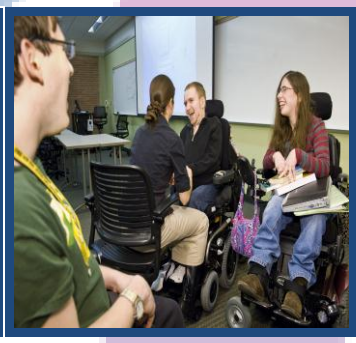
HARROW SAFEGUARDING CHILDREN BOARD

ANNUAL REPORT

2015 to 2016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HSCB ANNUAL REPORT 2015-2016

CONTENTS

1. Forward by Chris Hogan, HSCB Independent Chair

This year, my second as independent Chair, has brought both rewards and challenges in my task of ensuring that the safeguarding of children in Harrow is effectively coordinated and that the Board fulfils its statutory objective and functions. We do not directly commission services, but we seek to influence services and practice through the contribution of Board members and the partnership. We actively encourage challenge through our discussions and are keen to learn when things don't go as well as they should and when mistakes are made so that we can make the improvements to further strengthen our safeguarding work.

We have audited our member agencies' work; undertaken reviews; reflected on and disseminated learning; and invested in partnerships to achieve a positive impact on our children's lives.

As you read through this report, you will I hope, better understand what we do and how we carry out our work.

We have over the last 12 months strengthened our strategic partnerships and revised our meeting format to build in "What we know" mapping exercises, involving all agencies in the sharing and collation of intelligence about key issues, such as looked after children, children with disabilities, young people involved in Child Sexual Exploitation (CSE) and gangs and children who go missing.

We have scrutinised the Multi-agency Safeguarding Hub (MASH) and the section 47 enquiry process; undertaken a detailed section 11 audit programme with all partners; some in conjunction with Brent Safeguarding Children Board; and carried out two multi-agency case audits.

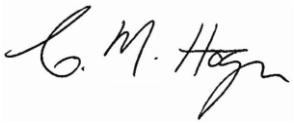
We have continued to embed the lessons from the Family E Learning Review, building on the huge success of the DVD and have published two serious case reviews. We have had very positive feedback on our annual conference and our business planning work this year focussed on the future as recommended by the Wood report and included a self-audit on our effectiveness.

Over the next year we will continue to build on the good work in place addressing neglect and domestic violence, effectively responding to CSE and harmful sexual behaviours, increasing our understanding of children who go missing and increasing our efforts to prevent young people getting engaged in gang activity or becoming radicalised.

Our key priorities will be a refocus on core business, to continue to reduce vulnerabilities for young people, to actively incorporate the views of young people and staff and to further our effective collaboration with other strategic partnerships.

We will do this in the knowledge of likely changes in the structure and size of the multi-agency safeguarding partnership as outlined in forthcoming legislation bringing a potentially stronger cross boundary approach.

I am confident that the current partnership has the capacity and competence to meet these challenges and I want to thank all those people working on the frontline; youth workers, social workers, children's health practitioners, school staff, and voluntary sector staff as well as those in housing and the police who have all played a part in keeping children in Harrow safe.



2. The role of LSCBs

Section 14A of the *Children Act 2004* requires that the Chair of the Local Safeguarding Children Board (LSCB) publishes an annual report on behalf of the whole Board to reflect the performance and effectiveness of local arrangements to safeguard and promote the welfare of children in its area. The report should also identify any areas of weakness, their causes and the action taken to address them.

Harrow's annual report also includes lessons from reviews undertaken within the reporting period.

(i) Statutory and Legislative Context for LSCB

The roles and responsibilities of the LSCB are set out in primary legislation, regulations and statutory guidance. Section 13 of the *Children Act 2004* requires each local authority to establish a LSCB for their area and specifies the organisations and individuals that should be represented on it.

Section 14 of the *Children Act 2004* sets out the objectives of for LSCBs, 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 LSCB are set out in the *Local Safeguarding Children Board Regulations 2005*. 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 their 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.

Government guidance '*Working Together to Safeguard Children 2015'* provides the most recent expectations of boards in relation to membership, role of the Chair, resourcing and areas of accountability. As a minimum, LSCBs should:

- 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

(ii) Statutory Board partners and relevant persons and bodies

The HSCB's membership for 2015 to 2016 is outlined below, with a record of each agencies attendance at Board meetings. Members representing agencies are required to have sufficient seniority so that they can:

- 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 written and verbal reports.

HSCB Board Membership and Attendance April 2015 to end of March 2016

Representing	Name	Title	Attendance
HSCB	Chris Hogan	Independent Chair	4/4
Police BOCU	Mark Wolksi/ Emma Richards	Deputy Chair & Acting Chief Superintendent	4/4
Lay Member	Michelle Weerasekera	HSCB	4/4
Lay Member	Robert Pinkus	Healthwatch	2/4
Director of Children's Services	Chris Spencer	Corporate Director, People Services	3/4
Political Accountability	Simon Brown/ Christine Robson	Lead Member & Assistant, Children & Young People	4/4
Harrow People Services	Paul Hewitt	Director, Children & Young People Services	3/4
Designated Nurse	Sue Sheldon	Harrow CCG	3/4
Designated Doctor	Ruby Schwartz	Harrow CCG	2/4
Named GP	Genevieve Small	GP	2/4
Compass	Hannah Kaim-Caudle or representative	Service Manager	2/3
Police CAIT	John Foulkes or representative	Detective Chief Inspector	3/4
Cafcass	Linda Kim-Newby / Phyllis Dyer	Head of Service	1/4
Harrow Council / Public health	Andrew Howe or representative	Director of Public Health	1/4
Harrow CCG	Javina Sehgal/ Sue Whiting	Chief Operating Officer	2/4
London Northwest Healthcare Trust	Amanda Pye or representative	Director of Nursing	4/4
NHS England	Martin Machray / Bronagh Scott	NW London Area	0/4
Royal National Orthopaedic Hospital	Julie-Anne Dowie / Zilla Huma	Director of Children's Services	2/3
Voluntary Sector	Rowena Jaber	Director, The WISH Centre	4/4
Voluntary Sector	Dan Burke	Director, Ignite Trust	2/4
High Schools	Geraldine Higgins/ Hazel Paterson	Headteacher Sacred Heart Headteacher Kingsley	2/4
Infant & Nursery Schools	Rutinderjit Mahi-Pooni	Headteacher Kenmore Park	4/4
Independent Schools	Andrew McGregor / Lynne Plummer	Safeguarding Lead Harrow School Safeguarding Lead John Lyon Sch'	3/4
Sixth Form Colleges	Sharon Honey / Helen Richards	Safeguarding Lead Stanmore	4/4
National Probation Trust	Juliette Wharrick / Antony rose	Assistant chief Officer	2/4
London Community Rehabilitation Co'	Katrina D'Austin / Sam Rosengard	Acting Assistant Chief Officer	4/4

London Ambulance NHS Trust	Philip Powell / Paul Bushell	Deputy Station Officer	0/4
Harrow Education & Commissioning	Pauline Nixon	Interim Divisional Director, Schools & Commissioning	3/3
Harrow Safeguarding Adults Board	Visva Sathasivan or representative	Head of Safeguarding Adults Services (LA)	4/4
Harrow Housing, Resident Services	Raymond McGilchrist or representative	Senior Professional, Housing Management	2/4
Quality Assurance Sub committee	Neil Harris	Service Manager, quality Assurance (LA)	4/4
Case Review Sub Committee & CNWL	Catherine Knights	Associate Director, Safeguarding & Safety CNWL	3/3
Learning & Development Sub committee	Simon Sackwild	Lead for Special Needs – Shaftesbury School	4/4
CSE Sub committee	Nasheen Singh or representative	Head of Service, Children's Access Team	2/3
Adviser to the Board	Sarah Wilson	Senior Solicitor, Harrow Legal Services	3/4
Adviser to the Board	Coral McGookin	HSCB Business Manager	4/4
Adviser to the Board	Janine Young	HSCB Learning & Development Officer	2/4

(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. The current chair is independent of local services and has extensive experience in child care services.

It is the responsibility of the Chief Executive 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.

- **Lead Members, Chief Executive and the Corporate Director of People's Services**

The LSCB Chair should work closely with all LSCB partners and particularly with the Director of Children's Services. In Harrow the functions of the Director of Children's Services are held by the Corporate Director of People's Services. The Director has responsibility for improving outcomes for children, Local Authority Children Social Care functions and local cooperation arrangements for Children's Services.

