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HARROW SAFEGUARDING CHILDREN BOARD

ANNUAL REPORT 2014 TO 2015

HSCB ANNUAL REPORT 2014-2015

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HARROW SAFEGUARDING CHILDREN BOARD

ANNUAL REPORT 2013 TO 2014

1. Forward by Chris Hogan, HCSB Chair

I am pleased to introduce the Harrow Safeguarding Children Annual report for 204/15 which summarises our work, our achievements and our challenges over the last year.
The report provides an assessment of safeguarding services for children in Harrow as a baseline for establishing refreshed and clearly defined priorities for the coming year.

This is my first report as Chair of HCSB, as I took up the post in October 2015 building upon a solid foundation laid by my predecessor Deborah Lightfoot. It is important to acknowledge this and to thank Deborah for her work and commitment. It is of note also that the new Board lead professional Coral McGookin took over the role from her predecessor Elisabeth Major in November 2015. I am grateful to Elisabeth for her detailed handover to us both and for her availability post departure.

This report then reflects 6 months of leadership by the previous Chair and Lead professional and 6 months after the transfer of leadership. As such the year outlined will describe the work in the first part of the year and show the changes in approach and emphasis after November 2015.

As a public report we review the progress made against the priorities set out in the 2013/14 business plan which were;

- From early help to safeguarding the most vulnerable -practice is multi agency, child focussed and effective;
- To encourage effective safeguarding communication between strategic groups, the community ,children and young people and to and from the LSCB;
- The LSCB provides a reliable safeguarding standard in a community of change ;
- Safeguarding quality assurance is every agency and sectors business"

In our evaluation of the work, I think it reasonable to say that our key achievements have been a strengthening of quality assurance systems, improved communication between agencies, a focus on the impact of training, a refreshed and invigorated approach to Child sexual exploitation, and a review and rethink of the Board's structures.

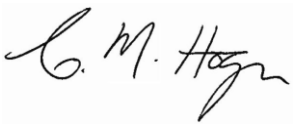
The areas identified for further improvement include the revision of our dataset to ensure full multi agency ownership of information and analysis of such information, further strengthening the relationships with faith groups, community groups and the wider community with particular focus on their role in addressing such issues as CSE and radicalisation, more effective and efficient commissioning of learning reviews and serious

case reviews with a specific push to identify and disseminate the learning as soon as possible and holding agencies to account for the progress on their action plans following reviews, and an embedded ownership of the Board's work with all members. There are also practical improvements planned that include the commissioning of a new Website so that we strengthen the Board's communication with practitioners and the wider community.

This is the first report from Coral and myself and we know there is lot to do and many challenges ahead. The report demonstrates the ways in which by working together and as individual agencies, partners are improving how well they protect children and young people and safeguard their welfare.

The more we improve the more we know how much more there is to do in the light of emerging national priorities and in ensuring that everywhere in Harrow all adults listen to, respond to and take into account children and young peoples' wishes and feelings. The Business Planning Day in April 2015 identified this as one of our key new priorities for the next year.

In conclusion I want to thank all those in Harrow who work hard to keep Harrow's children and young people safe.



2. THE ROLE OF LSCBS

There is a statutory requirement under section 14A of the Children Act 2004 for the Chair of the LSCB to publish on behalf of the whole Board an annual report on the effectiveness of child safeguarding and promoting the welfare of children in its local area.

The report should provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action. The report should also include lessons from reviews undertaken within the reporting period.

(i) Statutory and Legislative Context for LSCBs

The role and responsibilities of the Local Safeguarding Children Board (LSCB) are set out in primary legislation, regulations and statutory guidance. Section 13 of the **Children Act 2004** required each local authority to establish a LSCB for their area and specifies the organisations and individuals that should be represented on it. Harrow Safeguarding Children Board (HSCB) was established in 2006.

Section 14 of the Children Act 2004 sets out the objectives of an LSCB, which are to:

- Coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children; and
- Ensure the effectiveness of what is done by each such person or body for those purposes

The functions of LSCBs are set out in the **Local Safeguarding Children Board Regulations 2006.** These are:

a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

   i. the action to be taken where there are concerns about a child's safety or welfare including thresholds for intervention;

   ii. training of persons who work with children or in services affecting the safety and welfare of children;

   iii. recruitment and supervision of persons who work with children;

   iv. investigation of allegations concerning persons who work with children;

   v. safety and welfare of children who are privately fostered;

   vi. cooperation with neighbouring children's services authorities and heir Board partners

b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children raising their awareness of how this can best be done and encouraging them to do so;

c) monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children, and advise them on ways to improve;

d) participating in the planning of services for children in the area of the authority;

e) undertaking reviews of serious cases and advise the authority and their board partners on lessons to be learned.

Working Together to Safeguard Children 2013 provides the most recent statutory guidance for the responsibilities of LSCB. It sets out the expectations of Boards in relation to membership, the role of the Independent Chair resourcing and areas of accountability.

The guidance states that in order for an LSCB to fulfil its statutory functions, it should use data and, as a minimum:

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

LSCBs are an oversight and scrutiny body which does not commission or directly deliver frontline services.

(ii) Statutory Board partners and relevant persons and bodies

A LSCB must include at least one representative of the Local Authority and each of the other Board partners set out in section 13 of the Children Act 2004. The HSCB's membership for 2014 to 2015 is outlined below, with a record of each agencies attendance at Board meetings.

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

- speak for their organisation with authority
- commit their organisation on policy and practice matters; and
- hold their own organisations to account and hold others to account

In practice this means routinely attending meetings and scrutinising all its written reports.

HARROW SAFEGUARDING CHILDREN BOARD
MEMBERSHIP AND ATTENDANCE - AS AT END OF MARCH 2015

Representing	Forename	Title	Attendance
HSCB Chair	Chris Hogan (from Oct 14)	Independent Chair	2/2
Vice Chair	Peter Stride	DCI Metropolitan Police	3/4
Lead Member for Children's Services	Simon Brown	Councillor – Children, Families & Education Portfolio	4/4
Director of Children's Services (participating observer)	Chris Spencer	Interim Corporate Director, Children & Families	4/4
Designated Doctor	Ruby Schwartz	Doctor representative	1/4
Designated Nurse	Sue Dixon	Nurse representative	3/4
Named GP	Genevieve Small	GP representative	2/4
Lay Person	Michelle Weerasekera	School Governor	4/4
Lay Person	Robert Pincus	Healthwatch	4/4
Cafcass	Linda Kim-Newby	Senior Service Manager	3/4
Public Health	Andre Howe	Doctor – Director of Public Health	3/4
CCG	Javina Sehgal	Chief Operating Officer	2/4
London N/W Healthcare Trust	Carole Flowers	Director of Nursing	2/4
London N/W Healthcare Trust	Carole Wallace	General Manager, Children's Services LNWLHT	2/4
NHS England	Bronagh Scott	Director of Nursing, N/W London	1/4
Royal National Orthopaedic Hospital	Julie-Anne Dowie	Director of Nursing	3/4
Voluntary sector	Hannah Kaim-Caudle	Compass Service Manager	2/4
Voluntary sector	Rowena Jaber	The WISH Centre Director	3/4
Voluntary sector	Dan Burke	Ignite Trust Director	1/4
Secondary Schools representative	Geraldine Higgins	The Sacred Heart Language College Head Teacher	2/4
Special Schools representative	Simon Sackwild	Shaftesbury High School	2/2
Primary Schools representative	Rutinderjit Mahil-Pooni	Kenmore Park Infant & Nursery School Head Teacher	3/4
Independent Schools	Andrew McGregor	Harrow School Safeguarding Lead	2/4
Independent Schools	Lynne Plummer	John Lyon School Safeguarding Lead	4/4
Further Education	John Keenan	Stanmore College Safeguarding Lead	2/4
National Probation Trust	Juliet Wharrick	Assistant Chief Officer	3/4

London Community Rehabilitation Co.	Katrina D'Austin	Senior Probation Officer	3/4
Child Abuse Investigation Unit – Met Police	John Foulkes/ Liam Adams	DCI/DI Metropolitan Police	4/4
London Ambulance NHS Trust	Paul Bushell	Deputy Station Officer	1/4
Harrow Council	Kamini Rambellas	Divisional Director, Targeted Services, Children & Families	4/4
Harrow Council	Alison Murphy	Education & Commissioning Divisional Director	2/2
Harrow Safeguarding Adults	Visva Sathasivam	Head of Safeguarding, Adults Services	1/4
Harrow Housing	Karen Connell	Senior Professional, Housing Management	3/4
Chair of Quality Assurance Sub-committee	Neil Harris	Service Manager, Quality Assurance	2/2
Chair of Serious Case Review Sub-committee & CNWL	Catherine Knights	Assistant Director of Operations, CNWL	3/4
Legal Advisor to the Board	Sarah Wilson	Senior Solicitor, Harrow Legal Services	3/4
Advisor to the Board	Coral McGookin	Business Manager for HSCB	2/2
Advisor to the Board	Janine Young	Learning & Development Coordinator	1/1

(iii) Governance and accountability

In order to provide effective scrutiny, the LSCB should be independent. It should not be subordinate to, nor subsumed within, other local structures.

Every LSCB should have an independent chair who can hold all agencies to account. During the period 2014 to 2015, the HSCB had a change of chair. The previous and current chairs were independent of local services, and had extensive experience in child care services.

It is the responsibility of the Chief Executive (Head of Paid Service) of Harrow Council to appoint or remove the LSCB chair with the agreement of a panel including LSCB partners and lay members. The Chief Executive, drawing on other LSCB partners and, where appropriate, the Lead Member will hold the Chair to account for the effective working of the LSCB.

The LSCB Chair should work closely with all LSCB partners and particularly with the Director of Children's Services. The Director of Children's Services has the responsibility within the Local Authority, under section 18 of the Children Act 2004, for improving outcomes for children, Local Authority children's social care functions and local cooperation arrangements for children's services.

- **Lead Members and the Corporate Director of Children and Families Services**

Quarterly meetings take place between the Chair of the HSCB, Chief Executive, Leader of the Council, and Corporate Director of Children and Families Services to ensure that

strategic and political Leaders are apprised of all relevant developments and as such, governance and accountability is strengthened through regular and clear lines of communication and effective challenge.

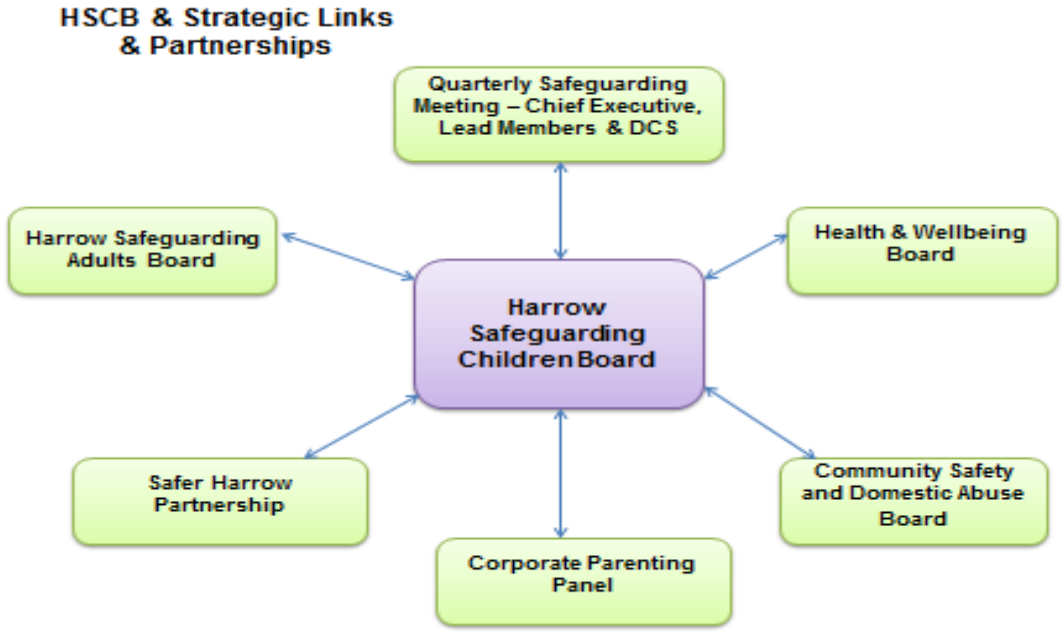
(iv) Links with other Strategic Partnerships in Harrow

The HSCB has strengthened its formal engagement with a range of strategic partnerships. Joint protocols have been reviewed for HSCB's relationship with:

- Health and Wellbeing Board
- Safer Harrow Partnership
- Harrow Safeguarding Adults Board
- Corporate Parenting Panel
- Community and Domestic Abuse Partnership

By ensuring membership of the Chair and Business Manager on the above partnerships, and by ensuring that all Board members carry the HSCB's key messages and its scrutiny function into other forums, the HSCB has been able to extend its influence and promote support for its priority work, expressed in other partnership strategies. This has been most evident in a joined up commitment to responding to developing concerns of Child Sexual Exploitation and learning from local reviews.

Strategic Partnerships Structure Chart



(v) The Revised Structure for the HSCB

The arrival of a new Chair and Business Manager provided the opportunity to examine the existing Board structure and its effectiveness in harnessing a truly multi-agency contribution to achieving the objectives and priorities set out in the previous Annual Report 2013-14 and the HSCB's Business Plan 2014-15.

