reviews started in previous years.
Actions included:

- Learning sheets drawn up and launched at Lunchtime Learning Events.

- Recommendations to the National Panel included:
    - That barriers to timely information-sharing across borders for families who move areas frequently, be considered as a theme for a national review.

    - For the Metropolitan Police Service and other area forces to consider providing full access to the Police National Dataset checks for Police MASH representatives – so that all relevant information is available.

5. Training and Development

Introduction

The Harrow Safeguarding Partnership is committed to maintaining and developing the awareness and skills of the multi-agency workforce. An effective safeguarding system relies on the ability of the wider workforce and the voluntary and community sector to know the signs and indicators of abuse and neglect and what action they should take when they have concerns. Another pillar of the safeguarding system is the network of safeguarding leads, variously called 'designated', 'named' and 'nominated' professionals, who are the first point of contact and advice for members of staff with safeguarding concerns. The training and development provided by the Partnership reflects the training needs of both parts of the system.

The report shows that there has been more training provided by the Partnership in relation to safeguarding children than there has been for adults, and this reflects the greater investment provided to the children's board. With the move to a more integrated partnership support team and an uplift in funding from adult social care, this differential will reduce over the next year. In particular, training for the voluntary and community sector will be extended to address adult safeguarding.

Safeguarding Children

HSCB training

The HSCB provided 17 training days in 2021/2022 and 179 professionals from across the multi-agency safeguarding workforce attended.

The training covered a range of issues at different levels of knowledge and expertise including:

- Introduction and advanced multi-agency safeguarding training
- Domestic abuse at introductory and advanced level
- Child mental health and parental mental health

The training also addressed recommendations from Reviews:

- Perplexing presentations[7]
- Hoarding and self-neglect

Working with the Voluntary Sector

The Harrow SCB has commissioned Voluntary Action Harrow (VAH) to provide safeguarding children training and advice to the private, voluntary and faith sectors for several years. VAH has a very successful track record in reaching and supporting these sectors.

[7] Perplexing presentations is the term now applied to cases where adults present themselves to medical professionals with one or more unexplained symptoms and also when adults as parents or carers present their children with one or more unexplained symptom.

In 2021/22, VAH delivered the following:

- 3 Single agency safeguarding training sessions [Level 2]
- 10 multi-agency safeguarding training sessions [Level 2]
- 3 safeguarding sessions for nominated safeguarding leads [Level 3]
- 3 safeguarding support forums
- 6 safeguarding newsletters
- 16, 1:1 support sessions

Total reach:

- 143 Organisations
- 325 Participants

Alongside the training and 1:1 support, VAH also represents the voluntary sector on the quality assurance and learning and development sub-groups providing valuable community input and using the learning to inform their advice.

Schools – Designated Safeguarding Leads (DSL) Forum

The Harrow Safeguarding Children Board facilitated the termly DSLs forum. The forums addressed a range of safeguarding issues as well as providing an invaluable opportunity for attendees to highlight concerns and share practice. In particular, the forums allowed for discussion about issues arising as a result of the lockdowns. Specialists from a wide range of services attended the forums providing expert advice and guidance. There were a total of 227 attendees.

Annual Safeguarding Self-assessment - children

Section 11 (s11) of the Children Act 2004 places a statutory duty on organisations to make arrangements to ensure that in discharging their functions they have regard to the need to safeguard and promote the welfare of children. Governance arrangements for all relevant organisations should ensure that the specified functions are being monitored and met.

Although, s11 requirements relate to children's services, the HSP in its commitment to its 'Think Whole Family' approach is extending this exercise to test the same standards in relation to services for adults with Care and Support Needs. Hence a a joint audit of the HSCB & HSAB was carried out.

Why have an audit?

This new HSP audit has been developed to test how well organisations have embedded the understanding of safeguarding responsibilities into the knowledge and practice of their staff.

Audit Themes

Results are based on 1019 completed returns.

- 88.8% of respondents said that safeguarding children was included in their induction. This was slightly less for adult safeguarding for which the figure was 76.9%.

- The vast majority of respondents (96.6%) have received safeguarding training in their current employment.

- Over half (56.6%) of respondents had not attended multi agency training.