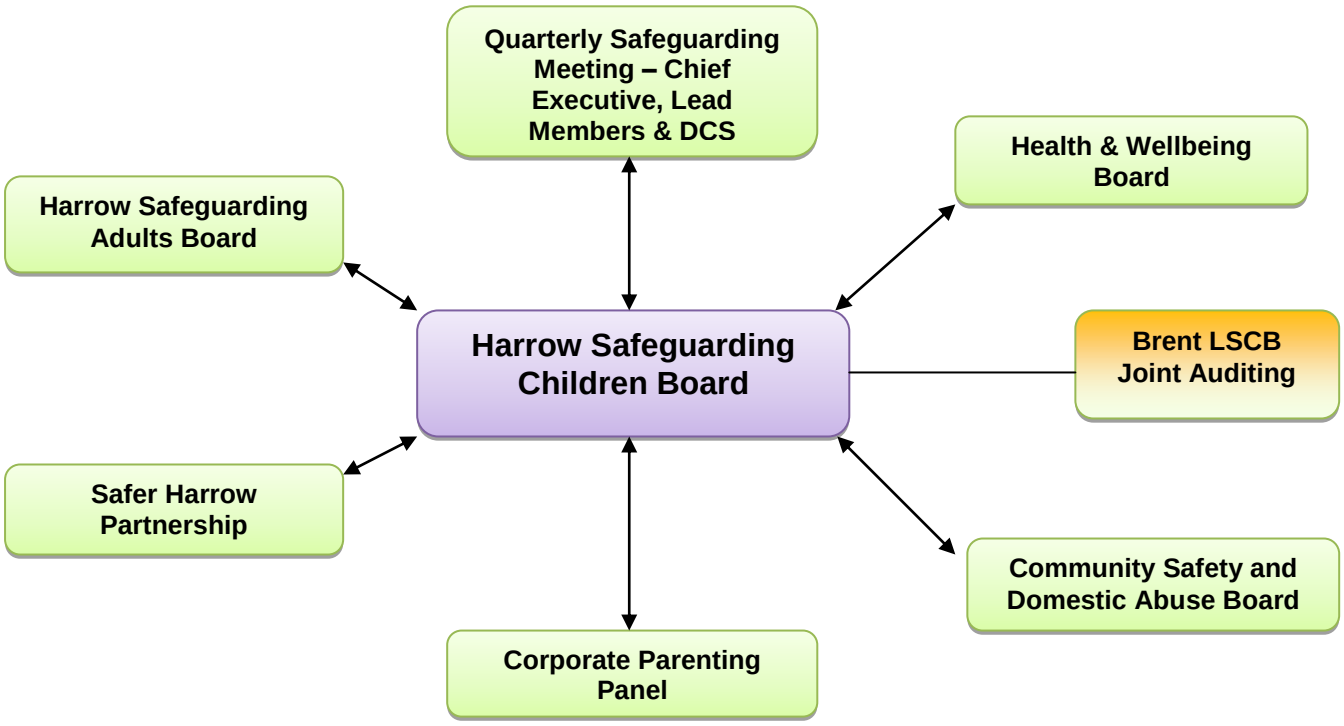
Quarterly Safeguarding Meetings take place between the Chair of the HSCB, Chief Executive, Leader of the Council, Portfolio Lead Member and the Corporate Director of Peoples Services. These meetings help to ensure that strategic and political leaders are apprised of all relevant findings and developments and as such, governance and accountability are strengthened through clear and regular lines of communication.

(iv) Links with other Strategic Partnerships in Harrow and Neighbouring LSCBs

The HSCB has developed protocols with all relevant strategic partnerships in Harrow to confirm lines of engagement and to ensure that the HSCB's priorities are understood and supported by other strategically led activity. This has been most evident in the continued joined-up approach to responding to Female Genital Mutilation and radicalisation with the Safeguarding Adults Board; youth violence, vulnerability and exploitation with the Safer Harrow Partnership; and embedding learning from local serious case reviews across all partnerships.

In addition, the HSCB has initiated joint auditing work with Brent LSCB as part of a growing move to work more collaboratively with neighbouring LSCBs. This development has been particularly welcomed by those members whose agencies are covered by more than one LSCB, as this helps to avoid duplication and inconsistency.

HSCB & Strategic Links:

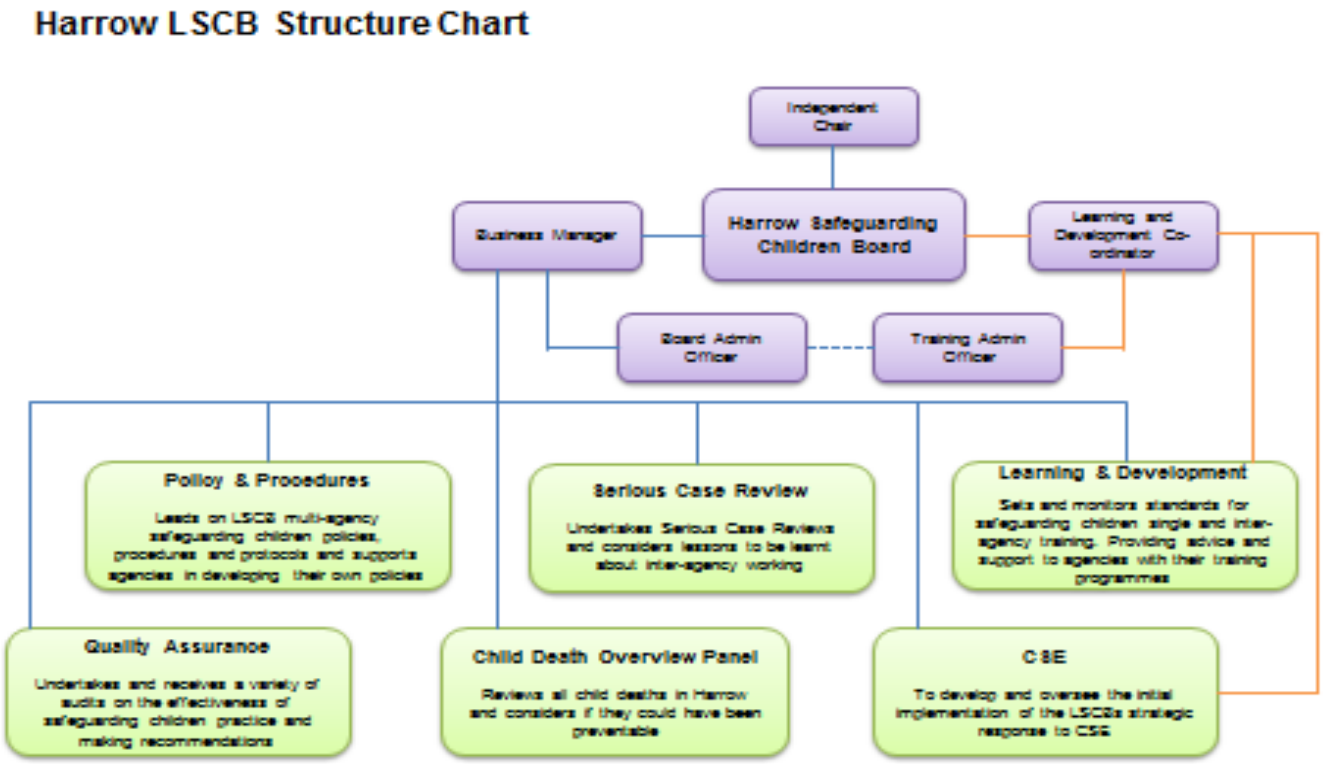


(v) HSCB Structure

The HSCB refreshed its structure in early 2015 to better reflect its new priorities and to drive forward required developments for Child Sexual Exploitation and the revision of available policies and procedures. The new structure also reflected the Board's acknowledgement that all agencies were facing considerable challenges for resourcing; both financial and staff time. Two sub-committees were ended, transferring lines of reporting into the remaining sub-committees or by reporting directly into the main Board.

These new arrangements also brought about the potential for linked intelligence to be identified, so that the Board achieves a reliable oversight of the inter-face between certain vulnerabilities and risk factors, e.g. data and intelligence on missing children, trafficking, gangs and CSE. Systems for achieving a reliable profile are still in development and this is covered in more detail later in the report.

The existing structure of the HSCB is as follows:



(vi) HSCB Priorities 2015-16

The annual Business Planning event took place in April 2015. This was the first Business Planning event under the steer of the new independent Chair and new Business Manager. To incorporate an element of external challenge, Professor Michael Preston-Shoot (Faculty Dean at the University of Bedfordshire and an Independent LSCB Chair) was commissioned to help facilitate the event and scrutinise the Board's effectiveness. Progress against existing priorities was explored and the Board determined its new priorities for 2015 to 2016 in the light of current issues for Harrow and emerging national themes

To ensure that work remained focussed throughout the year, all activity within the Sub-committees was then aligned to one or more of the Board's new priorities. In addition, the main Board meetings incorporated a new thematic approach to priority areas, involving multi-agency "What we know" mapping exercises to gain a comprehensive profile of the issue and the quality of service provision from all relevant organisations.

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 – Self harming

Priority 2: Actively incorporate the views of children and staff : ensuring that 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 and Domestic Violence Board - Chief Executive & Members' Safeguarding Meeting - Safer Harrow Partnership

3. Demographics and Themes in Harrow – What we know and how this informs the work of the HSCB

(i) General Demographics

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. 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.

The number of Harrow's 16-18 year olds, not in education, employment or training remains low (2.5%). Permanent exclusions for the academic year 2014 to 2015 totalled 25 across all school types. This was an increase of three on the previous year.

Harrow is one of the most ethnically diverse boroughs in the country. In 2011, 43% of the population were from an Asian/Asian British background, 42% from a white ethnic 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.

The national census does not ask people to define their sexuality, but data from research by the Treasury and Stonewall Charity estimates that approximately 5-7% of the population are lesbian, gay or bisexual.

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; one all-through free school; two special needs high schools and one pupil referral unit. 87% of these are judged good or better, 12% require improvement and 1 is inadequate.