New sub committees were established: Child Sexual Exploitation (CSE) and Policy and Procedures Committees. It was identified that a new energy was required to support both of these areas of existing work. The CSE sub-committee was a direct response to a revised CSE Strategy, written to reflect the learning from the Rotherham Report August 2014 and the thematic review of CSE undertaken by Ofsted November 2014. At the time these reports

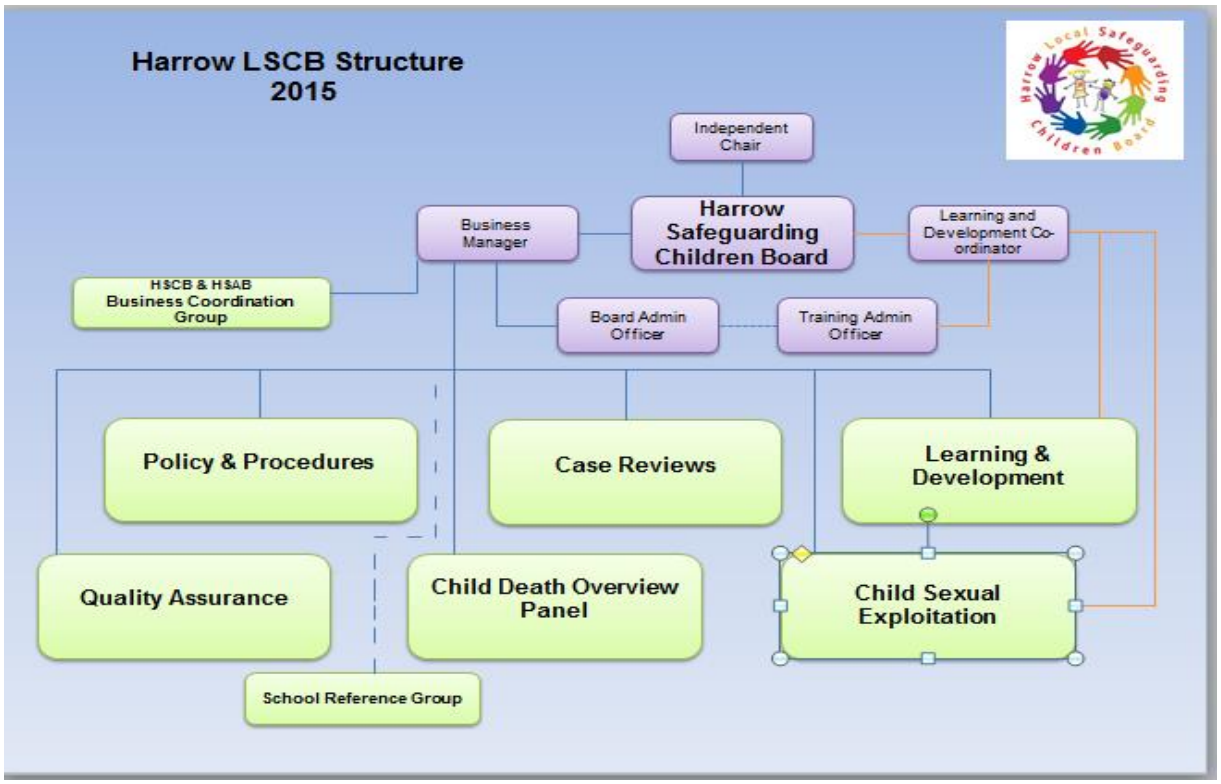
were published, CSE was not considered to be a significant problem in Harrow, but learning from these reports and reviews triggered a strong commitment across the partnership that there would be no room for complacency.

Taking feedback from practitioners, we also learned that a more accessible, user friendly and attractive HSCB website was required. By establishing a new Policy and Procedures Sub-committee, the HSCB has developed a multi-agency structure to support the development, revision and promotion of local procedures and guidance – for children/young people, their families, local communities and practitioners.

In order to make the HSCB more obviously applicable to children of all ages, a previous logo depicting infants has been replaced with a more generic one and the website itself promotes a full spectrum of ages, diversity and abilities.

To balance the resource implications of setting up new sub-committees, both financial and staff time for all partner agencies, it was agreed that the work of two of the existing sub-committees could be continued through different arrangements. The Cultural and Diversity Sub-committee was re-formed as a Cultural and Diversity Reference Group for the HSCB and the Private Fostering, Trafficking and Inter-country Adoption was disbanded, with the work translated into task and finish activity and with specific reporting made directly to the HSCB.

This 'refresh' of the structure has re-energised a commitment to supporting the work of the HSCB, with the CSE sub-committee in particular, attracting a wide range of practitioners from the statutory and voluntary sectors. The revised structure for the HSCB developed in the early part of 2015 is as follows:



vi(vi) HSCB Budget 2014-15	£
Harrow Council including Business Support	149,173
Police	5,000
Royal National Orthopaedic Hospital	5,000
Community Rehabilitation Company	1,000
Cafcass	550
Central North West London Hospital Trust	15,000
Harrow Clinical Commissioning Group	15,000
London North West Hospital Trust	15,000
Training Income	11,585
Sale of USBs	110
Total Income	**217,48**
Staff & Consultancy Expenditure:	**£**
LSCB Chair	26,970
Professional Support (full time BM, part time L&D co-ordinator)	86,094
Training Admin (.5 FTE)	12,488
SCRs	40,210
Voluntary Outreach work	9,750
Independent Review of LSCB	4,760
Staffing & consultancy expenditure Total:	**180,272**
Delivery costs:	**£**
Annual Conference	5,337
Training Providers	8,910
Venue Hire	4,060
LSCB Website	4,325
Publications	8,998
Catering & Misc	3,351
Delivery Costs Total:	**34,981**
Total Expenditure:	**215,253**

3. LOCAL BACKGROUND AND CONTEXT

Harrow is an Outer London borough in North West London covering 50 square kilometres. Around 243,500 people live in Harrow and compared to the London average it has a greater proportion of older people and a lower proportion of those in their 20s and 30s. The population is expected to grow overall in the next 10 years with the proportion of those of working age decreasing.

Harrow has a General Fertility rate of 67 births per 1,000 women, compared to London which has 66.5% and England 64.2%.

Almost a quarter of people in Harrow are aged 18 or less. By 2012, the population of children and young people will increase by 2%. 27% of children and young people in Harrow are from a white ethnic group. The largest ethnic group is Asian at 37%.

Health outcomes for children and young people in Harrow are better than those of London and England as a whole, and young people in Harrow have a higher level of educational attainment and fewer are not in education, employment or training than the London and England averages.

Harrow is one of the most ethnically diverse boroughs in the country. In 2011 42% of the population were from a white ethnic background, 43% from an Asian/Asian British background and 8% from a Black/African/Caribbean/Black British ethnic background. Over the next 10 years it is anticipated that the local Black, Asian and minority ethnic population will increase from 54% to 68%.

On average there are around 3,500 births in Harrow each year. Around 43% are from the Asian and Asian British ethnic group.

Over 40% of pregnant women in Harrow do not have an antenatal assessment by the 12th week of pregnancy which is significantly lower than the average for England. There are a number of reasons why the ethnicity of mothers in a local area may have an influence on the needs which the services provided must meet. Certain conditions are known to be more common in particular ethnic groups. Mothers and their families who have recently moved to the UK may have difficulties reading or speaking English, and different cultural norms may exist.

Together with a wide range of ethnic diversity Harrow also has a high level of religious diversity being home to one of the largest Hindu populations in the country at 26%. There are also greater proportions of people of Muslim faith and of the Jewish faith than the national average.

Harrow is ranked 203rd in relation to deprivation out of 354 Districts in England (where 1st is the most deprived). Most of this deprivation is in the centre of the borough with pockets of deprivation in south and east Harrow.

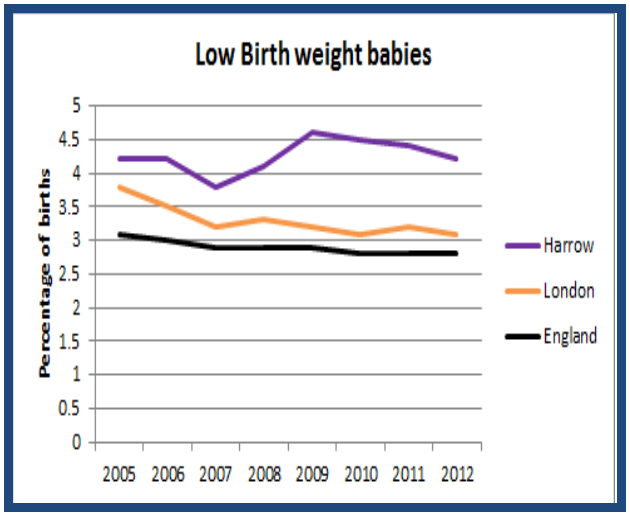
Harrow is home to 55,800 children aged 0 to 17 .There are 59 schools: 44 primary with 26 of those having nursery classes,11 high schools - 8 of which are Academies,1 all through free school,2 high special schools and 1 pupil referral unit .87% of these are judged good or better ,12% require improvement and 1 is inadequate.

(i) Vulnerable children and families

The level of children living in poverty in Harrow is 21.3% and this is above the average for England which is 20.6%, but lower than the average for London which is 28%. Children in poverty are not evenly distributed across the borough – ranging from 31.9% in Wealdstone ward to the lowest in Pinner South ward at 8.4%

Only 2% of all pregnancies in Harrow are with women under the age of 19 years. Teenage pregnancy is associated with poorer outcomes for both young parents their children. Teenage mothers are less likely to finish their education, more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers. Teenage pregnancy rates have been consistently lower in Harrow than those in London and England.

The proportion of babies born at a low birth weight in Harrow is significantly higher than both the regional and national averages. There is also a higher than average infant Mortality Rate.



Commentary
The rate of low birth weight in Harrow is significantly higer than those of London and England. They have been consistently high. Some of this is thought to be due to the ethnic make up of our local population rather than issues such as smoking in pregnancy which is low in Harrow.

As with the national picture, domestic abuse continues to rise. In 2013, 5,617 women and girls aged 16 to 59 experienced domestic abuse in Harrow. The Domestic and Sexual Violence Strategy 2014 to 2017 gives emphasis to developing a preventative climate and not just focus on post-violence interventions.

There is little firm data with regard to forced marriage, honour based violence (HBV) and female genital mutilation (FGM), but national research suggest they are most commonly practiced in communities with links to particular countries. Those countries make up a significant proportion of Harrow's population and therefore local strategies must remain proactive in these particular areas of risk. As there is no precise way of identifying those at risk, changing accepted or tolerated norms is viewed to be the most effective way of influencing behaviour. The HSCB, Health and Wellbeing Board and the Safer Harrow Partnership reflect this approach in their strategies for communicating with local communities.

About 3,100 were in need of a service from the Authority between 01/04/2013 and 31/03 /2014. This includes children 'Looked After', those supported in their families or independently and those subject to a protection plan.

The rate of children Looked After under the age of 18 in Harrow has been consistently lower than both the London and the England average for the past 5 years. There is a greater ethnic diversity in Looked After children in Harrow and children of mixed and black ethnicity are over represented.

The age profile of Harrow's 'Looked After' children is also different to that of London and England. Harrow has a higher proportion in the 16+ age group.

(ii) Young People and Substance Misuse

Alcohol related ambulance call outs for young people under the age of 18 in Harrow show a downward trend since 2010 (54) to 2014 (34). Of these, the highest number by age group was the 15-17 year olds. Previously females significantly outnumbered males, but the opposite pattern is now evident.

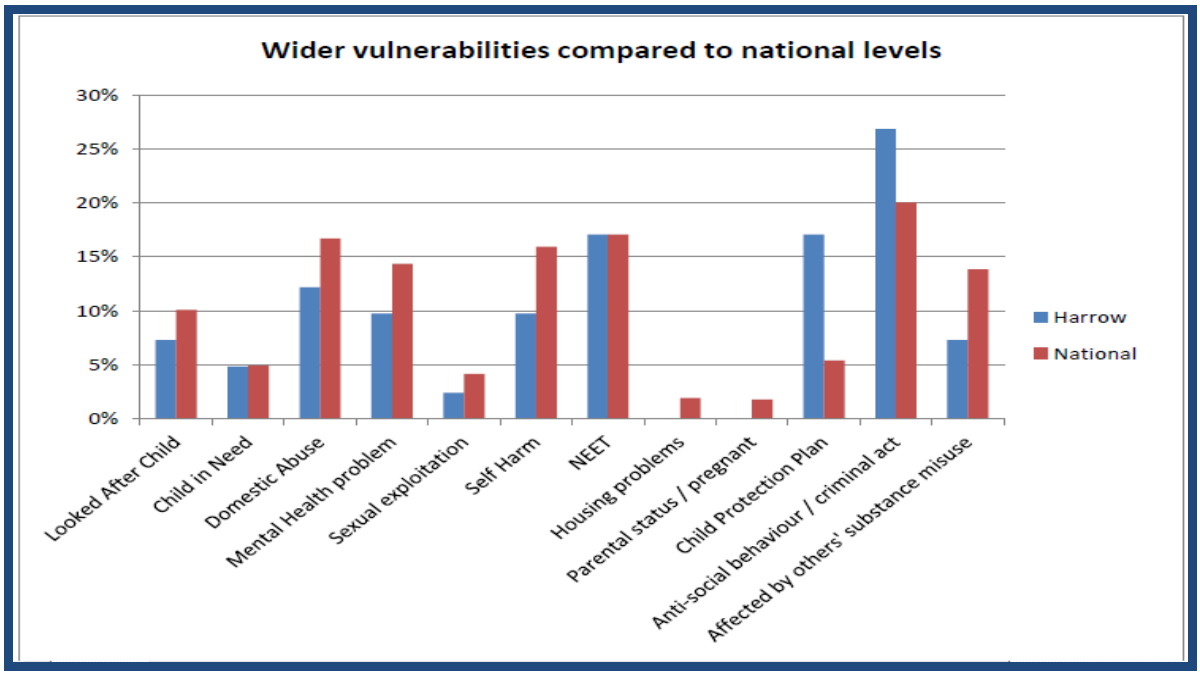
Hospital alcohol misuse related admissions for young people also show a decreasing trend over the last 5 years. Harrow is the ranked 4th lowest in London compared to the nearest statistical neighbours.

With regard to drug misuse, there was an unexplained peak in 2012-13, but generally there has also been a decrease relating to young people over the last 5 years. Harrow has a significantly lower rate of opiate and 'crack' users between 15-54 year olds per thousand population than the London as a region.

A significant proportion (43%) of young people who are in contact with the Youth Offending Team have drug (mainly cannabis) or alcohol as one of the risk factors in their offending and the services of Compass and ASK are engaged to support the young people with these issues. These services include outreach work e.g. EACH and Ignite.

The aims of the interventions are to: reduce problem behaviour; increase involvement in positive activities; increase confidence and self-esteem; improve academic attainment; reduce criminal activity; improve mental health; improve family relationships; and improve attendance at school.

Although the rates have been decreasing for young people over the past 5 years, the links with other vulnerabilities indicate the complex nature of issues for young people.