- The majority of respondents (78.2%) confirmed that their training needs were identified in supervision.

- 97.1% of respondents knew how to locate their organisation's safeguarding procedures with 89.7% confirming they had read the procedures.

- Nearly a fifth of respondents were unable to identify their safeguarding lead.

- Almost a fifth of respondents did not know who to consult if they had a safeguarding concern about a member of staff or volunteer.

- Over 85% of respondents were familiar with their organisation's whistle-blowing procedures.

- 633 respondents knew how to contact children's social care for child protection or child in need concerns compared to 386 respondents who did not know.

- Over 75% of respondents said it was lawful to share information about an adult with care and support needs when a crime had been committed.

- More than 50% of respondents were unsure or believed it was not lawful to share information, where permission had previously been refused, for a repeat safeguarding concern about an adult with care and support needs.

- 625 respondents said, yes, it was legal to share information to promote the welfare of a child with 394 respondents saying they were unsure or believed it was not legal to share the information.

- Nearly 95% of respondents said yes it was legal to share information to safeguard a child from abuse or neglect.

- More than 850 respondents were not aware of any key messages from case reviews in Harrow for adults with care and support needs or children.

Safeguarding Adults

HSAB Training

The following training was provided:

- Domestic Abuse Training - 17 attended [Level 2/3]
- Safeguarding Adults Basic Awareness Training - 33 attended [Level 1]
- Safeguarding Training for Housing Professionals - 29 attended [level 1]

Alongside the above training, members of the Board did the following:

- The ICB continued to support Primary Care through the provision of Safeguarding Adult training. The Designated Nurse for Safeguarding Adults within the ICB [Harrow Borough] has been a point of contact for GPs in regard to safeguarding advice and queries.
- Both CLCH and CNWL updated their domestic abuse policies and routine enquiry training was rolled out for champions so they can support practitioners and teams to respond appropriately to abusive situations.
- Domestic abuse is included in all levels of CLCH safeguarding training resources.
- CNWL held a conference on domestic abuse and launched guidance for staff who might be experiencing domestic abuse in their personal lives.
- LNWH safeguarding team developed Domestic and Sexual Abuse (DSA) Safety Planning information and publisised it in the PULSE Newsletter, the Trust Intranet and with the safeguarding partnership.
- The Maternity Safeguarding Team at LNWH celebrated the first anniversary of the Hibiscus Clinic, a community-based service for non-pregnant women with Female Genital Mutilation (FGM). The Trust recorded 142 incidents of FGM in 2020/21, one of the highest levels of reporting in the country.
- St Giles Trust, co located at LNWH NHS Trust Emergency Department, and the Safeguarding Children Team delivered 2 contextual safeguarding sessions to staff. Contextual Safeguarding is now incorporated in the Trust Safeguarding Children level 3 training.

- The Trust set up a contextual safeguarding network with multi-professional membership including Doctors, Nurses and allied health professionals who meet regularly.

Review of self-neglect in council housing

Members of the HSAB decided to review whether incidences of self-neglect were disproportionately high in council tenancies. The Harrow Business Intelligence Team researched this and found:

- Whereas 11% of households in Harrow have a postcode assigned to a council housing area 23% of concerns for self-neglect (excluding those in residential and nursing care) were associated with a council housing postcode.

Whilst this suggests that there are more concerns of self-neglect in council housing than in non-council housing, it is also the case that vulnerable people receiving social care services are more likely to live in council housing, so this may be more of a general issue around vulnerability. The HSAB re-committed to joint working between Housing and Social Care colleagues to address concerns about self-neglect.

Annual Safeguarding Conference – adults and children

152 professionals from across the multi-agency workforce attended the annual conference. Expert speakers presented on a range of issues [see below] and workshops allowed participants to hear in more detail about specific issues and discuss and share information with each other.