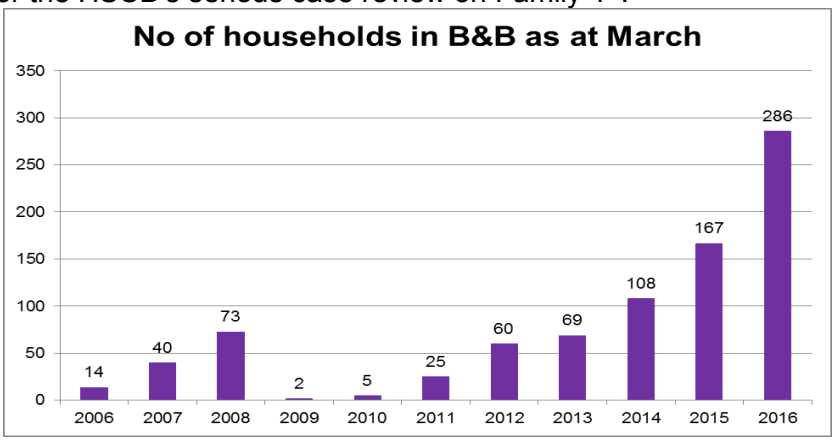
(ii) Vulnerable Groups and vulnerability factors

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.

Of its 55,800 children and young people, about 3,100 of children in Harrow were assessed as in need of a service from Social Care between 2013 and 2014. This includes children 'Looked After' by the Local Authority, those supported in their families or independently, and children who were subject of a child protection plan.

In line with the Children Act, local councils must identify the extent of need in their area and make decisions about the levels of service they provide. Harrow is ranked 251 out of 326 (where 1 is least deprived in the 'Income Deprivation Affecting Children Index) and the percentage of children living in poverty is slightly below the England average.

We are living in unprecedented times with over 600 households (June 2015) being housed by Harrow Council in temporary accommodations. Over 100 of these households live in accommodation where they share facilities with other homeless households, and over 150 are being accommodated outside Harrow. Those families in bed and breakfast accommodation are shown in the diagram below. The acute rise in homelessness is a direct result of welfare reform (see relevance for the HSCB's serious case review on Family 'F'.



In response to the steady increase in demand, Harrow has and is undertaking a number of initiatives to:

- Reduce the number of families who become homeless
- Scrutinise all applications to ensure they are genuine and that we owe the family a statutory duty
- Increase current supply of temporary accommodation
- House families away from Harrow/London,
- Develop new supply of temporary and permanent accommodation (long term plan)

The HSCB has been raising awareness of the current challenges, so that all agencies provide each other with accurate assessments of need, thereby helping to secure housing provision to the most vulnerable families.

(iii) Children in need

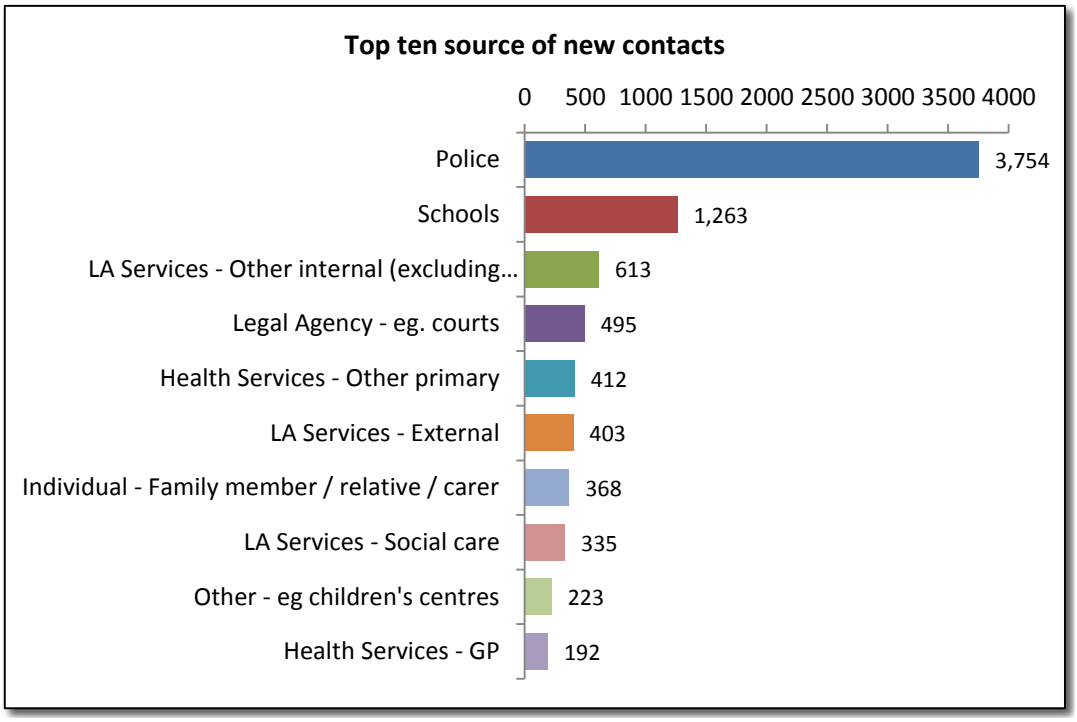
Harrow's children 'in need' rate has increased following a revision of thresholds for eligibility of social care services. It now has a similar proportion of children 'in need' compared to its statistical neighbours; the rate has been increasing since 2012 in Harrow. This produces an additional demand on both universal and specialist services.

Nearly two-thirds of Harrow's children under 18 'in need' are from Black and Minority Ethnic Groups (BME) and this reflects the population of the borough.

The proportion of children 'in need' from Asian or Asian British origin is over one quarter; higher than for statistical neighbours (19.8%), London (13.1%) and England (6.2%).

The number and rate of referrals per 10,000 children in Harrow was historically low compared to national averages, but since 2013 there has been a rise due to revised thresholds and the changing demography.

40% of contacts with Children's Services come from the Police; followed by schools 13% and health services at 10% - similar contact and referral pattern to more recent years.

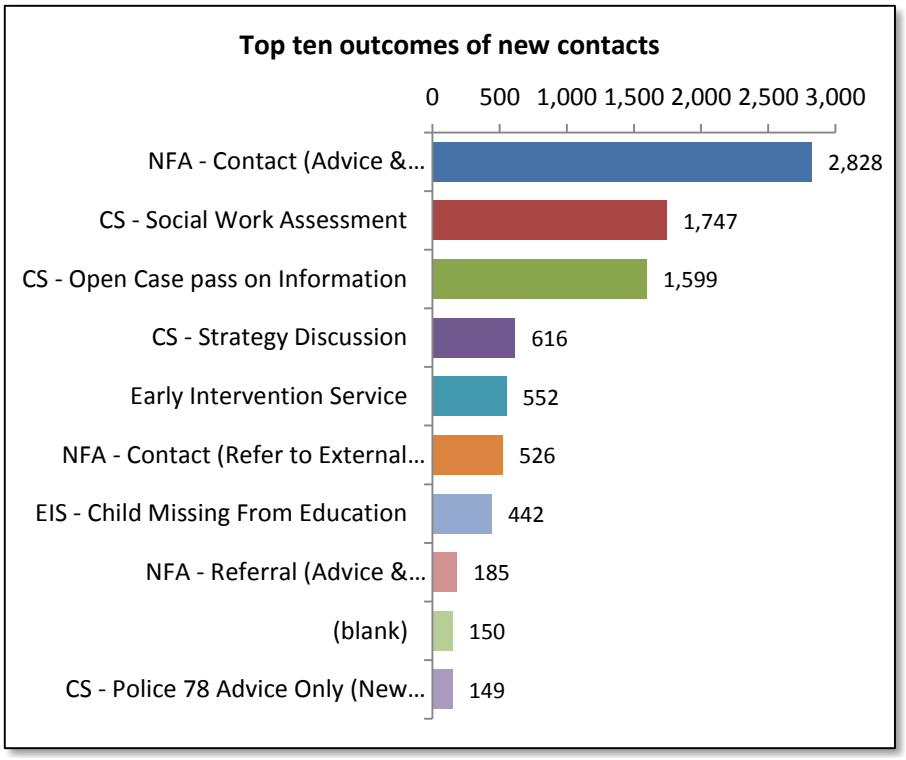


HSCB Scrutiny and challenge:

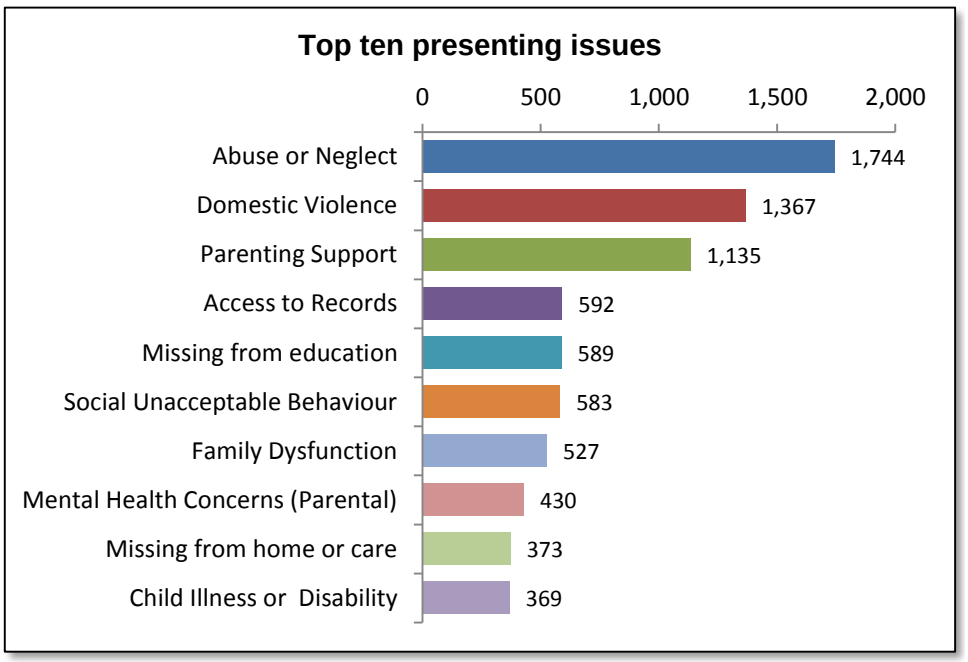
The Quality Assurance Sub-committee sought an explanation for the lower number of referrals coming from the health sectors. In response a report was provided which indicated that restructuring for health visitors in particular has meant that they have less universal contact with children. This was felt to reduce the opportunity to identify concerns and needs.