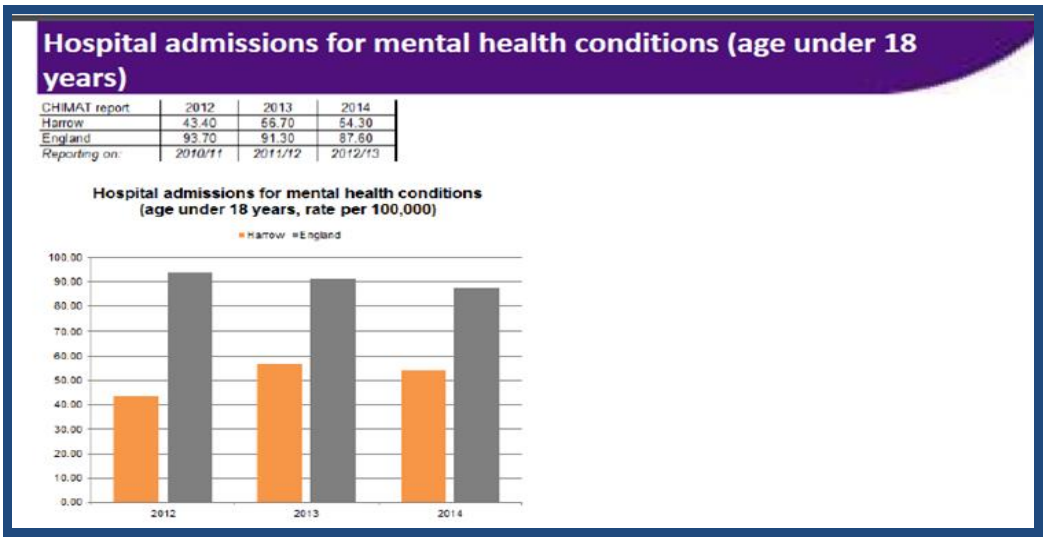
(iii) Young Carers

It is difficult to estimate the number of young carers, although the 2011 Census showed 2,272 self-declared young carers who were under the age of 24 years. Most are not known to social care or receiving support, but an online survey of young cares accessing the Young Carers Project showed that the majority felt they were benefitting from attending project, mostly because of the opportunity it provides for meeting other carers and the activities it provides.

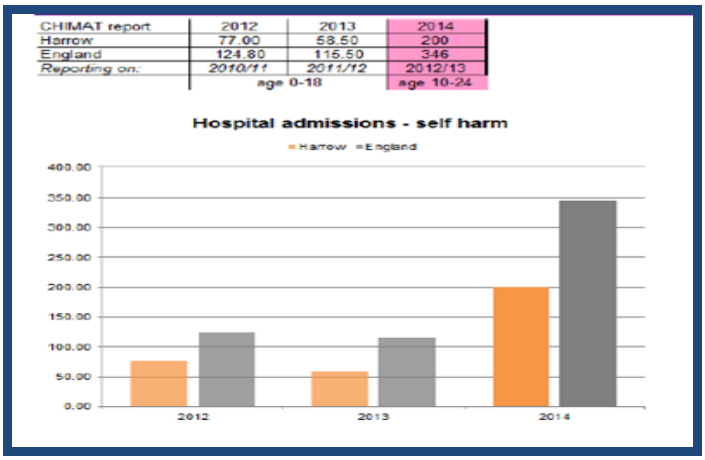
(iv) Child and Adolescent Mental Health

In Harrow, the estimated prevalence of any mental disorder (8.8%) or emotional disorder (3.4%) for children aged 5-16 if lower than the average rates for England (9.6% and 3.7% respectively).

In Harrow, the hospital admissions rates for mental health are lower than the average rates for England. The estimated number of children aged less than 18 years requiring Tier 3 CAMHS services was 1,025 and those requiring Tier 4 CAMHS Services was 45.



Hospital admissions in Harrow for self-harm in young people aged 10-24 are also lower than the average for England.



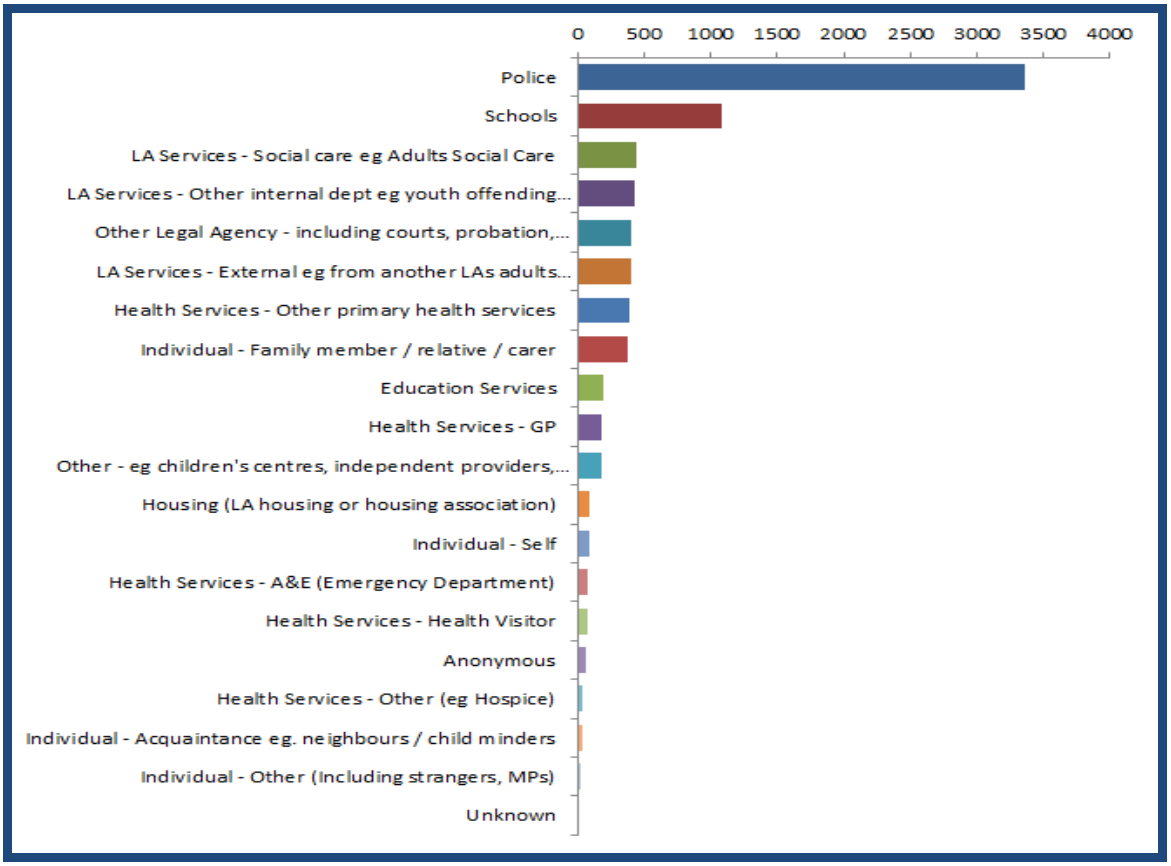
4. PERFORMANCE AND ACTIVITY - What the local data tells us

(i) Contacts in Children's Services

Over 40% of contacts in children's services come from the police, followed by schools at 14% and health services at 10%.

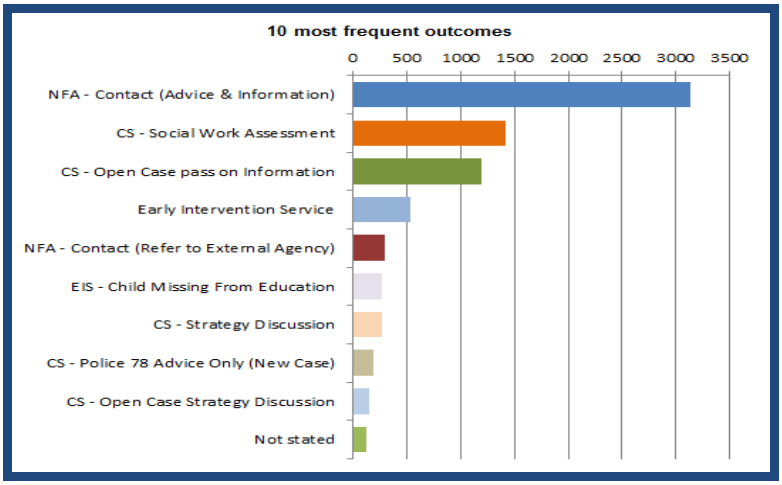
45% of new contacts (Merlins) resulted in no further action by children's services, 18% resulted in a social work assessment; and 7% went to the Early Intervention Service. 17% of 'Merlins' were for existing clients within children's services.

The presenting issues help to identify the kind of pressures placed on children's services to support service planning. Changes were made to this list during the year e.g. possible neglect or abuse has been broken down into the four main categories to give a more accurate reflection of the presenting issues. Child Sexual Exploitation (CSE) was added in the latter part of the year and by the end of the business year children's services had 20 contacts with concerns about CSE. Domestic abuse, neglect and abuse remain the largest reasons for contact, followed by parenting support and challenging behaviour.



(ii) Outcomes

There was increased activity both in the social work teams and Early Intervention Services in 2013-14, but this gradually dropped for social work teams. Early Interventions Services remained slightly higher.

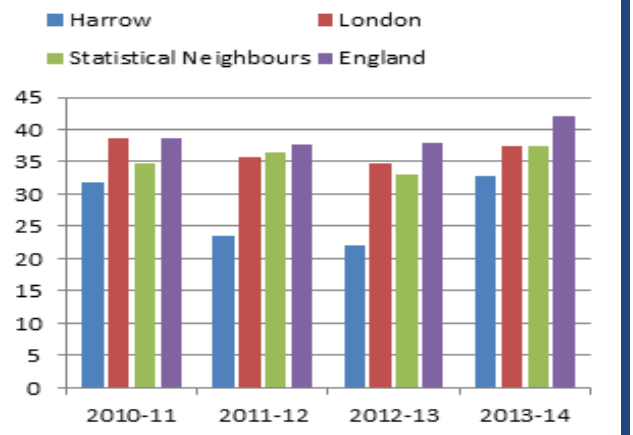


Both the number and rate of section 47 enquiries (the statutory enquiries carried out by the Local Authority to establish whether a child is at risk of significant harm) have continued to fall compared to 2013-14. The MASH (Multi-agency Safeguarding Hub) has now been embedded and it is possible that with the information that is gathered and shared, children are more effectively going straight for assessments rather than becoming the subject of s47 enquiries.

The number of child protection plans rose significantly in the 2013-14 period and for the first quarter of 2014-15. Subsequent quarters have shown a drop in trend with the rate per 10,000 falling from 40 to 32. There was a rise of 13.5% in the overall numbers of children starting a child protection plan in England in 2013-14. As well as the possibility of the rate of abuse and neglect rising, the rise in numbers could be due to changes in the thresholds; increased awareness; and referrals to social care due to the media coverage of high profile cases.

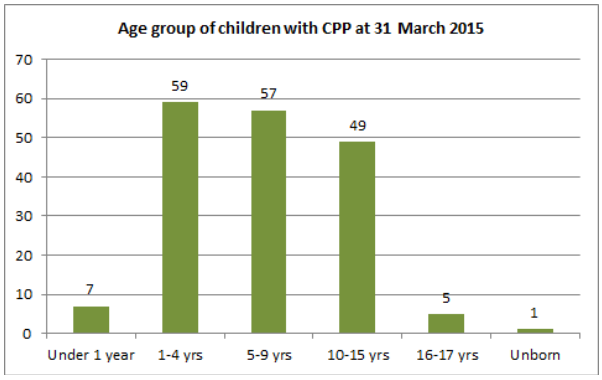
Children who are the subject of a Child Protection Plan, rate per 10,000

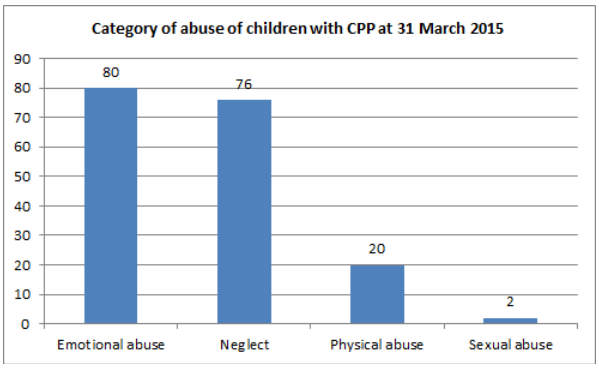
	2010-11	2011-12	2012-13	2013-14
Harrow	32	24	22	33
London	39	36	35	37
Statistical	35	36	33	38
England	39	38	38	42



Updated annually

The highest number of children who required a child protection plan fell in the age group of 1-4 and 5-9. Over 85% of children requiring a child protection plan fell under the categories of emotional abuse and neglect.



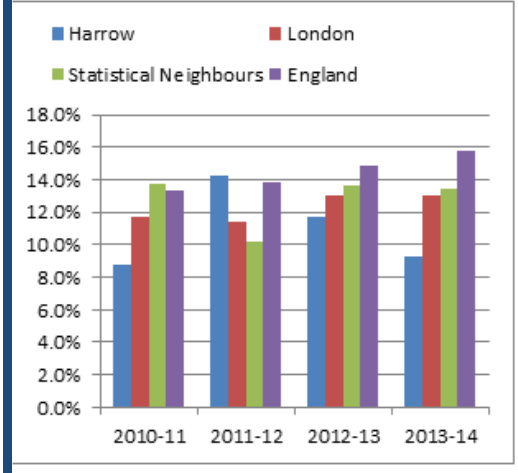


The number of children subject to a child protection plan for two years or more had fallen to zero during the 3rd quarter of the year. This indicates timely progression and resolution of plans.

With regard to children becoming the subject a child protection plan for a second or subsequent time, the figures show an improvement over the last two years. Harrow's year end position was 12.1% (29 out of 239 children); lower than the rate for statistical neighbour and England as a whole.

Children reregistered on the Child Protection Register

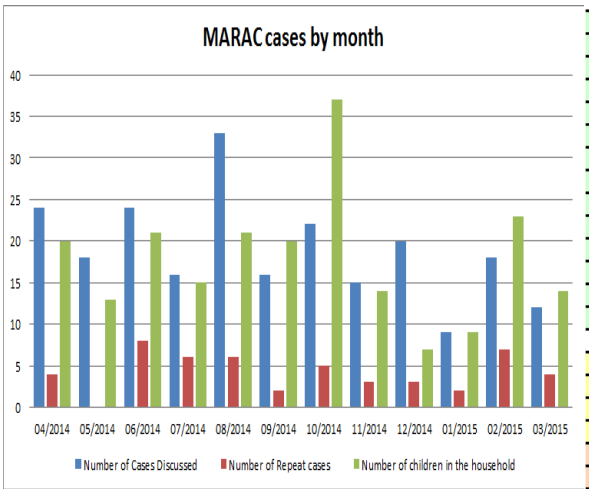
	2010-11	2011-12	2012-13	2013-14
Harrow	8.8%	14.2%	11.7%	9.3%
London	11.7%	11.4%	13.0%	13.0%
Statistical	13.7%	10.2%	13.6%	13.4%
England	13.3%	13.8%	14.9%	15.8%



Updated annually

(iii) MARAC

The number of families discussed at the Multi Agency Risk Assessment Conference (MARAC) varied month on month – ranging from 33 down to 9 cases. The number of children varies because of the varying number of children affected in a household. 48% of the cases discussed at the MARAC belong to minority groups.