Expert Speakers:

- Dr Henrietta Bowden-Jones OBE *Gaming Disorder: new Treatment Pathways for the NHS*

- Dr. Peter Buzzi *Safeguarding & Relationship-based Practice in a Digital World: Learning from Voices and Experiences of Adults and Young People*

- Carly Jones *Safeguarding Autistic Women and Girls*

- Neil Fairbrother *The difference between Contextual Safeguarding and Online Safeguarding*

Workshops:

- Digital Fraud and Scams

- Introduction to NCA CEOP and their education programme
- Contextual safeguarding – young person's perspective
- Social media and gangs
- Responding to online sexual abuse of children.
- Extremist content and online platforms
- Loan sharks

2022 Annual Conference: Attendance and feedback from participants

We want to ensure that our safeguarding learning events lead to better professional practice – and improve the lives, wellbeing and outcomes of children, adults with support needs and their families in Harrow. Below is a selection of feedback from attendees:

- *Raised my awareness of the complexities of the digital world for our CYP.*
- *Found Dr Buzzi's talk really useful and thought provoking. Sue Hill gave such a personal and moving account of the awful preventable tragedy that happened to her daughter which hit home how real the danger from online contact can be.*
- *It was good to hear up to date topics and what is being done more broadly in terms of Stalking as well as with Safe to net.*
- *All the areas covered were very useful. We have a great responsibility to our children, and it has definitely given rise to some actions we could and should take in our school. I am eager to go back and discuss with my DSL.*
- *Each speaker increased my knowledge which I can implement in practice.*
- *Will now know where to refer young people with gaming addiction.*
- *Well-chosen topics; very Insightful; engaging and interesting - thank you; high quality; excellent knowledge presentation and challenge; very informative; insightful having a speaker from the banking world; very informative and much needed for the times; All topics were interesting, speakers did a great job!; all the topics and speakers were brilliant! so engaging! I thoroughly enjoyed all of them; I imagine someone worked hard to research and acquire such knowledgeable and good speakers; the topics were very informative and kept me engaged throughout; very informative and presented in a way that does*

not feel like a lecture but rather as stories; good variety of speakers - all very interesting in their own right.

6. Allegations Against Staff and Volunteers - children's workforce

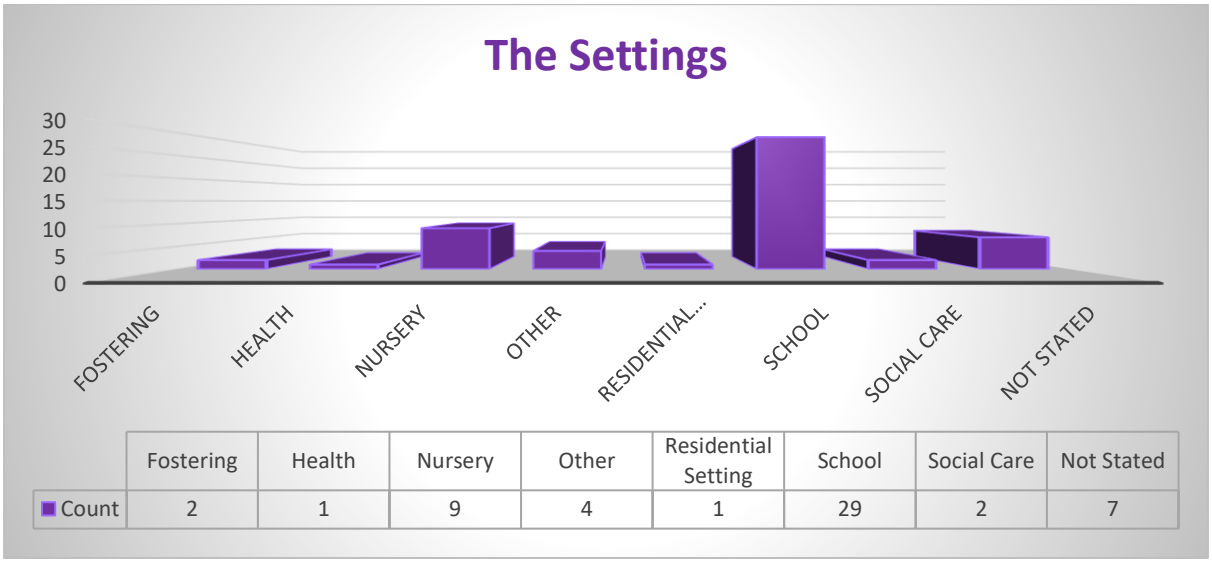
Each year the HSCB requires the Local Authority Designated Officer (LADO) to report on activity around the management of allegations.
In 2020/21:

- The Local Authority Designated Officer (LADO) role continues to comply with the London Child Protection Procedures and the Working Together to Safeguard Children (2018) Guidance (updated 2020).