Benchmarking with other areas has confirmed that this is a national trend and an area for continued monitoring.

40% of new contacts resulted in no further action from Children's Services. These include those cases referred on to other agencies for alternative support. 19% required a social work assessment; 7% involved the initiation of child protection procedures and 6% required an assessment by Early Intervention Services.



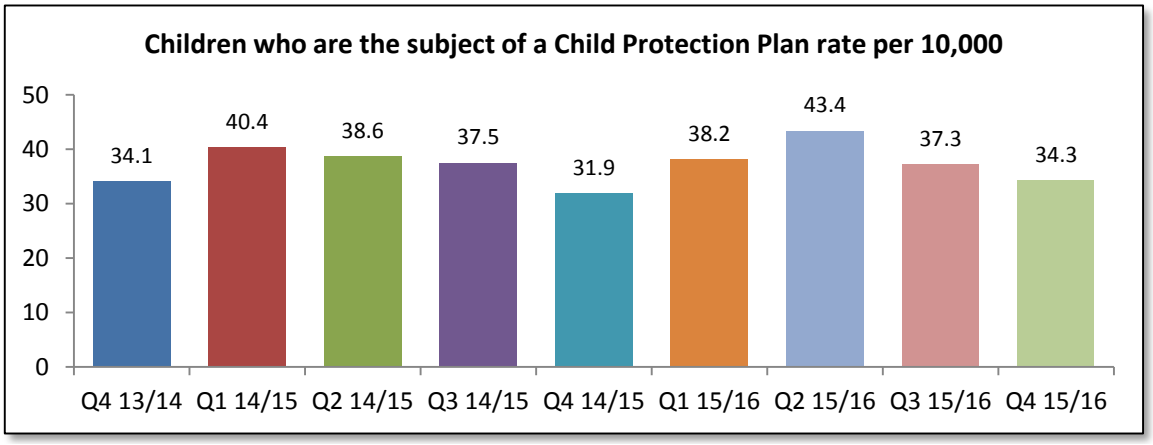
As in previous years, the presenting issues for these contacts showed that abuse, neglect, domestic abuse and parenting support were the most frequent reasons. The most common category of need across the country is abuse or neglect. The second most common category is family dysfunction (approximately 18%). Other categories include child with disability or illness and family in acute stress (about 10% each).



There was a continued increase in activity for the social work teams and a drop in allocations to the Early Intervention Services. The core offer and thresholds for Early Intervention Services were under review and this may have had an impact on the number of allocations.

Social work activity had increased, although child protection activity had decreased towards the end of the year. **Child protection enquiries – rate per 10,000:**

	2012	2013	2014	2015
Harrow	54	91	114	90
London	106	107	112	137
Statistical Neighbours	98	99	123	143
England	110	112	124	138



There has been a rise in the number of children with child protection plans from the same period in the previous year; slightly higher than our statistical neighbours. Plans lasting two years or move have decreased significantly, as well as those involving a second or subsequent plan.

Oversight, Scrutiny and challenge:

A Child Protection Conference annual report was received by the Quality Assurance Sub-committee. This report informed the HSCB that:

- Social workers were successful in sharing conference reports with 80% of families prior to conference
- 88% of children had their voice heard at conference in some form. Other children were considered too young to consult.
- 98% of conferences were quorate
- 87% of social worker visits were recorded as taking place and 96% of children were seen on visits
- 91% of social worker reports were identified as satisfactory, good or excellent.
- Where reports or practice were considered unacceptable, Chairs discuss practice concerns with the social workers and their managers.

Low attendance by the National Probation Service and Community Rehabilitation Company (CRC) was identified and the Sub-committee sought explanation and action from these services. All cases with child protection plans were then checked against these agencies' records. Communication and engagement issues have since been resolved

(iv) Children Looked After by the Local Authority

Children 'looked after' include all children being looked after by a local authority; those subject to court orders and those looked after on a voluntary basis through an agreement with their parents.

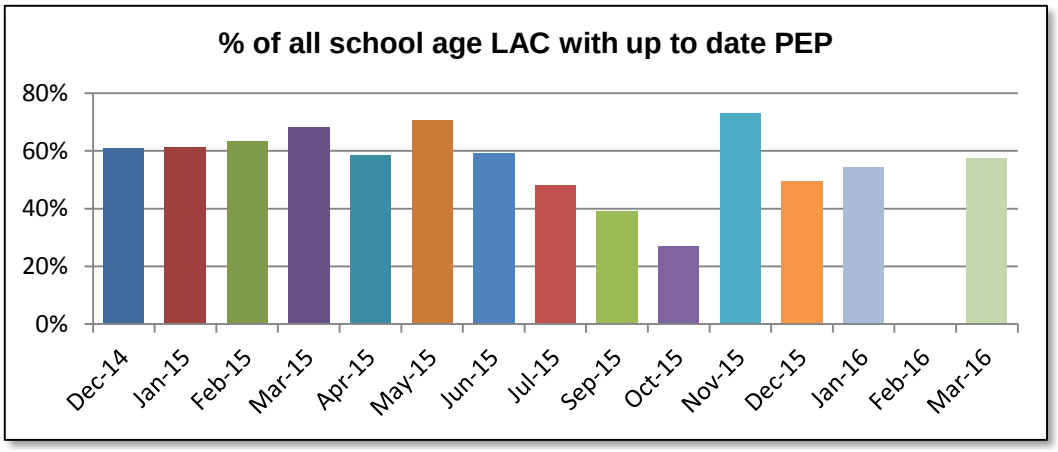
Nationally, there are 60 looked after children per 10,000 children in the population. The rate in Harrow was fairly stable historically and was substantially lower than England, London and statistical neighbours.
In Harrow, a higher proportion of 'looked after' children are male compared with England overall (5% difference).

The rate of children ceasing to be 'looked after' has been increasing over recent years and in Harrow this appears to be at a greater rate than for England, London and statistical neighbours. Strong extended family networks are common amongst the local communities which could explain a lower figure in Harrow, but the incoming populations tend to be from communities with a tendency towards higher levels of vulnerability and consequently rates for children 'looked after' could increase.

Children looked after, rate per 10,000

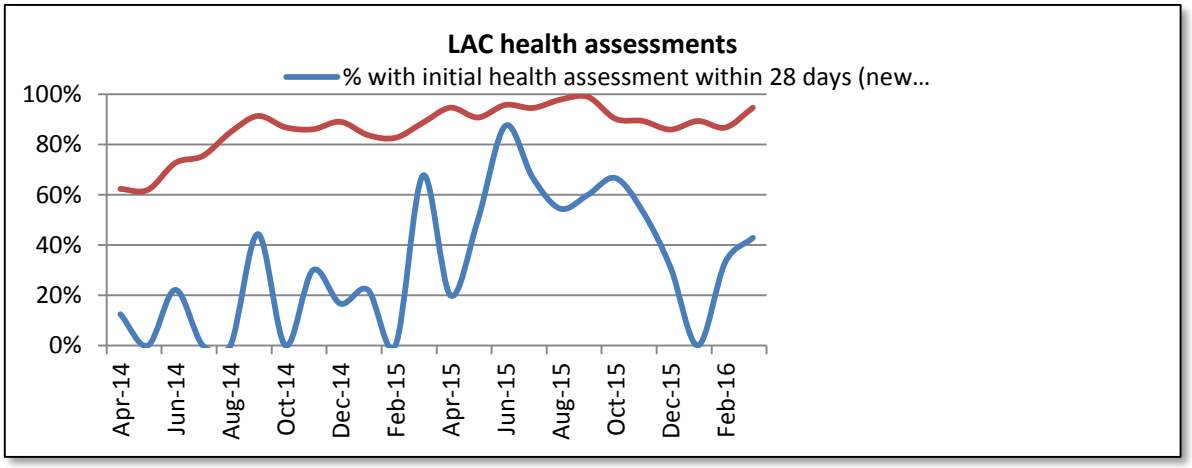
	2012	2013	2014	2015
Harrow	29	31	30	29
London	57	54	54	52
Statistical Neighbours	43	43	43	41
England	59	60	60	60

Personal Education Plans (PEPs) are required for every Looked After Child and the Headteacher for Virtual Schools oversees these plans for children aged 3-19 and those leaving care, as well as those with special needs up to the age of 25.