Source of Referral to MARAC for 2014-15	
Police	106
IDVA	67
Children's Social Care	8
Primary Care Service	10
Secondary Care/ Acute trust	0
Education	0
Housing	4
Mental Health	0
Probation	1
Voluntary Sector	3
Substance Abuse	8
Adult Social Care	6
MASH	1
Other	13

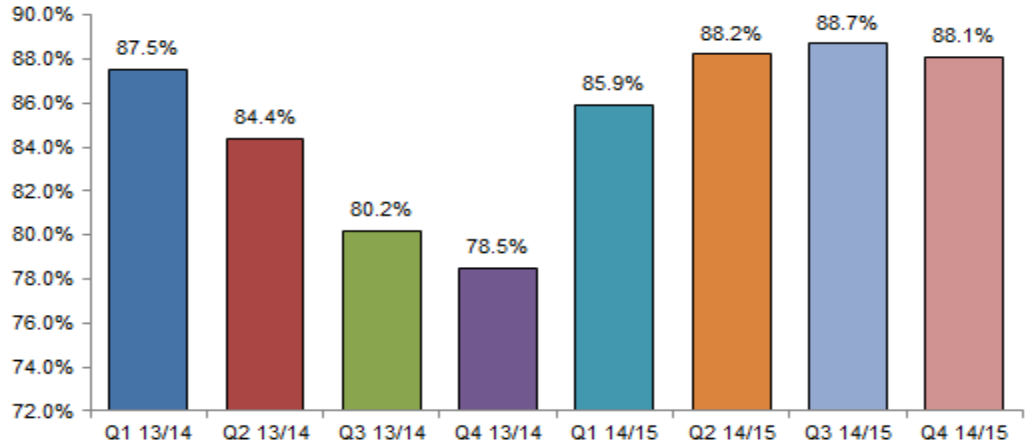
Number of cases from black and minority ethnic	104
Number of LGBT cases	2
Number of cases where victim has a disability	3
Number of male victims	3
Number of victims aged 16-17	2
Number harming others aged 17 or below	0

Data shows an overall stability in referrals, assessments and child protection activity, although there was a drop in activity compared to the previous year. Key measures looking at timeliness of these activities show an improvement.

(iv) Assessments completed by Children's Social Care Services

Timeliness of Assessments, percentage completed within 45 working days, Year to Date

Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15
87.5%	84.4%	80.2%	78.5%	85.9%	88.2%	88.7%	88.1%



Equivalent annual rate per 10,000 (Q1 to Q3 rates have been grossed to give provisional year end position Q4 rate is actual rate)

	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15
Number	578	650	655	490	504	476	456	493
Rate				433	364	354	348	346

Commentary
This indicator measures whether children who are in need are being assessed in a timely manner. From April 2013 Local Authorities have moved to Single Assessments that replace Initial & Core assessments. The new measure looks at the proportion of assessments completed within 45 working days.
Performance has shown continual improvement throughout the year . Performance continues to show a significant improvement from 2013-14 with an improvement of over 10% on timeliness. comparator data on this indicator has not been published because local authorities moved to a single assessment at different points in the year. Our volume of assessments have dropped, 1929 assessments were completed in 2014-15 compared to 2373 in 2013-14

(v) Missing children/young people

Data for children missing from home or care shows that a high proportion of children who go missing are Children 'Looked After'. In 2014-15 there were 98 instances of children being absent without authorisation but whose whereabouts were known, all 98 instances were for

children Looked After. Of the total 354 recorded missing instances, 301 were for Looked After children. There were no children know to have been missing from school.

	2014/15			
	Q1	Q2	Q3	Q4
Number of instances of all children (including CLA) recorded as missing for any length of time - whereabouts known	9	22	86	98
Number of instances of all children (including CLA) recorded as missing for any lenth of time - whereabouts unknown	34	118	285	345
Number of instances of CLA recorded as missing for any lenth of time - whereabouts known	3	19	86	98
Number of instances of CLA recorded as missing for any lenth of time - whereabouts unknown	22	97	255	301
Number of children missing from education at end of quarter	2	see Note 1	0	0

Note 1: will be reported at Q3 due to school break in Summer

Commentary

DfE have published new **statutory guidance on children who run away or go missing from home or care**. From 01/04/2014 data has been collected on **all** instances of children who run away or go missing and reported as missing including those missing less than 24 hours.

The data reported is cumulative over 4 quarters, increased numbers are due to revised processes and training to ensure children missing less than 24 hours are recorded. . The whereabouts of about 22% of children missing were known. e.g. being with people / at places without authorisation and considered to be risky.

About 85% of missing episodes are for Children Looked After. A number of CLA have had several instances of going missing. Robust procedures and joint working is required to ensure safety and reduce instances of going missing. Upon Reurn Police carry out a Safe and well being check, the current arrangements for return interviews are under review.

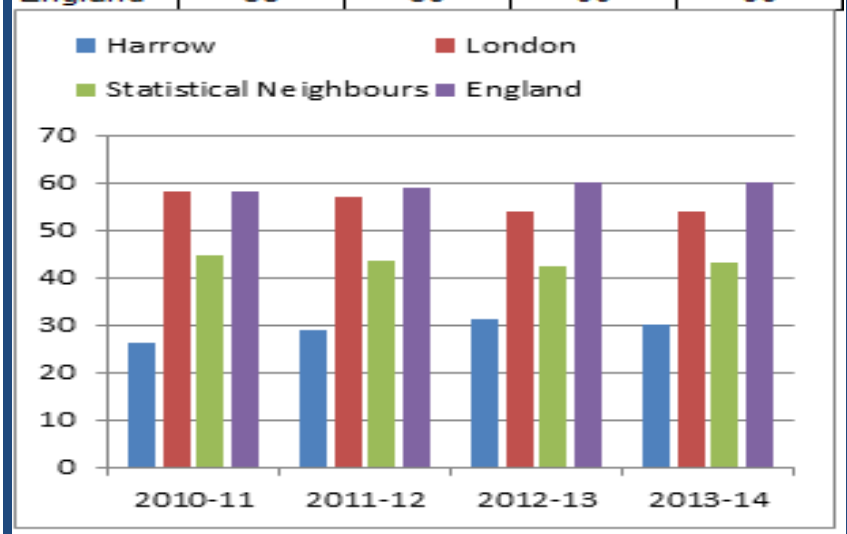
Data has been collected locally and therefore comparator data is not available. The DfE will collect data for instances of Looked After Children going missing.

(vi) Children 'Looked After'

The number of children Looked After had risen since the second quarter of the year, following a period of stability. Harrow continues to have a significantly lower rate of children Looked After than comparators. Harrow's rate of children Looked After is 32 per 10,000. The rise in children subject to child protection plans may in turn lead to a subsequent increase in children being Looked After. There was an overall picture of stability with regard to improvements in health and education plans. Fewer new children Looked After were being placed more than 20 miles from home. Steps continue to be taken to minimise placement changes wherever possible.

Children looked after, rate per 10,000

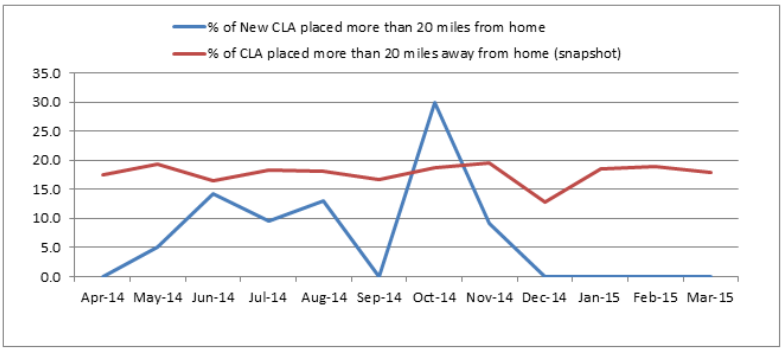
	2010-11	2011-12	2012-13	2013-14
Harrow	26	29	31	30
London	58	57	54	54
Statistical	45	43	43	43
England	58	59	60	60



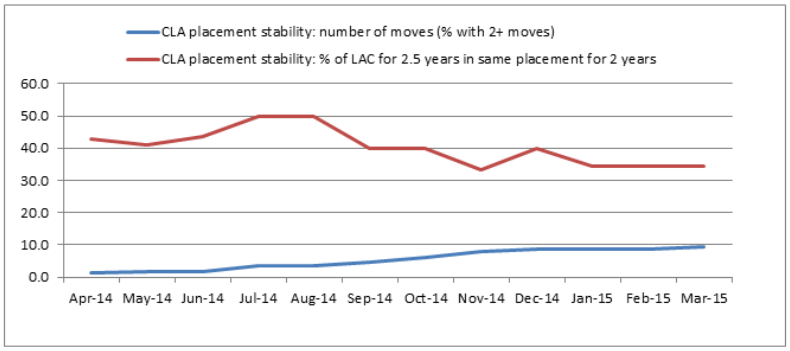
Updated annually

Children Looked After - out of area, and placement stability

	% of New CLA placed more than 20 miles from home	% of CLA placed more than 20 miles away from home (snapshot)
Apr-14	0.0	17.6
May-14	5.0	19.3
Jun-14	14.3	16.4
Jul-14	9.5	18.4
Aug-14	13.0	18.1
Sep-14	0.0	16.7
Oct-14	30.0	18.8
Nov-14	9.1	19.6
Dec-14	0.0	12.9
Jan-15	0.0	18.5
Feb-15	0.0	18.9
Mar-15	0.0	17.9



	CLA placement stability: number of moves (% with 2+ moves)	CLA placement stability: % of LAC for 2.5 years in same placement for 2 years
Apr-14	1.2	42.9
May-14	1.8	40.9
Jun-14	1.8	43.5
Jul-14	3.7	50.0
Aug-14	3.6	50.0
Sep-14	4.8	40.0
Oct-14	6.0	40.0
Nov-14	7.8	33.3
Dec-14	8.6	40.0
Jan-15	8.7	34.5
Feb-15	8.7	34.5
Mar-15	9.5	34.5



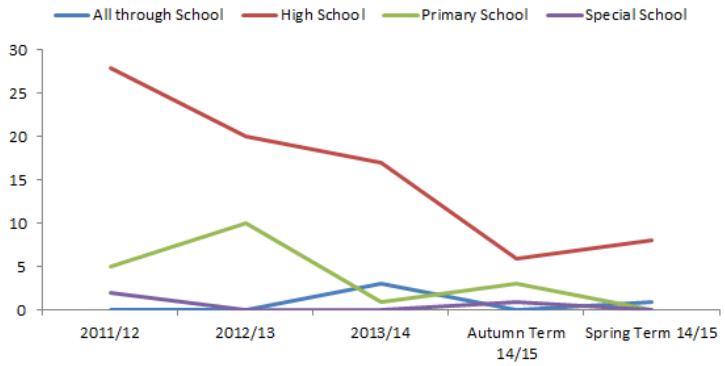
(vii) Education

Harrow has 59 schools. 51% inspected were judged as 'outstanding'; 87% were judged 'good or above'. Of the remainder, 3 were on track to achieve a judgement of 'good' within 6 months and the remainder to achieve 'good' within a year. Almost 60% were judged as outstanding with regard to behaviour and safety.

Exclusions for the last academic year (2013-14) showed a reduction from the previous year, especially in high schools. This trend appears to be continuing for high schools, but 3 exclusions in primary schools and 1 from a special school created an increase compared to the previous year (but remains lower than previous years).

- Permanent Exclusions as % of Harrow School Population

School Type	2011/12		2012/13		2013/14		Autumn Term 14/15		Spring Term 14/15	
All through School	Not reported.				3	0.01%	0	0.00%	1	0.20%
High School	28	0.20%	20	0.16%	17	0.05%	6	0.05%	8	0.07%
Primary School	5	0.03%	10	0.05%	1	0.00%	3	0.01%	0	0.00%
Special School	2	0.54%	0	0.00%	0	0.00%	1	0.25%	0	0.00%



The number of children home schooled was 75 as at March 31st 2015. These children are monitored by an Education Welfare Worker.

The number of young people (16 to 18) not in education, employment or training (NEET) in Harrow, remains one of the lowest in the country.

(viii) Youth Justice

Harrow's latest figure for first time entrants to the Youth Justice System (YOT) represents a slight increase on the previous quarter's data. However, this is lower than the figures for quarter one and two. The YOT comparator data for the last few years shows a decline in the number of first time entrants to the young justice system. This is a trend which is also reflected nationally. Changes in the criminal justice system now put a greater emphasis on keeping young people out of the system by using alternative interventions for those committing minor offences or identified as at risk of offending.

Harrow's most recent re-offending rate of 43.17% accounts for 60 re-offenders from a cohort of 139. While the actual number of re-offending has reduced, the rate as a % of total offenders has increased, indicating the challenges presented by a small 'hard core' of offenders.

Over the past 3 years, Harrow's number of young people in custody has varied from 12 to 21 in any 12 month rolling period. Harrow's custody rate is slightly higher than the England rate, but comparatively lower than the London rate. Offending data for children who are Looked After is being worked on to include for future analysis.

In October 2014 an inspection of the Youth Offending Service in harrow was undertaken by HM Inspectorate of Probation. This was carried out through an examination of 14 cases.

The inspection found a mixed picture with evidence of some good work to reduce reoffending, but also a number of important areas for improvement, which included work to protect the child or young person. The quality of assessments in respect of safeguarding and vulnerability was found to be poor and management oversight of cases ineffective.

Just prior to the inspection there had been a substantial turnover of staff, so inspectors were pleased to find that practitioners were committed, knew their cases well and were keen to improve practice.

In response to the inspection findings, YOT produced an action plan based on HMI Probation and YJB guidance. An immediate audit of a further 14 cases was carried out, which confirmed that the young people were being adequately safeguarded.

The action plan, which includes amongst other developments, monthly observations of practice and an annual audit of supervision, is being monitored by the Youth Justice Board. The HSCB also scrutinised the action plan in January 2015 and has programmed progress reports for both the Quality Assurance Sub-committee and the main HSCB meetings in 2015.

(ix) Workforce

Workforce data shows a high turnover rate for social workers and health visitors. Recruitment of qualified and experienced social workers remains difficult with continuing reliance on agency workers. This is under continuous scrutiny by the HSCB and is a theme in the conversations between the Chair and the Director of Children's Services.

5. HSCB SUB-COMMITTEE ACTIVITY

5.1 SERIOUS CASE REVIEWS/LEARNED LESSONS REVIEWS

This Sub-committee carries out reviews, including the statutory requirement to undertake Serious Case Reviews, on behalf of the HSCB. During the period 2014 to 2015, this sub-committee oversaw and completed one Learned Lessons Review and one Serious Case Review. It also initiated another Serious Case Review which is on-going at the time of this report being written.

The Sub-committee also undertook enquiries and evaluations of single agency matters, where it was felt that lessons of good practice could be identified, as well as areas for improvement.