- The service has continued to maintain its profile within the children's workforce and maintains awareness raising within the children's community within Harrow by way of training sessions and workshops.

- The case work recording system is fully incorporated in the social care MOSAIC system in a standalone and secure system. The MOSAIC system provides embedded monthly and annual performance reports.

- This reporting period includes the post pandemic period and the re-opening of schools and all educational settings including nurseries, which in the previous reporting year had been restricted to keyworker children and those children subject to Local Authority safeguarding plans.

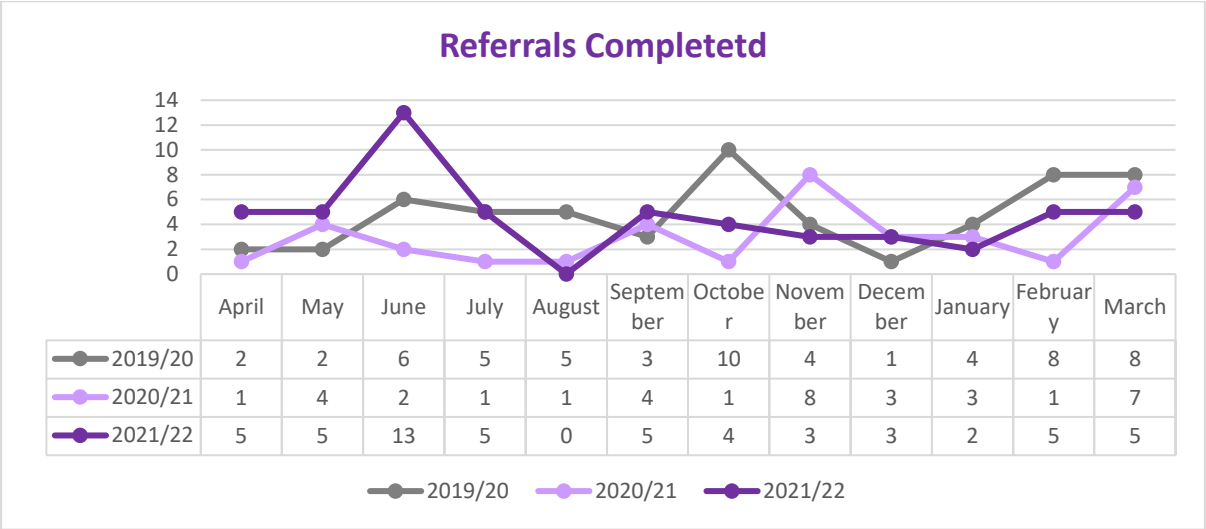


	Fostering	Health	Nursery	Other	Residential Setting	School	Social Care	Not Stated
Count	2	1	9	4	1	29	2	7

- The reopening of schools has increased contacts with the LADO. Anecdotally, it also seems that consultations have increased in comparison with 2020/21. *Nb consultations occur where advice is given but it doesn't lead to a contact*. This suggests that LADO consultations remain at a significant level, however, whilst there is a robust and accurate reporting system in place to evaluate

contacts and referrals, there is no pathway system for reporting consultations.

- In comparison to the previous reporting year there has been an increase in the referrals that met LADO threshold from 39 to 55 and a shift in the contacts from 69 to 53.



	April	May	June	July	August	September	October	November	December	January	February	March
2019/20	2	2	6	5	5	3	10	4	1	4	8	8
2020/21	1	4	2	1	1	4	1	8	3	3	1	7
2021/22	5	5	13	5	0	5	4	3	3	2	5	5

- It is noted the increased use of virtual communications such as MS Teams has created more flexibility and inclusivity in the way in which LADO meetings are held and the benefits are evident.

- There remains significant delay in some of the cases which met criminal threshold and required forensic examinations by the Police. Cases leading to criminal proceedings were also subject to delay as a result of the impact of the 2020/21 pandemic and this has led to a delay in the closure of some cases.