HSCB Scrutiny and Challenge:

Virtual School: Following concerns identified in a HSCB Serious Case Review, the Board sought reassurance about improvements in the Virtual School Service, particularly with regard to children placed out of area. These developments are described more fully under the section 'Learning from Reviews', but a progress report to Board confirmed that the quality of PEPs is being raised and that pathway plans have improved, with stronger links to the Children Looked After Health Assessment Team.



Harrow had been performing poorly with regard to health assessments for looked after children; levels were significantly lower compared to statistical neighbours, London and England. With the introduction of the Children Looked After Health Assessment Team significant improvements have been achieved (see Learning from HSCB Reviews).

Special Educational Needs: Harrow has a higher proportion of Children Looked After with special educational needs compared to statistical neighbours, London and England. This could be due to an actual higher prevalence or just a better detection rate.

Youth Offending: In general the Youth Offending Team manage caseloads that reflect national trends; an increase in drug related offences for males in particular. Female offences are more

linked to violence against another person. The reoffending rates are of concern, also reflecting national trends.

A snapshot of the YOT current caseload in May 2015 shows that there were 13 young people who were also looked after, which represents 16.25% of the total YOT caseload. five of the 13 (38.4%) became looked after as a result of being remanded by the court. Of the 41, 13 re-offended, seven (53.8%) of whom had been in the looked after group.

Oversight, Scrutiny and Challenge:

Reports to the HSCB confirm that Children Looked After are more at risk of re-offending. Emotional state and resilience issues relating to this cohort of young people also impacted on their ability to maintain their education, employment and training. The HSCB were informed of YOT Priorities to address this:

1. Improve the outcomes for children looked after worked by YOT particularly in terms of their re-offending and education/employment/training (NEET rates)
2. Ensuring that young people with mental health needs receive the right support

The revised structure for YOT included an increase in staffing capacity. Frontline YOT practitioners have increased from 3 to 5.5; a dedicated 1.5 Restorative Justice (RJ) post has been created to assist embedding RJ practices across the Youth Offending Team. A dedicated 0.5 victim worker role; a full time education specialist role; increased Mental Health provision from 2 to 3 days; an additional Deputy Team Manager.

(v) Early Intervention Services

The HSCB receives regular progress reports on the development of Harrow's Early Intervention Services and embedding the Team around the Family approach. The thematic inspection carried out by Ofsted in 2014 identified a number of strengths as well as areas for further development:

There was good evidence of improved outcomes for children and families; strong flexibility to changing needs; good embedding of learning from serious case reviews; good training and focus of HSCB training.

Areas for development included the need to better engage all universal services in assessment and planning delivery.

Oversight, Scrutiny and Challenge:

The progress reporting to the HSCB has confirmed:

- Champions are in place to help provide support, advice and guidance to practitioners in universal services
- An Early Help Advisor was located in the Multi-agency Safeguarding Hub (MASH) to aid earlier identification of families that could benefit from an Early Help assessment and help the team interpret appropriate thresholds for Early Help Services

Impact: 75 cases had been diverted from MASH to universal services; 55 cases were tracked over a three month period and only one required a re-referral to MASH. This is a good indication that families have benefitted from earlier help and that thresholds are appropriate.

Over 200 professionals attended Early Help training and 180 attended themed early help surgeries.

The estimated prevalence of special educational needs in Harrow has remained consistent over time (2.6%) and is lower than the London and England average (2.7 and 2.8% respectively). The number per 1,000 of children with moderate learning disabilities in Harrow is lower than the London average but higher for children with severe learning difficulties.

Approximately 180 children in Harrow are reported to be deaf and known to services. 99% of these receive teaching support, family visits, family and school liaison and provision of hearing aid checks.

The number of blind children and young people between 0 and 17 registered with Harrow is 20 and the number of partially sighted is 30. Approximately one third of blind and partially sighted children have additional needs and fifty pupils in the borough have a statement of special education needs or School Action Plus.

Ten per cent are taught in special schools while the rest attend mainstream schools.

Local data from the School Census for Harrow recorded 163 children with Autistic Spectrum Condition. Clinical Commissioning Group (CCG) data from 2012 estimated higher numbers; 110 children aged 9-10 and 255 aged 5-9. Over eight times more boys than girls were diagnosed in Harrow.

HSCB Monitoring and Challenge:

The Harrow Core Offer (the approach to meeting the needs of pupils with Special Needs and/or Disabilities) included a range of services, which supported 279 families; of which 206 accessed a direct payment, 25 used Kids Direct and 48 engaged with Kids Can Achieve or Mencap. In total 517 children and young people (under 18 years of age) received a care package.

The HSCB was notified that the only residential children's Unit in Harrow for children with disabilities achieved an inspection grading of 'Outstanding' for the sixth consecutive year

Children with Disabilities Service merged with the Transition Team at the end of the financial year (March 2016), producing a new 0-25 pathway. As part of its monitoring responsibilities, the HSCB prioritised the evaluation of this new service in its new Business Plan 2016-17.

(vii) Domestic Abuse and Multi-Agency Risk Assessment Conference (MARAC)

The number of cases discussed at MARAC is stable at around 50 per quarter. 40% of cases discussed were from minority ethnic groups. 76% of the referrals to MARAC are from Police and the Independent domestic violence Advisors (IDVAs).

Domestic abuse accounted for over 11% of the presenting issues for referrals to Children's Social Care (1,744 cases), but it is well known that it features alongside many of the other main presenting issues such as abuse and neglect, parental substance misuse and parental mental health.

Members of the HSCB are represented on Harrow's Domestic and Sexual Violence Forum to ensure that they inform and support each other's activity, including the annual Violence Against Women and Girls 'White Ribbon Day'.

(viii) Young carers

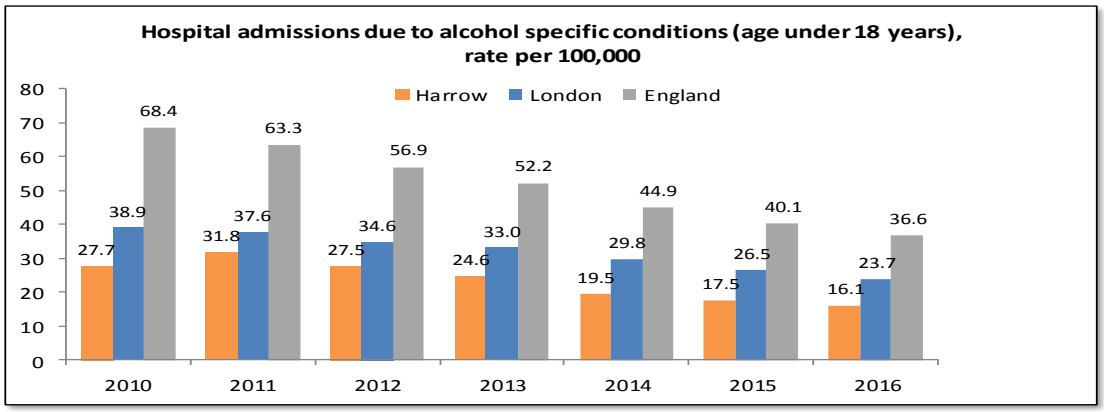
It is difficult to estimate the number of young carers although the 2011 Census shows 2,272 self-declared young carers aged 0 – 24 in Harrow. The vast majority of these are hidden, i.e. not known to social care or receiving any support.

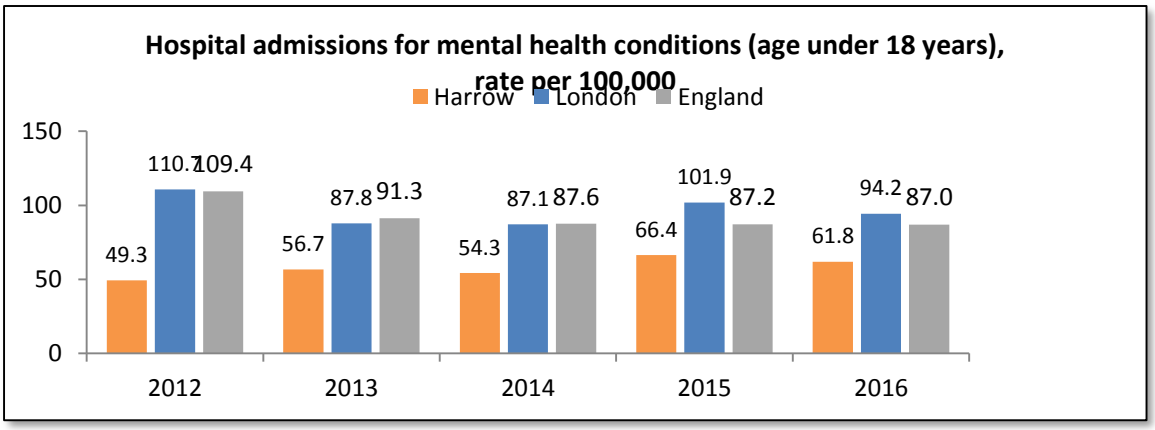
The majority of known young carers achieve the expected levels of attendance (for all children) which may indicate that school is an important part of their lives. An independent assessment found that mental health needs amongst parents and carers is an area of growing concern for schools, particularly primary schools.