The overall objective of this Sub-committee is to extract learning points, through proportionate review methods so that they can be disseminate across all partner agencies via the activities of the Learning and Development Sub-committee.

(i) Learned Lessons Review: 'Family E'

Reviews are often carried out by the HSCB when a case does not meet the criteria for conducting a Serious Case Review, but nevertheless it is felt that lessons could be learned to help strengthen local practice. They are referred to in Harrow as Learned Lessons Reviews. This particular Learned Lessons Review was carried out by an independent reviewer to ensure that our scrutiny was robust.

The case involved a large family where long-term neglect was a key feature and many professionals had contact with the family over several years.

The review confirmed the importance of early intervention and the need for a 'team around the family' approach in our work with children and families. There were other key learning points which related to the importance of considering connections between child and animal cruelty and neglect; working with resistant families; and considering all siblings when undertaking assessments.

To assist the learning process, a film was created to replicate the key learning points from this review and present it in a more memorable form, which focusses on how a child might tell their story. A cartoonist was commissioned to then express the story visually.

Children with experience of acting were recruited from a local school. This followed discussion with them and their parents about what their engagement would involve. They had a chance to look at the script and make changes to it so it sounded more natural.

The Film has been cascaded across local services and embedded into local training for both neglect and to reinforce our Early Intervention approach.

Feedback from the film has been very positive. It was initially on You-Tube and viewed over 1,500 times. LSCBs from across the country have also been making use of our film and have used it in conferences, meetings and training. The NSPCC has also cascaded the film widely and it is still available on their website.

(ii) Serious Case Review: 'Child R'

The HSCB completed and published a Serious Case Review which related to the tragic death of a seventeen year old young man who had been 'Looked After' for several years. This review also involved a wide range of local services as well as a number of agencies from across the country. The young man came with his family to this country from Eastern Europe when he was a young boy. The cultural and language aspects of working with families new to this country became an important factor in this review.

Two independent reviewers were commissioned to lead the work and produce the final report. A hybrid model was used to conduct the review, which incorporated elements of the SCIE (Social Care Institute for Excellence) model and more traditional methods. One of the key objectives was to ensure that the views and perceptions of front line staff were obtained and considered for the review. Consequently, this process involved a high number of face to face interviews with staff. Another objective was to engage the family and where possible extract the views of the young person himself from previous recordings and recollections. Letters written by the young person informed the review and his mother contributed generously to our understanding through her account and perceptions of the agencies' involvement.

The challenges of working with young people with complex needs, including substance misuse, mental health and offending behaviour were evident throughout this review. Messages from other reviews and the findings of research commissioned by the Association of Directors of Children's Services in 2014: *'That difficult age: developing a more effective response to risks in adolescence'*, confirmed the difficulty of finding appropriate placements for young people with complex needs, and the consequences of often having to place young people in establishments some distance from their home area to receive appropriate care. Such placements often isolate the young person from their local connections and present a range of obstacles for continuity of care for the 'home area' agencies involved.

These messages were consistent for our own Serious Case Review, but there were related findings that exposed particular weaknesses in the arrangements for both health and educational continuity of care. For all services there was a tendency for planning to be fairly limited to a crisis response, at the expense of keeping a focus on longer term planning.

The need for staff across all agencies to be more proactive in understanding the impact of cultural change on families new to this country was evident, particularly where a distrust of authorities might be brought with them from their homeland experiences.

Since publishing this Serious Case Review, the HSCB has been active in disseminating the lessons identified across both individual and multi-agency briefing events.

At the time of this annual report being written, significant developments have taken place in the arrangements to support children 'Looked After' through a new Children Looked After Health Assessment Team being commissioned and a Virtual School Improvement Plan being implemented. Both new arrangements will ensure more robust systems for oversight and a focus on longer term considerations of the needs for each child.

(iii) On-going Serious Case Review: Child F

In September 2014 the HSCB instigated another Serious Case Review following the tragic death of an 11 month old child. A similar model for the review has been applied to that of the review for Child R. It is anticipated that the learning from this review will be published in

autumn 2015, however, the early findings have been used to create an initial action plan, ensuring that the necessary changes can be implemented.

(iv) Individual Agency Management Reviews

As well as undertaking full multi-agency reviews, the Serious Case Review Sub-committee also requests single agency enquiries where concerns have arisen about local practice and lessons can be drawn or changes made from analysing the circumstances. During the period 2014 to 2015, the Sub-committee conducted a number of these analyses.

The span of the Sub-committee has extended to working with more unusual stakeholders, e.g. a funeral parlour and the Registrar of Births, Marriages and Deaths. The broader reach emphasised the importance of the existing priority of the Board that safeguarding is every sector's business – and good practice in this respect was found in some of the cases analysed.

Good practice was identified in the support set up within a school following the sudden and unexpected death of a student.

Areas for development were identified through a joint review with a neighbouring LSCB, which resulted in the strengthening of joint working protocols with a local hospital. In another example, learning from a case where a child with special needs went missing whilst on an organised trip, has led to the tightening up of risk assessments and contingency planning.

(v) Monitoring the Implementation of Action Plans

A key aspect of undertaking these reviews is ensuring that the learning resulting from them makes a positive difference to practice. This Sub-committee ensures that in the first place, the recommendations made are translated into appropriate action plans and that their implementation is monitored through to completion. In the latter part of the business year, the Sub-committee put considerable time into ensuring that any outstanding actions for the previous 2 years have been completed satisfactorily. This activity plays an important part in feeding into the HSCB's Learning and Development Framework which then establishes through audits and other forms of feedback whether the learning has made a measurable difference for children and young people in Harrow.

OUTCOMES/IMPACT

- Good practice was found in schools responding to bereavement – supporting pupils and staff
- The reach of individual management reviews extended to the business sector, thereby helping to embed safeguarding messages to a broader community
- The HSCB's Learned Lessons Review strengthened a shared understanding of the link between animal and child abuse – and safeguarding children training has been embedded into local RSPCA training
- A powerful DVD learning tool was created following the Learned Lessons Review – focussing on the perspective of the children. This has received excellent feedback

both locally and across the country as an effective training tool for understanding the impact of neglect on children:

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- The learning from Serious Case Review: Child R provided a strong steer for the development of the new Children Looked After Health Assessment Team, set up to strengthen health assessments and ensure continuity in planning for each child
- The same review also provided a strong steer for the improvement plan for the Virtual School, strengthening oversight of assessments and longer term planning
- The HSCB's Case Review Sub Committee undertook a review of the progress of action plans relating to Serious Case Reviews and Learned Lessons Reviews undertaken in the past two years – to challenge any slippage and identify any repeated learning

5.2 QUALITY ASSURANCE

(i) Section 11 Audits

All LSCB member agencies are required to ensure that their safeguarding arrangements are consistent with the requirements laid out in Government Guidance: Working Together to Safeguard Children, which specifically refers to the measures described under section 11 of the Children Act 2004 and sections 157 and 175 of the Education Act 2002.

Most LSCBs carry out a support and challenge exercise through a 'section 11 audit' undertaken across all member agencies and extend these same standards to guide relevant providers in the private and voluntary sector. These are extensive, but valuable pieces of work that offer some assurances to LSCBs about the effectiveness of arrangements in their own areas or help identify where more work needs to take place. These tend to be undertaken bi-annually and a full s11 auditing process was not undertaken in the business year 2013-14. In this last business year however, the HSCB has undertaken a complete review of its section 11 auditing process and has introduced a number of changes to ensure greater reach and reliability to the process. At the time of writing this report the following changes have been embedded:

OUTCOMES/IMPACT

- The s11 tool has been updated, aligned with the Pan London model; and most importantly it seeks to gain evidence of the impact of agencies' arrangements.
- To promote efficiencies for member agencies, the HSCB has joined with one of its neighbouring boroughs, Brent to undertaken joint s11 audits where agencies provide services that overlap both boroughs. This will save these agencies having to repeat the support and challenge part of the process.

- The support and challenge interviews with Board representatives take place in the form of scrutiny interviews being carried out by a panel made up by the Chair of the HSCB, Business Manager; and a minimum of two representatives from the Quality Assurance Sub-committee. This method of interviewing ensures that member agencies take collective responsibility for scrutinising each other.

- Previous s11 equivalent audits with schools have generally received a very poor response. A review of the audit tool which had been used for schools revealed that it was too ambitious in that it went far beyond the remit of statutory guidance. This understandably caused confusion about the responsibilities of the HSCB, and made the tool unnecessarily lengthy. The HSCB listened to the concerns expressed and has revised the tool in cooperation with Harrow's School Improvement Partnership. The new audit for schools is scheduled to be implemented in autumn 2015...

(ii) Multi-agency Case Audits

The Quality Assurance Sub-committee carries out multi-agency case audits, selected randomly, but with the intention of capturing the quality of support and intervention across the different levels of our local thresholds i.e. from Early Help to statutory intervention including Children in Need, Child Protection. Cases selected also include children Looked After and Children with Disabilities.

In June 2014 and in October 2014 multi-agency safeguarding audits were undertaken of 10 cases each. The methodology included review of case files, compilation of findings into a standard review template; interviews with practitioners; and examination of the findings through a scrutiny panel.

Findings from the Multi-agency Case Audit - June 2014 audit

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Identified key strengths/progress:

- **Stronger sense of multi-agency working:** Practitioners and auditors evidenced strong communication on a number of cases which included cases involving concerns of Forced Marriage; pre and post-birth liaison. There was also evidence of contributions to legal proceedings, health care assessments which contributed to good management of risk and timely outcomes for the child e.g. excellent progress for adoption.
- **Good assessment work:** Sound multi-agency assessments were found in child protection plans; and good single agency assessments were found for maternity, health visiting, paediatric, school nursing, Early Intervention Services and CAHMS. These led to clear decision making for the children e.g. clarity around the need for legal proceedings.
- **Voice of the child:** Previous audits have identified the need for practitioners to identify and understand the voice of the child, particularly for non-verbal children. This audit evidenced good progress across a good range of agencies.
- **Good managerial oversight:** Evidence of improvements in managerial oversight was evidenced in cases involving the use of Police Powers of Protection, sexual exploitation and Forced Marriage.

Identified key areas for development:

- **Regularity of visits to children/families:** It was not clear whether visits were taking place regularly or that the visits were not always adequately recorded. This was an issue for management oversight.
- **Communication:** From some cases it was evident that more challenge was required to ensure that relevant information was shared in a timely manner.
- **Diversity:** Variable practice was identified in obtaining information on matters relating to diversity and in analysing any implications from this.
- **'Step-down' arrangements:** the audit found a need to strengthen and clarify the arrangements for when a child moves from a protection plan to a Child in Need Plan or after a Supervision Order has ended.

Findings from the Multi-agency Case Audit - October 2014 Audit

Identified key strengths/progress:

- **Systems:** There were good examples of practitioners understanding information sharing protocols and timely sharing of relevant information between social care, adult mental health services, police and substance misuse services. Particular improvements had been noted with the application of pre-birth procedures bringing about timely interventions.
- **Thresholds:** The majority of cases evidenced a good application of thresholds across agencies, with timely responses to child protection concerns; cases showed a prompt response within universal and early help services to step up to Child in Need and Child protection when appropriate; there was also strong evidence of identifying the need for additional services when required and for securing these services – these actions supporting the early help approach
- **Assessments:** There was evidence of good engagement with parents and efforts to reach fathers not in the household; where there was resistance from parents, agencies worked together effectively through joint visiting to help facilitate access and assessments. There was good evidence of chronologies from health and education being used to inform and update assessments; Adult mental health and substance misuse services were active in providing assessments to support risk assessments undertaken by social care; and the quality of specialist assessments from SALT and other therapists were timely and crucial in achieving a rounded picture of the child and his/her needs.
- **Information Sharing:** Evidence of early identification and referral of domestic abuse from health practitioners was found, as well as timely liaison between Compass workers and social workers, which ensured that assessments were well informed and kept up to date. Schools too showed a timely showed timely sharing of concerns as well as liaison for initiating early help and therapeutic services.
- **Child focus:** there was strong evidence that older children in particular were being seen, and being documented as being seen alone by both social workers and CAHMS workers. For younger children there was evidence of some improvements in capturing observations of non-verbal children by social care, schools, therapy services and mental health. Effective advocacy was found in achieving culturally matched placements and evidence of appropriate involvement of interpreters. The work of Speech and Language Therapists was clearly managed in accordance with the child's pace and needs.
  There were cases where agencies had been persistent and tenacious in their attempts to engage with young people who were sometimes hard to engage. Social care and schools were determined to follow through on agreed plans rather than to start from scratch again with every new placement/school – thereby building in continuity for the child and keeping a focus on relevant timescales for progress of the

child; Creative work was identified by Mental Health Services, where previous attempts had not worked for a young person.
In one case, the young person requested a change of social worker and the manager responded by initiating an exploration in to why this was, indicating that the young person's voice was heard and taken seriously.

- **Supervision / Management oversight:** The audit found that unscheduled supervision and management advice was regularly sought and provided appropriately across a range of agencies. There was also evidence of regular management of regular management oversight and escalation where cases had been highlighted for concern.

Identified key areas for development:

- **Systems:** No clear systems were in place to ensure the transfer information about children previously excluded from school to a new out of area provider; IT systems obstructing the entry of information relating to diversity into health visitor records; lack of 'flagging' system in place for health professionals for mothers who have previously had children with child protection plans
- **Thresholds:** in one case, non-engagement with mental health services by a young person led to the case being closed without contingency arrangements being discussed with other agencies.
- **Assessments:** chronologies were not always up to date in social care records – the required regularity for updating chronologies appeared to vary between teams. In some s47 enquiries, social care did not always contact key partners for information - and in some cases where they did communicate, they did not always make it clear that the communication was in the context of a s47 enquiry. The need to take children's needs for access into account when placing a parent into mental health care
- **Information Sharing:** the administration for inviting key practitioners to meetings and the circulation of minutes following meetings was a theme requiring further attention. Shortfalls in these arrangements caused delays in engaging the right people and actions. In addition, some agencies awaiting information were not sufficiently challenging in addressing concerns about the impact of these delays.
- **Child focus:** Whilst some health IT systems obstructed appropriate entry regarding ethnicity, there was some indication in social care recording of a lack of understanding of its importance by practitioners e.g. entries of 'not applicable' for white British children or not entering information that a child came from a traveller community.
- **Supervision / Management oversight:** in one case, social care had not met the required visiting schedule and this was not picked up by managers. Good intervention and challenge by the Independent Reviewing Officer Service addressed the concern.