- Police - There were no referrals in relation to Police Officers in this reporting period. It needs to be noted that the Police Officer would need to be in a position of power and control over children to meet the threshold for LADO involvement. All other Police complaints/allegations are made to the Police complaints committee. However, the LADO was concerned about the lack of involvement with service, and it would appear the police address matters internally rather than refer to LADO or at least consult with the LADO. There was 1 contact regarding suitability/position of trust made via social care.

Appendices

HSCB Budget & Expenditure 2021-22

Budget	
Harrow Council including Business Support	-222,888
Police / MOPAC	-5,000
National Probation Service and CRC	-1,000
NHS NW London	-20,400
Training Income	-8,200
Total Income	**-257,488**
Staffing & consultancy expenditure	
LSCB Chair	20,250
Professional Support (full time BM & part time L&D co-ordinator)	116,162
Training Admin (0.8 FTE & sick cover)	53,518
SCRs and Independent Auditing	7,472
Recruitment expenses	1,403
Voluntary Outreach work	14,000
Total	**212,806**
Delivery Costs	
Council charges	36,137
Annual Conference	200
Training Providers	2,400
LSCB Website & 3-year Chronolator™ Licence	4,320
Catering & Misc.	1,625
Total	**44,682**
Total Expenditure	**257,488**

Meeting attendance

Harrow Strategic Safeguarding Partnership	May-21	Oct-21	Jan-22	Total
Independent Chair	1	1	1	3/3
Elected Member	1	1	1	3/3
CCG	1	1	1	3/3
Metropolitan Police Service	1	1	1	3/3
Local Authority	1	1	1	3/3
Schools - Primary	1	0	1	2/3
Schools - Secondary	0	0	0	0/3
Designated Nurse - Children	1	1	0	2/3
Designated Nurse - Adults	0	1	0	3/3
London Fire Brigade	0	0	1	1/3

HSAB	Jul-21	Sep-21	Dec-21	Mar-22	Total
Trading Standards	0	0	0	0	0/4
CCG	1	1	0	0	2/4
CLCH	0	1	0	0	1/4
Elected Councillor	1	0	0	0	1/4
RNOH	1	1	1	1	4/4
Lay Member	0	1	0	0	1/4
LNWHT	1	1	1	1	4/4
Business Intelligence	1	1	1	0	3/4
WDP	0	1	1	1	3/4
MPS	1	1	1	1	4/4
Probation	0	0	0	0	0/4
Chair of HSAB	1	1	1	1	4/4
Commissioning	0	0	1	1	2/4
London Fire Service	1	1	1	1	4/4
CNWL	1	0	0	0	1/4
Healthwatch Harrow	0	0	0	0	0/4
Community Connex	1	1	0	0	2/4
Mind in Harrow	0	0	1	1	2/4
DBS	0	0	1	1	2/4
Northwest BCU	0	0	0	0	0/4
Age UK	0	0	0	0	0/4
Housing	1	0	0	0	1/4
Harrow Council - Children Services	1	1	1	1	4/4

HSCB Subgroup Attendance	Jun-21	Dec-21	Mar-22	Total
Independent Chair	1	1	1	3/3
Vice Chair/Lay Member	1	1	1	3/3
Elected Member	1	1	1	3/3
CCG	0	0	0	0/3
Met Police	1	1	1	3/3
Local Authority	1	1	0	2/3
Designated Nurse	1	1	0	2/3
CNWL	1	1	1	3/3
LNWUHT	1	1	0	2/3
RNOH	1	1	1	3/3
Secondary Schools	1	0	0	1/3
Special Schools	1	1	1	3/3
Independent School	1	1	0	2/3
Colleges	1	1	1	3/3
WDP	0	0	1	1/3
Voluntary Sector Rep	1	1	1	3/3
Public Health	1	1	1	3/3
Housing	1	1	1	3/3
Probation	1	1	0	2/3
London Ambulance Service	0	0	0	0/3
London Fire Brigade	0	0	0	0/3
CAFCASS	1	0	0	1/3

Harrow Safeguarding Partnership Structure