An on-line survey of young carers accessing the Young Carers Project at Harrow showed that the majority of young carers felt they had benefited from attending the project. The benefits ranged from meeting other young carers to enjoying the activities delivered. The young people were also consulted about a redesign of the service.

(ix) Substance misuse, mental health and self-harm

A detailed drug and alcohol assessment for Harrow was completed in 2014. It found that dependency in Harrow is generally low. Trends for young people are also showing declines. Alcohol specific admissions among under18 year olds have shown a year on year consistent decline since 2010.There has also been a drop in mental health related admissions, but an increase in hospital admissions due to substance misuse and self-harm.





NB. Hospital admissions for self-harm (age 10-24), rate per 100,000 in 2015 were Harrow 164.1, London 2.4.8 and for England 352.3.

Oversight, Scrutiny and Challenge:
As part of its annual scrutiny programme, the HSCB received a performance report from CAMHS (Child and Adolescent Mental Health Services) which confirmed:

- There are approximately 720 cases open to CAMHS at any one time
- Following learning from a recent serious case review, the team has established much more effective links with the Children Looked After Assessment Team
- A clear Transitions into Adult Services Protocol has been embedded
- Following the learning from the serious case review, CAMHS introduced a more robust approach to young people not engaging with services, including a flexible booking system. The service will persist with the offer of engagement and notify the referring organisation where they have not been successful

(x) Youth offending

There has been a decline in the number of first time entrants to the youth justice system. This is a trend which is also reflected nationally. Changes in the criminal justice system put a greater emphasis on keeping young people out of the system by pursuing alternative interventions for those committing minor offences or identified as at risk of offending.

The reoffending rate however has been rising in Harrow (1.2% increase) and elsewhere (London 1.8% and England 1.9%). In Harrow this amounted to 71 offenders out of the total cohort of 160. The average number of re-offences committed by each re-offender also shows an increase. For Harrow there was an increase on the previous year of 3.7% during the period 2013 to 2014. This compares with an increase in London generally of 7.8%.

(xi) Workforce

The HSCB has maintained a particular focus on the high turnover rate for social workers and health visitors in recent years and receives regular reports on recruitment, retention and sickness management arrangements.

The annual Social Care workforce return ending 30th September 2015, showed a small increase in number of social workers and a fall in the number of vacancies at that point (NB at the time of producing this annual HSCB report, substantial activity had taken place with regard to new and productive recruitment initiatives).

Health visitor turnover and sickness rates were showing an increase, whilst rates for school nurses were showing improvement.

4. Learning from Serious Case and Learned Lessons Reviews

2015-16 proved to be a very active year for the HSCB with regard to conducting reviews and embedding the learning to make a positive difference to the services for children and young people in Harrow.

(i) Family 'E' Learned Lessons Review

The HSCB and its member agencies continued to embed the learning from its previous Learned Lesson's Review called 'Family E'. This case showed the impact of long term neglect and domestic abuse on all members of a family and the learning emphasised the need for early intervention and better collaboration across children and adult's services. The creative use of a dvd to present the story from the children's point of view was a huge success, both locally and nationally. Demand for the dvd continues and its use has been incorporated into all relevant training programmes.

Two new Serious Case Reviews were conducted during 2015, with one published in November 2015 and the other in February 2016.

(ii) Young Person 'R' – Serious Case Review

The first review involved the tragic death of a 17 year old young man, referred to as 'young person R'. He experienced numerous placements across the country and died as a result of taking an overdose of drugs. R was loved by his family and liked by all the professionals who worked with him, all of whom showed great generosity in contributing to the learning in this review to assist others working with similar young people with complex needs.

A number of key learning points were drawn from this review:

- The need to understand the perspective of migrant families and possible lack of trust with statutory agencies – for practitioners to show greater curiosity and seek explanation for non-engagement by families
- The need to invest in early help to divert troubled young people away from substance misuse, anti-social or gang related behaviour
- Placement plans built largely around crisis intervention at the expense of longer term planning based on strengths and needs.

- The lack of continuity in health provision; compounded by frequent moves across the country
- The Virtual School Service for CLA did not function effectively
- A stop and start again approach with both mental health and substance misuse services, with little or no connection with their counterparts in R's previous areas of placement across the country.

These key learning points also reflected the findings of research undertaken by the *Association of Directors of Children's Services* in 2014 called **'***That Difficult Age'*, which emphasised the difficulty of finding suitable placements closer to home for young people with similar complex needs.

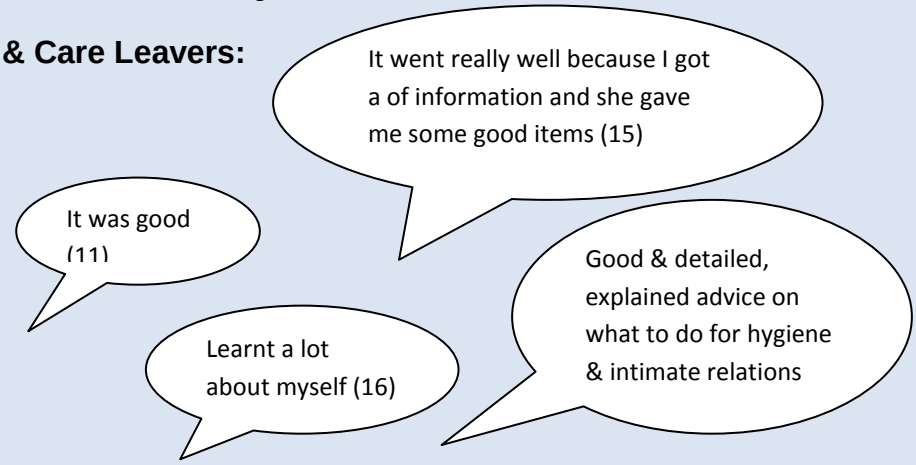
"That Difficult Age"

Outcomes / Impact

- A new Children Looked After Service was set up in June 2015. This followed an Ofsted inspection in 2012 which found the CLA Health service inadequate and there clear implications found in the Serious Case Review for 'R'. The CCG and LA worked together to design and implement a more responsive, integrated and person-centred approach, using CNWL as the provider.

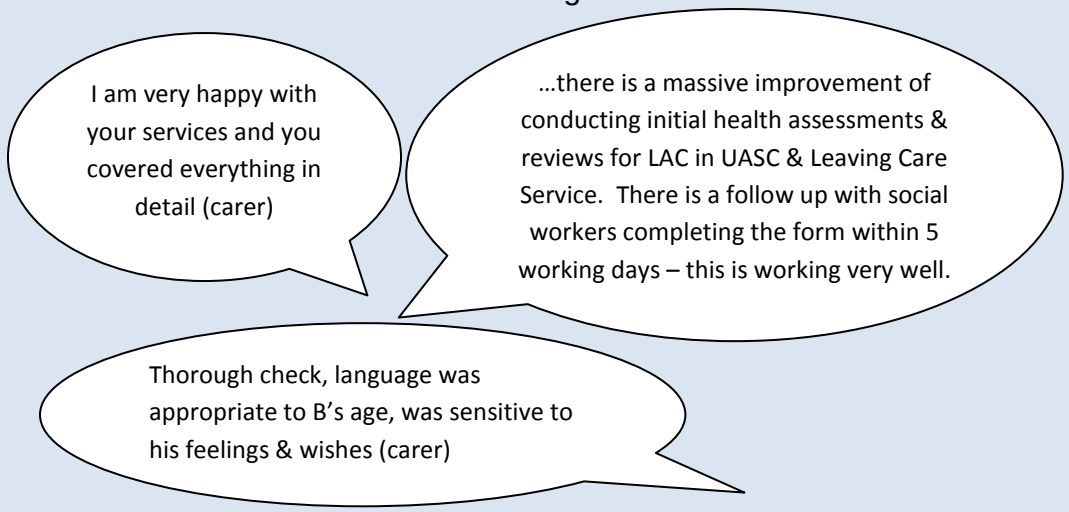
  The HSCB have received reports of positive early data indications on meeting targets for initial and reviews and receiving positive comments from young people, carers and managers.

CLA & Care Leavers:



Outcome / Impact – continued

Carers and Managers:



- A Virtual School Improvement Plan was put together for 2014-15 which identified clear priorities/actions and measurable success criteria. In particular these included actions to strengthen oversight, tracking and the achievements of CLA, particularly those placed out of area.

  A full time Headteacher of the Virtual School was appointed in July 2015 and robust reporting on age, ethnicity, attainment, Personal Education Plans (PEPs) and Pathways were put in place. The oversight confirmed at the end of spring 2016 that the quality of PEPs and rate of return needed to improve *(at the time of writing this report significant progress had been made),* but Harrow care leavers are 4% above the national average for care leavers attending university.

(iii) Baby F – Serious Case Review

The HSCB's second serious case review involved the tragic death of an 11month old baby. Baby 'F' was found submerged in a bath, having been left temporarily unsupervised by his mother. The young children in this family were subject to child protection plans for neglect and the mother was subsequenty found guilty of manslaughter.