OUTCOMES/IMPACT

- Improvements evidenced through repeated multi-agency audits:
- Evidence that improvements had taken place following the previous audit with regard to appropriate application of information sharing protocol
- A Mental Health Liaison post had been set up to advise social care within the Children in Need Team and this has strengthened communication and working relationships further

- Embedding of a clear understanding of pre-birth procedures which was evidenced through timely interventions and assessments
- A better understanding and application of thresholds by agencies were evidenced in the second audit – with clear efforts to secure additional services to support an early help approach where appropriate
- Evidence of effective challenge by the IRO service with regard to the timeliness of visits, producing improved outcomes for children Looked After
- Appropriate engagement of interpreters "This enabled the young person to benefit from the services and find non-harmful ways of dealing with risks".
- The work of Speech and Language Therapists was clearly managed in accordance with the child's pace and needs. " the success of the intervention moved the child from being very introverted to a position where the child showed much increased self-esteem"
- There were cases where agencies had been persistent and tenacious in their attempts to engage with young people who were sometimes hard to engage.

5.3 LEARNING AND DEVELOPMENT

The main objective of the Learning and Development Sub-committee has been to support the HSCB's Learning and Improvement framework, so that multi-disciplinary learning encourages effective working relationships to promote improved outcomes for children. This means that our focus remains on identifying improvements in the child's journey from 'needing to receiving' help.

2013 to 2014 was another busy year for the HSCB's training programme. Sixty multi-agency training sessions were run, in addition to designated teacher events. The training sessions attracted 1,240 practitioners; almost a 10% increase on the previous year, with an increase in attendance from the voluntary and faith sectors.

In addition to our Working Together and specialist courses, the HSCB has introduced new courses in response to local learning. These include 1. Race, culture, faith and diversity – its impact on safeguarding children effectively; 2. Peer on peer domestic violence and sexual violence; 3. Child sexual exploitation; and Neglected youth – part 2.

The HSCB also made good use of external expertise to boost local learning and the following courses proved very popular across the partnership: Forced Marriage and Honour Based Violence; Harmful Cultural Practices; Multi-agency Critical Incident Exercise (run jointly with our neighbouring borough Brent to achieve efficiencies); and Working with Victims of Sexual Violence.

Another key mechanism for helping to embed learning is our annual conference. This year, the focus was on Safeguarding Children to enhance their Emotional Wellbeing – for now and their future.

The theme of Emotional Wellbeing was chosen to support practitioners working with children and young people who need to build resilience in their lives to prevent the impact of emotional abuse. This key theme followed on from the conference of neglect where emotional abuse was seen as impacting on so many children and young people's lives when they had been neglected.

The key note speech by Roger Catchpole from Young Minds focussed on 'Attachment: a cornerstone of good mental health'. This was followed by discussion about how local practitioners influence the support and development of children and young people's emotional resilience in Harrow. Workshops then took places that were led by local specialists. These included;

- Early Help Assessment and TAF
- Learning from Harrow's Case Reviews
- Tackling Bullying: Virtual and Face-to-Face
- Services in Harrow to Support Children's Emotional Wellbeing
- Young Carers – Hidden and Found: Impact on Emotional Wellbeing
- How resilience can help to keep children safe

The Theatre Company, Alto Ego presented a powerful drama 'Chelsea's Choice', that they use in schools across the country to highlight the issues of child sexual exploitation. This stimulated good discussion about local provision. The HSCB's CSE strategy includes the commissioning of this performance for schools in Harrow. We had a key note speaker, Jo Harm from Ignite; it continued into the afternoon where we were looking at how we can practically build resilience in children led by a local practitioner from a local charity, the Ignite Trust.

To help embed the learning gained from the conference, all delegates were asked them to write down 3 things that they would take away from the conference to make a different to their own and their team's practice. This was reviewed three months later to see how well the learning was embedded or whether there were any obstacles that needed to be addressed.

OUTCOMES/IMPACT

- Feedback from practitioners on the impact on the conference:
- Understanding the whole child and where they have come from: I have followed this up by being quite direct with parents about their responsibilities
- I have made use of the Early Intervention Service
- I have worked with two families since the conference where I could have just focussed on the needs of the younger children, but since being made aware of issues for older young people from the conference, I have engaged with the older siblings too and helped them access specialist support
- The conference raised my awareness of CSE and I since completed a CSE assessment form for one of my cases
- I am now aware of the danger of being over optimistic and using terms like 'the child is resilient' as this can deflect focus away from the child toward the parent's needs. I am trying to ensure that social workers prove a rationale when using this statement.
- Following on from the conference I was allocated a case concerning a young girl who was at risk of CSE. I was able to use some of the information regarding 'beyond the surface' questioning which was helpful in being able to identify the level of risk she was exposed to. As a result I was able to work with the young person to build her resilience and identify what level of support she required.
- Building resilience: I am using the breathing techniques – and have shared these with clients and in my groups.

- Calming technique: I am working with staff and children to encourage calming techniques in class at various intervals to help children feel safe at school and build trusting relationships. In a recent Inset I shared the knowledge and staff seemed quite positive.
- Think child, think family: I have attended the Early Help Surgery and was able to discuss a case. I have used the Family Information database and referred to the Early Intervention Service
- I networked with several agencies at the conference – inviting two to attend our team meeting to share information. Once has already attended, creating a greater awareness of mental health service available to our clients.
- I have sent the E-safety information from the HSCB website and have shared it with parents that I am working with.
- The sexual exploitation information and links to technology use have enabled me to create a tutorial strategy at the college and to ensure safeguarding and CSE are included in a variety of activities – to make it ok to discuss and to develop knowledge and understanding for both students and staff
- Linking the missing children interviews with CSE – I have built CSE into reviewing the commissioning arrangements for children going missing.

5.4 CHILD SEXUAL EXPLOITATION (CSE) – WITHIN THE CONTEXT OF MULTIPLE VULNERABILITIES FOR YOUNG PEOPLE

Following the learning from the Rotherham Report and Ofsted's Thematic Inspection of Child Sexual Exploitation, it was agreed in Harrow that the strategic lead for addressing this growing concern should transfer from the Safer Harrow Partnership to the HSCB. This change brought about a new surge of energy across the partnership.

In November 2014, the HSCB revised its CSE strategy to reflect the nationally emerging themes and lessons and to ensure that the general lower crime rates in Harrow did not create any complacency with regard to identifying and addressing this vheinous crime.

At the same time a peer review was carried out with the London Boroughs of Enfield and Hounslow to evaluate the effectiveness of our existing arrangements and to identify any areas for development. The review findings with regard to strategic recommendations were reassuringly anticipated and reflected in our new strategy. The following developments have since taken place:

Collaboration with the Local Authority's CSE Co-ordinator

In response to the findings of the Peer Review into CSE, the Local Authority was swift in appointing a CSE Co-ordinator. This role has strengthened the quality of screening and risk assessing children and young people at risk of CSE for consideration within MASE (Multi Agency Sexual Exploitation Panel) established in July 2014. The Co-ordinator also acts as an important link with the HSCB's CSE Sub-committee, so that it is regularly informed of any significant issues or patterns across Harrow or cross border matters.

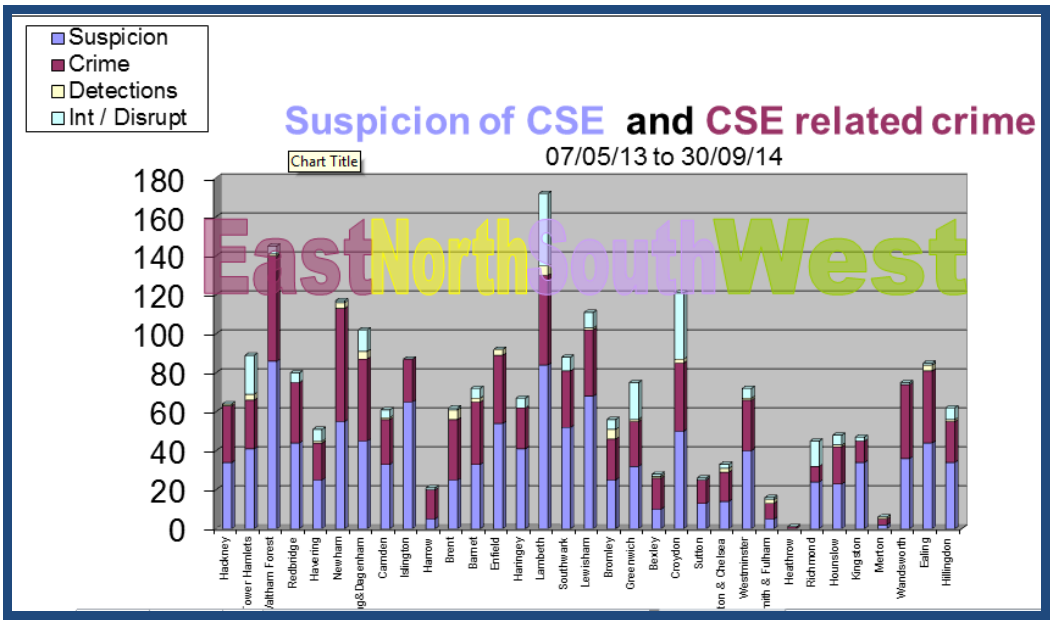
The HSCB set up a dedicated CSE Sub-committee to steer the multi-agency work plan. A strong commitment across the partnership, including the voluntary sector was evidenced by speedy sign up for membership

Two main streams of work were arranged:

(i) To map the scope the nature and scale of CSE and to evaluate the effectiveness of the multi-agency response;

- All providers have identified services that either provide a dedicated CSE service e.g. the WISH voluntary service for vulnerable young people, or those that incorporate a response to CSE via another provision e.g. drug and alcohol services; sexual health services; responding to Gangs Panel. A wide range of resources have been identified, but the on-going challenge is to set up information systems so that this important activity can be extracted and reliably measured, both qualitative and quantitively. There have been encouraging developments in this respect, where previously anecdotally based information is being replaced with stronger evidenced based data and collated intelligence.
- The HSCB monitors its notifications; level of disruption activity, and criminal processes (including conviction) through the data collated bi-annually by the Metropolitan Police. This also allows the HSCB to evaluate how Harrow compares with its neighbours and across London generally.

Whilst the figures remain comparatively low in Harrow, this needs to be considered in the context of other low crime figures. This does not mean that the HSCB and its member agencies can take their "foot off the pedal" with regard to the preventative and responsive action put in place; but it does mean that we must continue to robustly scrutinise the reliability of our data and ensure that CSE does not escalate in Harrow in the way that it has elsewhere across the country. At the time of writing this report, it is known that figures for CSE reporting and escalation to criminal investigation are slowly increasing in Harrow, which may reflect the new surge of raising awareness activity across the partnership.



- The HSCB scrutinises CSE within the wider context of data and intelligence drawn from other risks (known or potentially) faced by children and young people in Harrow. Rather than artificially compartmentalise these risks, the HSCB has tried to view how they might interrelate in Harrow. Consequently, the HSCB's CSE Sub-committee also receives data and intelligence on gang activity; trafficking; and missing children.

Local statistics show that the highest number of children and young people who go missing in Harrow are children Looked After. The known link between missing children and CSE is well established across the country. Consequently, the HSCB's focus on safeguarding for children Looked After remains a high priority. The number of children affected by trafficking is not known in Harrow. Figures from the Metropolitan Police indicate that Harrow does not present as an area of concern in London, but again, links with CSE, particularly where children are moved across boundaries will potentially fall into the category of intra-country trafficking. Until we build up a more reliable picture of trafficking across London, agencies must remain vigilant and always consider the relationship between trafficking, missing children and CSE.

(ii) To raise awareness for practitioners; children/young people; their families; and local communities

OUTCOMES/IMPACT

- All key member agencies as well a wide range of services within the voluntary sector have identified CSE Champions to act as a conduit for key information and to help embed training
- The existing HSCB CSE training was refreshed and an additional on-line training course was commissioned to ensure that our training reached the widest possible audience. The reach of the training is monitored on a monthly basis by the HSCB. At the time of this report being written, it is known that a wide range of practitioners are accessing this training.
- Tailored CSE briefing events have been led by the HSCB for health visitors; hospital staff; community groups; and business communities
- Using 'Operation Makesafe' materials (a Metropolitan Police initiative) and with the support of our local licensing body, the HSCB has delivered briefings to pubs and clubs via a 'PubWatch' event and through mailshots to all local hotels and bed and breakfast establishments.
- Using the HSCB commissioned training arm through Voluntary Action Harrow and Ealing Community and Voluntary Service, the HSCB extends its reach to some of the more remote voluntary and community sector groups. The success of their reach has brought about a new and dedicated arrangement to deliver bespoke CSE training.
- Using the local media, the HSCB promoted the national CSE Awareness Day in February 2015, directing practitioners and the public to local guidance and support.

5.5 CHILD DEATH OVERVIEW PANEL

The Child Death Overview Panel (CDOP) is an inter-agency forum that meets regularly to review the deaths of all children normally resident in Harrow. It acts as a sub-group of the Local Safeguarding Children's Board. The CDOP is accountable to the LSCB. During the review process, the CDOP may identify issues that need to be addressed such as:

- any cases requiring a Serious Case Review;
- any matters of concern affecting the safety and welfare of children and;
- any wider public health or safety concerns arising from a particular death or from a pattern of deaths in the area; a specific recommendation would be made to the LSCB.

The Panel held 3 meetings during 2014 in which 13 cases were discussed compared to 19 cases in 2013.

Child death is a very sensitive issue of crucial importance. The panel is committed to learning from every such incident and where possible, identify preventable factors and to inform action that can be taken to reduce the number of child deaths in the future. Within this report, we have identified some of the learning from those cases reviewed in 2014 and the subsequent steps that we have taken.

It is understandably difficult to find appropriate ways to seek the views of families about the support they receive after their child has died. However, parents are informed when their child's death is about to be reviewed, and are encouraged to contact the Chair of the panel, Dr Andrew Howe. In response, Dr Howe has spoken to or had contact with a number of bereaved families following panel meetings.

It is important to recognise and should be noted that as the number of child deaths is small, it is difficult to compare any conclusions with other National data.

Role and Function of CDOP

The Harrow Child Death Overview Panel (CDOP) has the responsibility to review all deaths in children up to the age of 18 years who were resident in the Borough at the time of their death or in the case of a neonate, whose parents lived in Harrow.

The key principles underlying the overview of all child deaths are:

- Every child's death is a tragedy
- Learning lessons to prevent future child deaths
- A joint agency approach
- To make recommendations to the LSCB so that positive action to safeguard and promote the welfare of children can be taken.

Child death review processes became mandatory in April 2008 and it is the responsibility of the multi- agency CDOP to review the cases of all child deaths to identify potentially preventable deaths. This report presents, at an aggregate level, an analysis of the information and summarises the actions taken over the last year.

The panel is formed of the multi-agency professionals from Harrow that are committed to safeguarding children.

Facts and Figures 2013 - 2014

During the year 2014 there were 3 CDOP meetings. The attendance of core members since the Panel's inception has been high. Panel members are expected to attend at least three out of every four meetings with the exception of the Designated Doctor Child Deaths who is expected to attend all meetings.

Commentary on cases reviewed

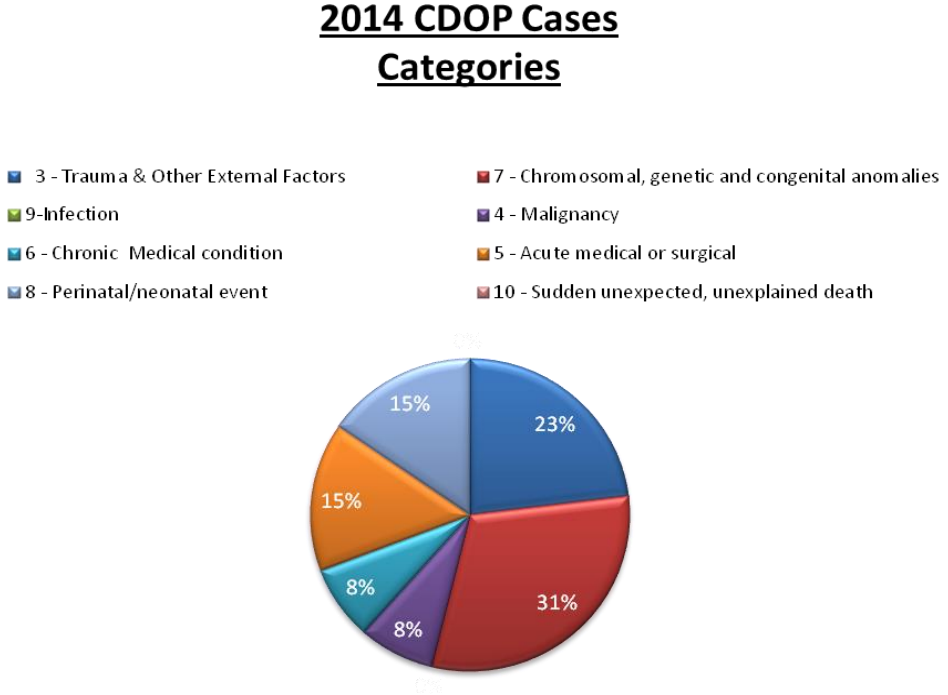
A total of 13 cases were reviewed in the period 1st January- 31st December. Due to the low numbers involved, it is difficult to complete any trend analysis. However we should continue to act as advocate for families to improve the health and wellbeing for infant and maternal health.

Gender

Overall, the CDOP figures for deaths in 2014 were 62% male and 38% female children. National statistics suggests that there are more deaths in boys than girls during the perinatal period, which is consistent with the 2013 data.

Cause of Death

The causes of death are shown in the table below. Chromosomal and genetic anomalies, perinatal and neonatal events, and trauma (Road Traffic Accident) / other external factors predominate.



Source: CDOP database 2014
Nationally, it has been shown that the two most common causes of perinatal deaths are perinatal/neonatal events due to prematurity and congenital malformations.

Ethnicity
Ethnicity is not recorded on death certificates therefore it is not possible to compare this information with the total number of deaths occurring in children. It is not possible to ascertain whether the numbers of child deaths is truly disproportionately higher in children from BME backgrounds. The largest cohort of child deaths in 2014 is equally split amongst White – British and Asian – Indian, both at 25%.

SUDIs – Sudden Unexpected Death of Infants
During 2014, none of the deaths were categorised as sudden unexplained infant death. Due to the low numbers involved, it is difficult to complete any trend analysis. There were no SUDIs in Harrow in 2014 or indeed in the previous 3 years.

Unexpected deaths
An unexpected death of a child is defined as death that was not anticipated as a significant possibility 24 hours prior to the occurrence.
In 2014 there were 4 unexpected deaths and 3 Rapid Response meetings were held

Preventability of death
From 1st April 2010, CDOPs were asked to identify whether or not there were 'modifiable factors' in a death. However, there are difficulties in distinguishing between these categories, i.e. of factors which definitely contributed to the death and of factors which may have contributed to the death, and ensuring a nationally consistent approach. These are factors, which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths. There were believed to have been 3 modifiable deaths in 2014. Due to the relatively small numbers of child deaths in Harrow, further information related to individual cases cannot be made available.

Number of deaths by quarter (Q1-4)

There is no consistent pattern observed in the number of deaths reviewed compared to the number of deaths occurring each quarter.

Lessons Learned

It is important to note that due to the low number of deaths, this makes it particularly difficult to provide an accurate statistical interpretation or trend analysis over a short period of time. Therefore any attempts to identify trends and patterns on an annual basis are limited.
All unexpected deaths were managed appropriately using the Rapid Response process.

When a child is born if they take any breath it is classified as a live birth irrespective of viability. Thus a 20 week foetus that breathes will be classed as a live birth even though they are not viable with life (less than 24 weeks gestation).

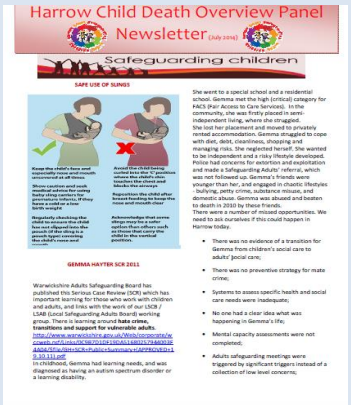
Infant deaths are the highest proportion of all child deaths, therefore measures to improve the health of pregnant women, reducing smoking and improving childcare practices to reduce the risk factors for sudden and unexpected infant deaths will have most effective impact on decreasing mortality.

The members of CDOP are committed to safeguarding children and learning lessons from previous child deaths in Harrow. From the 13 cases that were reviewed by the panel in 2014, the panel are awaiting the outcome of two Serious Case Reviews which will determine future learning. In October 2014 we held our first joint learning lessons meeting with Brent. The topics discussed were positional asphyxia, problems gaining information when a child dies abroad and the inhalation of foreign bodies particularly batteries.

OUTCOMES/IMPACT

- In 2014 Harrow CDOP encountered another infant death involving the use of a baby sling. This was the second case involving a baby sling in Harrow in the past 18 months.
- From the findings of the coroner there appeared to be a body of evidence that positional asphyxia can occur through the use of baby slings.
- To raise the safety awareness surrounding baby slings, the HSCB produced in July 2014, a dedicated newsletter which was disseminated locally through our partnerships and nationally through Public Health England.
- This was the second HSCB CDOP newsletter produced in 2014 as it was found to be a very useful tool to communicate the themes and learning from CDOP in Harrow.


Harrow Child Death Overview Panel
Newsletter (July 2014)
Safeguarding children
In this issue:
- Sling introduction
- Local Incident
- Safe Use of slings
- Gemma Hayter SCR 2011


Harrow Child Death Overview Panel
Newsletter (July 2014)
Safeguarding children
SAFE USE OF SLINGS
GEMMA HAYTER SCR 2011

6. EMBEDDING THRESHOLDS AND EARLY HELP

In January 2014, Ofsted carried out a thematic review of twelve cases in Harrow to help inform its evaluation of early help in England. There were some positive messages with regard to good practice, particularly with regard to the work of SALT (Speech and Language Therapy) reaching the needs of 2 years olds in Children's Centres; and with regard to the joint work between the Youth Offending Team, Early Intervention Services and the Police in responding to those affected by gangs.

It was recognised however, that more work was required in embedding Early Help across the partnership and ensuring consistent standards of work – that there was an over-reliance on the Early Intervention Service (EIS). The review also recognised that the HSCB had a good strategic grasp of the needs of the population and of the strengths and weaknesses of local arrangements for Early Help.

In response to these findings, an Early Help Assessment Co-ordinator became permanent in Harrow and a multi-agency steering group was formed to steer the strategic development and implementation of the Early Help Assessment (EHA).

From this development, a locality-based delivery model was established to support practitioners in universal services to complete the EHA and to coordinate Team Around the Family meetings.

In response to the Ofsted themed inspection recommendations, three Early Help Champions/MASH advisors were recruited; each leading on supporting practitioners within their locality. These roles form part of the wider implementation project around building and embedding the Common Assessment Framework (CAF) and the Team Around the Family (TAF) approach. They have been critical in ensuring the project reaches its objectives and successive milestones in order to developing effective and sustainable early help and preventative services within Harrow.

Early Help training launched in September 2014 and regular Themed Led Early Help Surgeries have helped to embed the multi-agency approach and they continue to increase in interest and attendance from practitioners from a good range of settings, particularly from schools, health providers and the voluntary sector. Staff feedback confirms that these are effective forums for sharing practice and obtaining advice on specialist areas.

These developments were accompanied by strong messages delivered within a communications strategy, including the use of the HSCB website, bulletins to schools, through training and team meetings – all to help embed the vision and benefits of this approach. This activity has helped to ensure the success of the projects and the buy-in from professionals across the partnership.

An agreed Quality Assurance Framework is now in place and reports to both the HSCB and its Quality Assurance Sub-committee. Within the Early Intervention Service cases are audited on a monthly basis. They are selected randomly, but within identified themes to ensure that workers from across teams have opportunity to participate in the audit process. Auditors use the London Safeguarding Children's Board Early Intervention Audit Pack and grading guidance, which was updated in January 2014 to reflect the new Ofsted Framework and local thresholds.

The Early Intervention Service (EIS) quality assurance framework aims to improve outcomes for vulnerable children and ensure effective coordination of early help services, through monitoring achievements against service standards. Quarterly reports on audits are

produced to identify themes, strengths in practice; and to outline any improvement activity required. There was 100% compliance with the completion of these case audits.

Findings from the first set of audits for the end of the business year 2014-15 identified a range of strengths and areas for development.

Initial areas for development included the need for minutes for Team Around the Family meetings to be made more 'SMART' with clearly stated goals and who is responsible; for greater consistency of management supervision and oversight; and the need for developing exist plans into universal services.

Practice observations have also taken place, where an EIS Manager observes a range of difference practices, including home visits, team around the Family meeting, professionals meetings, clinical case consultation, delivery of evidence based parenting programmes: Parents as First Teachers (PAFT); a focus programme on managing adolescent (Trip P); and Strengthening Families/Strengthening Communities.

Areas for further development included the need for practitioners to develop broader skills in holding critical or challenging conversations with families; and their need to understand the relevance of historical contextual information relating to family backgrounds.

In general the auditing and observations have confirmed a significant improvement in timeliness and completion of Early Help Assessments (within a 45 day timescale); and in the timeliness and completion of EIS goals plans.

OUTCOMES/IMPACT

- Findings from the first set of audits:
- In 2014 Harrow CDOP encountered another infant death involving the use of a baby sling. This was the second case involving a baby sling in Harrow in the past 18 months.
- A good understanding of thresholds was being embedded across agencies – reflected in appropriate referrals to the Early Intervention Service, and prompt and appropriate 'step up' and 'step down' responses when risks increased or decreased
- Assessments were found to be comprehensive; child centred and demonstrated holistic assessments of the 'whole family' needs
- There was consistent evidence of good partnership working across a range of services and examples of excellent facilitation of communication between the family and key partners
- There was strong evidence of regular contact with families and of effective engagement with them
- The findings of the practice observations generally support the case audit findings, showing evidence of good engagement with children and families; cultural sensitivity; good advocacy; timeliness and effective planning
- The AIM Project, which was developed to help with improving low school attendance. In 2014 a 76% improvement was reported

- In 2014 the Youth Development Team organised 189 activities which 443 young people accessed

7. PRIVATE FOSTERING

Private Fostering arrangements are made by agreement with the birth parent/s and concern the care of children under the age of 16 (or under 18 if disabled) by someone other than a parent or close relative with the intention that this care arrangement should last of 28 days or more. Where this is the case, the Local Authority must be informed and carry out an assessment of the care arrangements to establish if they are suitable and that there are no safeguarding concerns. In particular, any possible risks of trafficking are looked for.

Harrow has a Private Fostering written statement in place which outlines its duties and responsibilities to children and young people who are privately fostered. It has been active in raising awareness within a Marketing Plan, which has involved regular publicity campaigns and the production of local leaflets and information packs, which have been distributed to schools, local community and faith groups and agencies across Harrow. Links have also been established between the Adoption Support and Kinship Team, which undertakes the assessments and the School Admissions Team.

Adverts have been placed in Council and local media, and included in both Local Authority and HSCB bulletins; as well as being made available on the HSCB's website to help raise awareness across the wider community of what Private Fostering means – and information has also been disseminated through a number of meetings with individual and multi-faith forums.

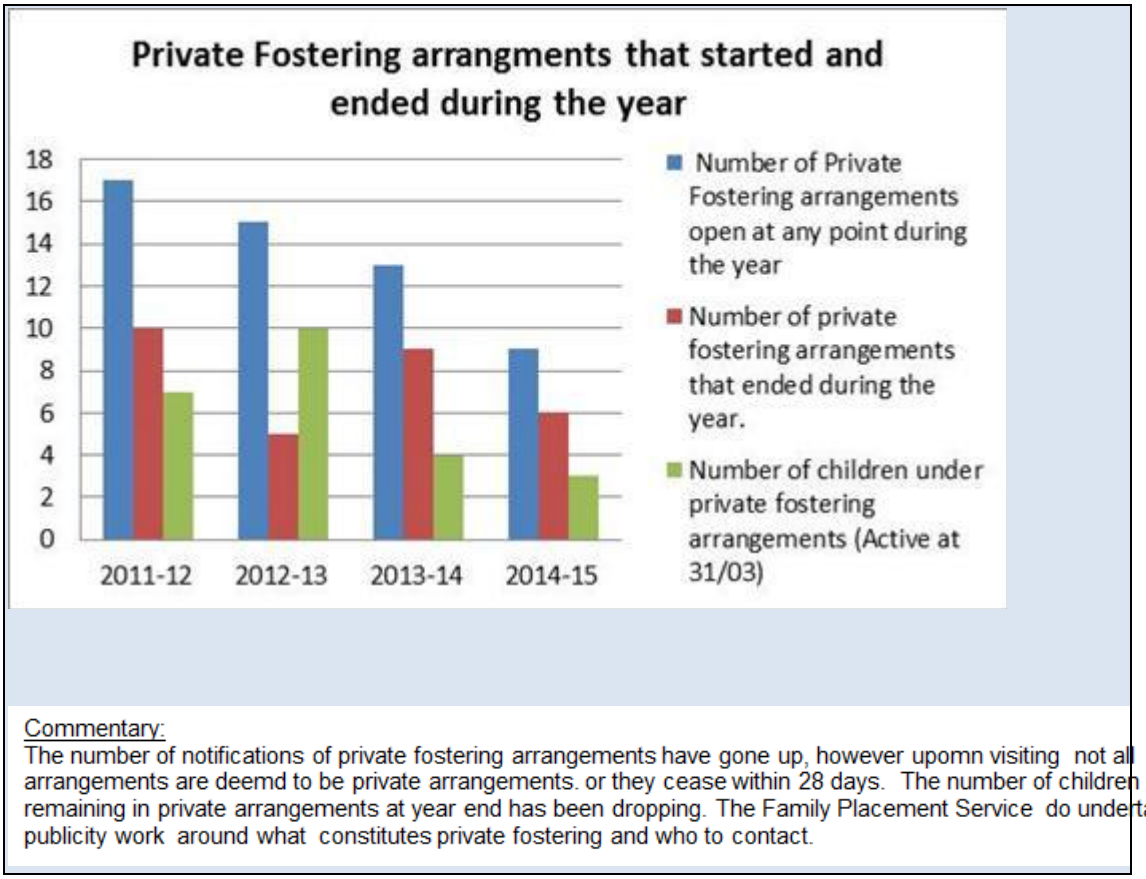
Once assessments have been undertaken, both parents and carers are offered support where required and advice about a range of local services which can be accessed. Children are seen on their own as part of the assessment to establish their wishes and feelings and the Children's Participation Coordinator, as well as an advocacy service are available for advice and support to the children and young people themselves.