The family were well known to agencies in Harrow, due to the mother's history of substance misuse and experience of domestic violence. Sadly, the mother did not engage in any signficant way with local or neighbouring services. A number of referrals from the community raised concern about the children suffering neglect and being exposed to drug misusing adults. The family moved regularly from one temporary placement to another and were usually difficult to locate; making assessments very difficult for those trying to help.

Key learning points from the review were:

- The need for all midwives to respond in a timely way to mothers presenting with actual or potential safeguarding issues – i.e. not just refer to specialist safeguarding services
- All practitioners should not make assumptions based on stereo-types of family backgrounds e.g. traveller families
- The need to recognise the additional vulnerability of families in temporary accommodation
- For Social Care to ensure that transfer of cases across authorities is properly negotiated and not based on assumption
- An over-reliance on using the police for protecting children and for assessing their welfare, when using local authority powers would be more appropriate and more effective
- Social Workers should give greater consideration to concerns raised by the public and not assume the information supplied is less reliable than referrals from professionals. In all such cases, an interview should be offered to seek more information.
- Greater effort should be made to contact and involve fathers and extended family members in assessments and planning.

Outcomes / Impact

- The HSCB revised *Harrow's Neglect Toolkit* and re-launched it through a robust dissemination programme led by the Local Authority and open to all agencies

Outcomes / Impact – continued

- Harrow's '*Thresholds Document'* was revised to reflect learning from the review; reflecting the additional vulnerabilities for cross border cases, families in temporary accommodation, and the importance of giving serious consideration to referrals from the public.
- Training led by Harrow Council's Legal Department for local police and social workers to embed a clearer understanding of when to apply each other's legal powers. A subsequent HSCB Multi-agency case Audit found evidence of a significantly improved understanding and application of these powers
- LNWHT (London North West Healthcare Trust) embedded the learning from this review with its Maternity Services to ensure that all midwives recognise and respond to their own safeguarding responsibilities, rather than assume responsibility sits with safeguarding specialists. A subsequent HSCB multi-agency case audit found good practice in front-door midwifery services indicating effective dissemination of the learning.
- The HSCB sought assurance from the Local Authority's Housing Services that the particular vulnerabilities of families with children on Child Protection Plans were taken into account when assessing the needs of families requiring temporary accommodation. As with other outer-London boroughs, Harrow is facing unprecedented and growing demand on temporary housing, but the HSCB is informed that the safeguarding needs of children remain a prioritising factor.
- The HSCB undertook a multi-agency 'mapping' exercise to profile Children Looked After in Harrow, their needs and scrutinise the quality of provision for them. This information ensured that all member agencies contributed to building the picture and identifying issues and challenges for the Corporate Parenting Panel

As part of its continuing commitment to learn and improve local practice, the HSCB oversees the implementation of all action plans relating to the serious case reviews undertaken and tests selected priority areas for evidence of improvement through its themed case audits.

The HSCB initiated a third serious case review at the end of 2015 which has not been concluded at the time of this report being written. Early learning from the review process has however, been extracted and incorporated into actions for individual agencies. The full reporting of this review will be reflected in the HSCB's next Annual Report.

5. HSCB'S Monitoring and Evaluation Activity

(i) HSCB Multi-Agency Case Audits

In the period March 2015 to April 2016, the HSCB's Quality Assurance Sub-committee carried out three multi-agency case audits. The first introduced a new methodology, based on lines of enquiry linked to key findings from local reviews and previous auditing. This replaced the previous model of auditing that had been very focussed on local authority procedures, which presented some difficulty for other agencies to apply in a consistent way.

The new model was received well by the partnership as it reflected key themes that they recognised as relevant to local practice development needs.

In the March and May audits a good application of thresholds was found across the partnership, as well as good arrangements for formal and ad hoc supervision. There were also indications of early identification of domestic abuse by universal services and appropriate referrals to Children's Social Care. Tenacity and flexibility were found in the practice of a number of different professionals when working with non-engaging young people or their parents; and recording was generally found to be up to date and comprehensive.

Key areas for further development included the need to record ethnicity and first language; the need to capture the voice/observations of pre or non-verbal children; the need for maternity services to consider previous history more robustly; and the need to ensure that Children's Social Care consulted and engaged all relevant agencies in child protection processes. The latter point prompted a further audit by the HSCB to establish whether section 47 enquiries with local agencies were being carried out thoroughly (see s47 Enquiries - Agency Audit below).

A further case audit in November revealed some good progress on the action plans stemming from the previous audit and from recent serious case reviews. This audit also identified areas for on-going attention, where insufficient progress was found.

HSCB Scrutiny and Challenge:
Good practice and progress on previous audit and review findngs:

- The good practice found in the first audit was largely maintained.
- Better understanding of police powers had been embedded in this audit following learning from a recent Serious Case Review
- Improved 'front-door' responses were found in midwifery services
- Good examples of capturing the voice of the child, including observations of pre and non-verbal children were found, particularly by therapists and health practitioners
- Continued evidence of good perseverance with non-engaging young people, particularly for drug and alcohol services. CAMHS confirmed that cases were not being closed automatically in response to non-attendance, and this linked to learning from a recent serious case review.

Areas for continued development:

- Developments in capturing the voice of the child were not always applied to siblings. This reflected findings in the previous audit as well as a recent serious case review
- Evidence of obtaining parental consent was not always obtained
- Recording of ethnicity and language remained an issue for some agencies
- Not all inter professional differences were brought to a conclusion or escalated following local procedures for resolving professional conflict/differences
- Not all relevant agencies had been consulted during s47 enquiries. This remained an issue from the previous audit (see s47 Enquiry – Agency Checks Audit)

(ii) S47 Enquiry – Child Protection Agency Checks Audit

The first s47 agency check audit was undertaken in September 2015 when findings from a multi-agency case audit indicated that not all agencies were being made aware of the child protection concerns until they were invited to the initial child protection case conference. This finding implied that full and appropriate agency checks might not be taking place as part of s47 enquiries and decision-making.

To establish whether this was an isolated problem or a more widespread practice issue, the HSCB audited further randomly selected cases. The result of this audit confirmed that there were wider practice issues to be addressed. Examples were found of some key agencies not being routinely contacted as part of s47 enquiries.

It was also found that where some health visitors and schools had been spoken to in the recent history of the case (but prior to the child protection concern arising) this was taken as a substitute for a s47 enquiry. This meant that those professionals were not given the opportunity to consider and offer any new information, or to reinterpret information in the context of a child protection concern. In this respect, they did not have the opportunity to inform or assist the enquiry.

In response to this finding, the LA introduced a checklist of agencies that should be contacted or considered for contact as part of all s47 enquiries. Laminate versions of the checklist were posted in team rooms.

- **Repeat s47 Agency Check Audit**

To monitor progress, a second audit was conducted six months later in March 2016. Nine randomly selected cases were examined.

Progress was found to be unsatisfactory. There was little indication from these cases that the use of the checklist had been embedded into practice.

In response, further action was taken by the Local Authority, which included uploading the checklist onto Framework I (the Local Authorities electronic recording system). This would help to ensure

that the checklist was visible on the system and its application included into the reporting process.

Implementation included written communication across the directorate explaining system changes, and two separate First Response Team briefings in team meetings to highlight practice improvement requirements. This action was accompanied by a number of team briefings to explain its introduction and application.

The HSCB incorporated further s47 auditing into its new annual auditing programme to monitor progress until satisfied with progress achieved.

(iii) HSCB Audit of the Multi-Agency Safeguarding Hub (MASH)

In January 2016 the HSCB commissioned an independent review of the functioning of the Harrow Multi-Agency Safeguarding Hub, (MASH) which operates as a *single point of contact* for concerns about children in Harrow and has been in operation for the past four years. The audit sought to ensure that the MASH was operating effectively. The objectives of the audit were to establish whether:

- Risks are identified and thresholds applied correctly
- Decision making is effective
- Cases are dealt with in a timely manner
- Relevant information is gathered, and shared appropriately and securely
- There is evidence of management oversight
- Partnership working is effective
- Each case is referred on to the correct agency
- Each child is safeguarded by the MASH

The independent auditor was joined by the Quality Assurance Sub-committee's multi-agency Scrutiny Group. The key findings showed that although some cases have been handled well, overall there were significant concerns about the current functioning of the Harrow MASH. In particular, these related to gaps in gathering information (particularly from schools and GPs); not establishing parental consent for information sharing in some cases; cases not being processed within the agreed MASH timescales; and an inconsistent approach to assessing levels of risk and need.

- **Action to effect immediate change**

Concerns about the functioning of Harrow's MASH were escalated to the Board and an immediate, detailed and robust action plan was put in place to address the weaknesses found in practice.

A second audit was programmed by the HSCB to follow in six months to seek assurance of improvements made against the action plan and the Local Authority set up weekly audits in the

interim period; the findings of which were reported to the HSCB's Executive Group and Quality Assurance Sub-committee.

Post 2015-16 update: The full findings of the second HSCB audit will be reported in the 2016-17 Annual Report, however significant improvements were found in all practice areas, revealing a strong commitment across the partnership to embed and sustain improvement.

(iv) Section 11 Audits for Statutory Member Agencies

Section 11 of the *Children Act 2004* places a duty on key persons and bodies to make arrangements to ensure that in carrying out their work they have regard to the need to safeguard and promote the welfare of children. These arrangements are outlined in government guidance and include a range of responsibilities, for example in relation to having appropriate governance, safer recruitment, training, policies and procedures in place.