In the previous year, there were 9 Private Fostering arrangements in place, with 5 new notifications made to the Local Authority. Of the 5 notifications, only 3 met the criteria for Private Fostering. These figures are low and it is understood that Private Fostering arrangements are extensively under-reported.

Engaging the community in reporting these arrangements is a national challenge as evidenced in the key findings of an Ofsted report 'Private fostering: Better information – better understanding 2014'. The revised Marketing Plan was presented to the HSCB in June 2014 and specifically aims to address the low notification rate with an extensive raising awareness programme.

OUTCOMES / IMPACT

	2011-12	2012-13	2013-14	2014-15
Number of notifications of new private fostering arrangements received during the year.	10	11	7	18
Number of cases where initial action was taken	9	11	7	18
Number of new arrangements that began during the year.	4	8	5	6
The number of private fostering arrangements that were continuing from previous year	13	7	8	3
Number of private fostering arrangements that ended during the year.	10	5	9	6
Number of children under private fostering arrangements (Active at 31/03)	7	10	4	3



Commentary:
The number of notifications of private fostering arrangements have gone up, however upomn visiting not all arrangements are deemd to be private arrangements. or they cease within 28 days. The number of children remaining in private arrangements at year end has been dropping. The Family Placement Service do undertake publicity work around what constitutes private fostering and who to contact.

8. SUPPORTING THE PREVENT AGENDA

The Counter Terrorism and Security Act 2015 placed new duties on agencies "to have due regard to the need to prevent people from being drawn into terrorism" of all kinds. Where children and young people are at risk of being drawn into such behaviour, this is viewed as a safeguarding issue. The HSCB therefore has been committed to support the Prevent agenda, which includes oversight of the multi-agency arrangements (The Channel Programme) to support young people who may be at risk. In addition, the HSCB works in collaboration with the Lead Officer for Community Cohesion to ensure that Prevent training: 'Workshops to Raise Awareness of Prevent' (WRAP) is provided on a regular basis and attendance from all sectors is monitored.

The HSCB promotes Government guidance for local parents and communities too through its dedicated website pages.

9. OUTREACH WITH THE VOLUNTARY SECTOR

The HSCB commissioned Voluntary Action Harrow (VAH) and Ealing Community and Voluntary Services to act as a training and outreach arm for the voluntary and faith sectors across Harrow. Whilst there was some good engagement with the Board from larger and more established voluntary groups, it was recognised that an outreach approach might help to reach some of the smaller and more remote groups – and thereby extend guidance on safeguarding to a broader community.

The aim of the work has been to promote, engage and enable consistent and best practice in safeguarding across the sector. The outreach team have successfully delivered safeguarding training to the community voluntary, faith and private sector in Harrow engaging hard to reach minority ethnic groups, organisations and communities.

By promoting and encouraging multi-agency working to those attending training we have created a better understanding of how organisations can work together more effectively to keep children and young people safe.

The Outreach Team have been inundated with requests for level 1, 2, and 3 safeguarding training & In house training.

The User survey came back with very positive responses with the Green Book being used highly for the following purposes:

- Organisation Safeguarding check list,
- Model Policy statement
- Articles from the Green Book

Direct feedback during session and after training sessions have made the outreach team feel that the overall support received by the community, voluntary and faith sector was crucial in encouraging good practice and taking up ownership of child protection concerns and then making referrals. Organisations feel they are able to disclose sensitive information and know that they will be supported fully to take the appropriate action and discharge their duty of care.

OUTCOMES/IMPACT

- The commissioned arrangement has been successful in achieving the agreed target number of training sessions – each session has been fully booked and there has often been a waiting list – indicating a commitment to meet safeguarding responsibilities by voluntary groups
- Due to a high level of demand, VAH delivered almost double the number of Level 2 sessions first set by the HSCB
- VAH and Ealing CVS provided bespoke training sessions to organisations in the form of seminars (to match the number of delegates requiring training) as well as when appropriate, combining the training with safeguarding vulnerable adults. This was particularly helpful and efficient for those organisations covering both service users e.g. Shia Ithna Asheri Madressa and Harrow Bereavement Care.
- Feedback from these sessions has been very positive – written feedback from most recipients describing a greater sense of confidence in knowing what to do if a safeguarding concern arose. Voluntary organisations have recommended the training to other voluntary groups.
- Following the training, some voluntary groups have sought advice and support about concerns that have arisen – and VAH have supported them in making referrals to MASH and the Local Authority Designated Officer (LADO)
- Organisations that attended the training are far more aware of the need to have a Nominated Safeguarding Person (NSP) and a deputy if it is a large organisation. Those that did not have NSP in advance of the training have not started the process of allocating a lead person to their organisation

- The VAH have made increasing contact with the more traditionally harder to reach minority and faith groups in Harrow. They have been provided with the HSCB voluntary sector safeguarding 'Green Book' and are setting up appointments for training and support
- The outreach team have set up a Children and Young Peoples Safeguarding forum to update on changes in legislation and provide a platform for discussion and raising awareness of safeguarding issues and to share good practice – to encourage consistent practice across the community, voluntary, faith and private sector. The first session was held and generated a lot of interest, so external speakers are being identified to help inform future meetings
- The VAH have helped with some communication difficulties between voluntary organisations and MASH – and where appropriate have helped redirect organisations to the Early Intervention Service – thereby helping to embed a better understanding of Thresholds across Harrow
- VAH have strengthened the link with the Early Intervention Service – promoting the Early Help Champions and ensuring that the VAH training gives clear focus on the continuum of need

10. BUSINESS CO-ORDINATION WITH HARROW SAFEGUARDING ADULTS BOARD

To ensure that our strategic plans co-ordinate, where appropriate, with Harrow Safeguarding Adults Board (HSAB), members of the two bodies meet formally on a quarterly basis. This arrangement also recognises the fact that since the Care Act 2014 (implemented in spring 2015), Safeguarding Adults Boards across the country are now on a statutory footing and this is likely to create new opportunities to combine some activities for greater effectiveness and efficiency.

Examples of existing overlap cover the monitoring and evaluation of transition arrangements i.e. the move from children's services to adult services where on-going needs require continuing support. Harrow's 'Think Family' approach to identifying and assessing need is clearly also of mutual benefit.

Areas of growing shared concern include the emergence or greater recognition of such risks as sexual exploitation; trafficking, FGM and gangs

OUTCOMES/IMPACT

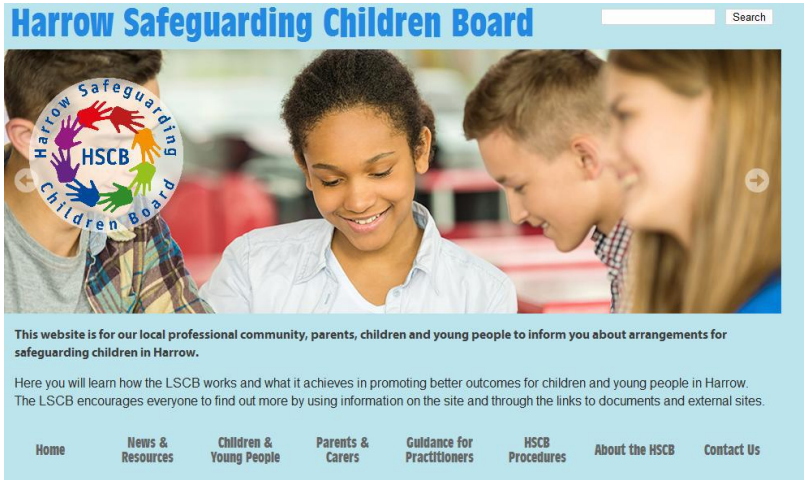
- A number of joint protocols were developed and formally launched by both Boards – these included a revised Transitions Protocol; Adult mental health and safeguarding children; Adult disability and safeguarding children
- A joint 'Think Family' best practice forum was held for staff across adults and children's services, which helped to embed the joint protocols and emphasise the importance of the existing information sharing protocol for safeguarding children and vulnerable adults

- An independent external file audit undertaken by the HSAB found that the Safeguarding Adults Team were demonstrably growing in confidence in the 'Think Family' approach, with all the relevant (audited) cases being appropriately referred to children's services
- In early 2015, the HSCB and HSAB jointly ran community events to embed learning around the risks of CSE
- Representation on each other's Boards and relevant sub-committees has ensured an effective flow of information to support strategic planning

11. HSCB: NEW WEBSITE AND CHANGE OF IMAGE

To ensure that the HSCB's website was more accessible to practitioners and the public, a review of the existing website was undertaken. This review led to the commissioning of a new website company and a complete refresh of the HSCB's website content. This activity ensured that guidance was updated and broadened to cover the extending remit of the Board.

The new surge of activity around vulnerabilities for young people also prompted the HSCB to reconsider its image - as presented through its website, logo and associated materials. Cartoon images of nursery age children were as a consequence replaced with a spectrum of real images of children, reflecting all ages, abilities and backgrounds. As well as reflecting the full remit of the HSCB, it is hoped that the new image will encourage greater access and future traffic to the new website will be monitored.



12. EXTERNAL SCUTINY OF THE HSCB'S EFFECTIVENESS

In September 2014, the HSCB commissioned an independent reviewer to help it judge its efficacy to discharge its duties and to provide a platform from which to move forward during a time of change in its own leadership.

The information for the review was gained from written documents supplied by the board and interviews with chairs of most subgroups, the Business Manager, Chair and Vice Chair of the Board.

Key findings from the review were as follows:

- The HSCB has benefitted from consistent good leadership from the independent chair, vice chair and business support team. The chair demonstrates a strong leadership role and exercises challenge on behalf of children across agencies within Harrow
- Membership of the HSCB complies with regulations and is of the correct level of authority to take forward its key priorities and the wider safeguarding agenda. There are clear expectations about the duties of membership
- Attendance at meetings and engagement with work of the HSCB is good overall, but there are some sectors where agencies continue to struggle to provide consistent representation
- The HSCB has a good understanding of local need and is aware of the strengths of the partnership and areas for further work.

In general, the independent reviewer concluded that the HSCB had made notable and wide ranging improvement in the effective discharge of its duties to safeguard and promote the welfare of children and young people in Harrow since it was previously reviewed by the same reviewer in 2011.

The reviewer also identified some areas for development in relation to:

- the integration and coherence of safeguarding priorities within the strategic framework
- increased accountability of some member agencies;
- systematic availability of both quantitative and qualitative information to the HSCB, including impact on outcomes for children.
- capturing the views and experiences of children and families

The reviewer advised that the HSCB identifies its priority areas of work in the short term to facilitate stability and focus of effort as part of its succession planning.

OUTCOMES / IMPACT
• newly defined priorities were identified and agreed through business planning activity, facilitated by an independent consultant to ensure external challenge • newly defined role descriptions were produced and agreed by Board members • terms of references were produced for new sub-committees and refreshed for existing sub committees. Role descriptions were produced for chairs and sub-committee members to provide clarity of function and help address any lack of engagement across the partnership • All relevant work of the sub-committees includes obtaining where possible, the views and experiences of children and their families; and, the perceptions and experiences of front line staff. Evidence of impact is sought and recorded at every meeting • the data-set for the HSCB was reviewed and updated to align with current national and local priorities; and broadened to ensure that the HSCB receives information 'in the round' from all member agencies and services. • Joint protocols between the HSCB and other strategic partnerships have been written and agreed where they did not exist and updated for those that were in place. The

lines of engagement in terms of personnel attendance have also been strengthened and the priorities of the HSCB have been formally acknowledged and supported across the partnerships

13. HSCB'S NEW PRIORITIES FOR 2015- 2016

The business year concluded with a review of what the HSCB had achieved against its existing priorities, with a view to identifying a clear new focus for future work. The HSCB set new priorities that are sufficiently ambitious with regard to identified needs for children and young people and harrow; set within a sound understanding of emerging national issues; and expressed through a fully multi-agency focused business plan.

The HSCB consulted children and young people in the development of these priorities. The issues covered by the priorities were understood and shared by the children and young people, but they added to the detail of what this should mean. Consequently, attention will be given to homophobic bullying; and methods of young people informing and influencing the work of the Board in more direct ways will be explored.

The following priorities were identified for the period 2015 to 2016. These are the HSCB's key areas of attention and will run alongside and enhance the on-going statutory responsibilities that are outlined for the LSCBs:

Priority 1: Reduce vulnerabilities for young people in Harrow: to achieve a reliable understanding of the single and overlapping risks faced by young people in Harrow, so that preventative action is **meaningful** to young people and targeted action is based on **sound** local intelligence and national developments

Missing children - Child Sexual Exploitation - Gangs - Trafficking - Female Genital Mutilation - Radicalisation - Forced Marriage – Cyber & Homophobic Bullying - Self harming

Priority 2: Actively incorporate the views of children and staff : ensuring that what we do and how we do it is **accurately and regularly informed** by the 'Voice of the Child' and the views of front line practitioners and their managers

Active listening - Observations - Communication – Valuing - Consultation – Empowering

Priority 3: Strengthen strategic accountability: to achieve **clarity** of function across senior management in all agencies and to ensure that the priorities of the HSCB are **acknowledged and supported** by other strategic partnerships in Harrow

Health & Wellbeing Board - Harrow Safeguarding Adults Board - Community & Domestic Violence Board - CEO & Members' Safeguarding Meeting - Safer Harrow Partnership - Corporate Parenting Panel