The HSCB carries out a detailed audit with each agency to seek assurance that children and young people are being effectively safeguarded and their welfare promoted by the arrangements in place. As well as completing a comprehensive audit exercise, each agency's Board member is required to attend a support and challenge interview with the Chair of the Board and members of a multi-agency scrutiny panel, resulting in recommendations for further action where appropriate.

This year, particular focus was put on seeking evidence of making a difference to children and young people, including how each agency embedded learning from serious case reviews and audit findings.

As part of a commitment to streamline this activity, the HSCB joined with Brent's LSCB to carry out s11 audits with agencies that cross both of our areas. This was viewed as a helpful efficiency for those agencies affected as they did not have to repeat the exercise for each LSCB.

Key findings:

- All agencies had the required statutory arrangements in place
- Agencies provided excellent examples of how they engage children and families in planning and assessment, both in terms of influencing individual cases and in influencing service development.
- All agencies provided evidence of their awareness and activity in relation to embedding learning from recent serious case reviews and auditing
- Agencies provided evidence of their internal auditing and monitoring activity in relation to safeguarding and promoting the welfare of children – however, some were reminded to make these open to external scrutiny through the HSCB's Quality Assurance Sub-committee
- Most agencies provided evidence of challenges faced with regard to internal resourcing for services

- Most agencies provided good evidence of appropriate inter agency working, including constructive challenge where appropriate

Adult Social Care auditing:
"The case file audit process is mature and has incorporated learning from SCRs and learned lessons reviews. Of particular relevance was the Baby D review where a number of staff forums took place. Additionally the family E video has been used and staff have commented on its powerful impact – reflected in audit findings for the Think Family Approach".

Police consultation:

Youth Question Time with the Cops, hosted by Harrow Police, aimed to raise awareness and encourage healthy discussion with the force on issues including cyber-bullying, stop and search, knife crime and counter-terrorism.

CAMHS engagement initiatives which include a child designed website called '**CAMHS and Me'**

What did coming to CAHMS mean for you?

"Good thing – to get help/ don't know what to expect."
"Final acceptance of the problem."
"Felt like going into the unknown."
"It was reassuring to know what help was available."
"Going to CAMHS doesn't mean you're crazy."
"The fact that I needed a mental health service made me surprised."
"It was like a weight off my shoulders now that I weren't keeping it all to myself."

CRC Governance and leadership:

We noted from the audit that the Chief Executive is a member of the London Safeguarding Board and that there is a Senior Lead for Safeguarding. We thought that the Probation Officer single points of contact - referred to as children's champions - with responsibility for promoting best practice and dissemination of relevant learning was a positive development and would want to hear more in the future about how this makes an impact.

Children Social Care handling complaints: Analysis of the way complaints are handled has shown speed and skill in processing complaints, with most resolved at early stages in the process. The analysis also indicated that this was a 'listening organisation', focused on service users. We were informed that in one case, the Ombudsman praised Children's Social Care and MASH. Most concerns about Case Conference decisions are also resolved at an early stage.

In previous years, there was little or no take up of LSCB auditing by schools in Harrow (four in 2014). This was investigated and consultations took place with a selection of volunteers from local schools. The outcome of this activity saw a revised self-audit tool and a workshop to help Headteachers and Safeguarding Leads understand the process and how best to provide evidence.

This new audit has seen an encouraging increase in submissions from schools (28 as at end of March 2016) and these have continued to arrive into the new business year. Every school is provided with a detailed letter outlining their strengths and any areas for development.

Strong compliance with safeguarding arrangements has been found across the majority of schools, with positive and swift responses to areas for improvement.

(vi) Evaluations of the HSCB and its Members

The HSCB recognises that measuring the effectiveness of local services is not enough. Scrutinising the collective and individual effectiveness of the members is needed to ensure that we have the right people steering the work of the Board. This can be particularly challenging where there has been frequent change in personnel e.g. the Police or organisational change e.g. CRC.

Throughout 2015 to 2016, the HSCB has undertaken three audits to gather evidence of achievements and challenges.

The first involved a collective evaluation of performance and achievements based on the existing inspection framework used by Ofsted. One of the actions from this exercise involved a further audit of individual member's effectiveness (referred to below). The vast majority of requirements explored within the collective evaluation audit were assessed as having been met with substantial evidence. There was also agreement on areas not fully met or in need of strengthening:

- Establishing a formal link with the Family Justice Board

  What did the HSCB do? Formal link with FJB confirmed as the Assistant Director for Cafcass who links via the London Safeguarding Board.

- Expanding the range of agencies reporting internal audits to the Quality Assurance Sub-committee.

  What did the HSCB do? Board level challenge took place and the calendar of single agency audits and reports better reflects the whole partnership - see appendix (ii)

- Each Board member to submit a personal audit return on their performance and achievements (relating to the priorities of the Board) as their agency's representative.

  What did the HSCB do? The Board produced a self-evaluation tool to capture evidence of each member's own achievements, challenges and activities that supported the

agreed priorities of the Board. The returns evidenced a wide range of activity led by the Board members themselves, including leading challenges within their own organisations/service to improve learning and practice, as well as taking challenges to other agencies to achieve better partnership working.

- Narrowing overall activity to focus on priority areas for the Board.

  What did the HSCB do? All sub-committee work plans have ensured that every activity is explicitly linked to one or more of the agreed three priorities of the Board for 2015 to 2016

- Action to reduce repeat learning points coming from reviews and audits – and ensure that learning makes a difference to practice

  What did the HSCB do? Repeated learning from reviews and audits are identified and prioritised for continued scrutiny. Multi-agency case audits are now constructed around these themes. The themes are incorporated into the learning events for all staff so that they are made aware of the priority areas for improvement.

- Refresh of website, policies and procedures – its accessibility to a wider audience and its content

  What did the HSCB do? A new website and a refreshed image were introduced in 2015. The new logo and content of the website were changed to better reflect children of all agencies and backgrounds, as well as the local community.

From image 2014

To new image 2015:

A new Policy and Procedures Sub-committee was set up to review all existing policy and guidance tools to ensure that they were up to date and relevant to emerging local and national themes, as well as to develop any local protocols in response to locally identified practice needs.

- Strengthening the link in local intelligence across vulnerabilities for young people affected by CSE, gangs and missing episodes

  What did the HSCB do? The remit of the CSE Sub-committee incorporates cross referencing and analysis of information relating to young people affected by multiple risk factors. Data and reports on missing children and youth violence and gangs are reported into this sub-committee.

- Improving the multi-agency audit tool to ensure that consistent information is received and assessed across all agencies

  What did the HSCB do? The original audit tool, which was primarily based on Children's Social Care processes, was replaced by one that focussed on themes relevant to all agencies. Each case audit since has taken feedback from auditors to help ensure that the audit tool is improved where required, to ensure that consistent information can be extracted from all participating agencies.

The third audit of HSCB effectiveness was undertaken at the Board's Business Planning and Development event by an independent consultant, John Harris. A full day of activity took place to explore where members positioned the HSCB's performance in relation to:

- How the HSCB relates to other strategic partner forums
- How visible and influential the HSCB was – impact on strategy and front line practice
- The effectiveness of Board meetings
- The effectiveness of the HSCB's scrutiny and challenge role
- How well the HSCB uses performance information
- The effectiveness of the HSCB in promoting engagement and participation of young people
- The effectiveness of the HSCB's *Learning and Improvement Framework*

Board members evaluated their individual and collective effectiveness in relation to the above measures and key collective findings were as follows:

What we were concerned about: Thresholds and practice issues within the MASH; hidden victims e.g. young people affected by CSE and gangs; and the impact of reorganisation on continuity of care.

What was going well: A stronger improvement culture and response to auditing; improved relationships between agencies; embedding learning from serious case reviews and learned lessons reviews; improved Quality Assurance; and political and strategic recognition of the HSCB.

What needs to happen: Further embed safeguarding as a shared responsibility across the community; continue involving the voice of the practitioner and the child in all relevant HSCB

reviewing and auditing activity; further dissemination of good practice; avoid 'mission creep' and keep focus on core business; and integrated a focus on children with disabilities across all Board activity. This exercise culminated in reaching agreement on the HSCB's new priorities for 2016 to 2017.

6. Child Sexual Exploitation

Children at risk of Child Sexual Exploitation (CSE) are often some of the most vulnerable in our society. In recent years numerous reviews into this growing concern across the country have highlighted the extent of the problem, the difficulties and sometimes resistance in addressing it. There have also been a range of initiatives developed to help combat this crime and to support victims. Continuous work is needed to ensure that practitioners and communities acknowledge its existence, are able to recognise the signs and know how to respond.

The HSCB's revised *CSE Strategy 2016 to 2018* built upon the learning from the national reviews, from the *Rotherham Independent Inquiry* in 2014 to the more recent *Casey Report* in 2015, where sustained organisational denial of the issue was found. Although referrals regarding concerns of possible CSE have been slowly increasing in Harrow, our figures remain amongst the lowest across London. It has been important therefore, to avoid any complacency drawn from these figures; for communities and practitioners to remain informed and vigilant; and for young people themselves to be equipped to recognise the risks and know where to get help in Harrow.

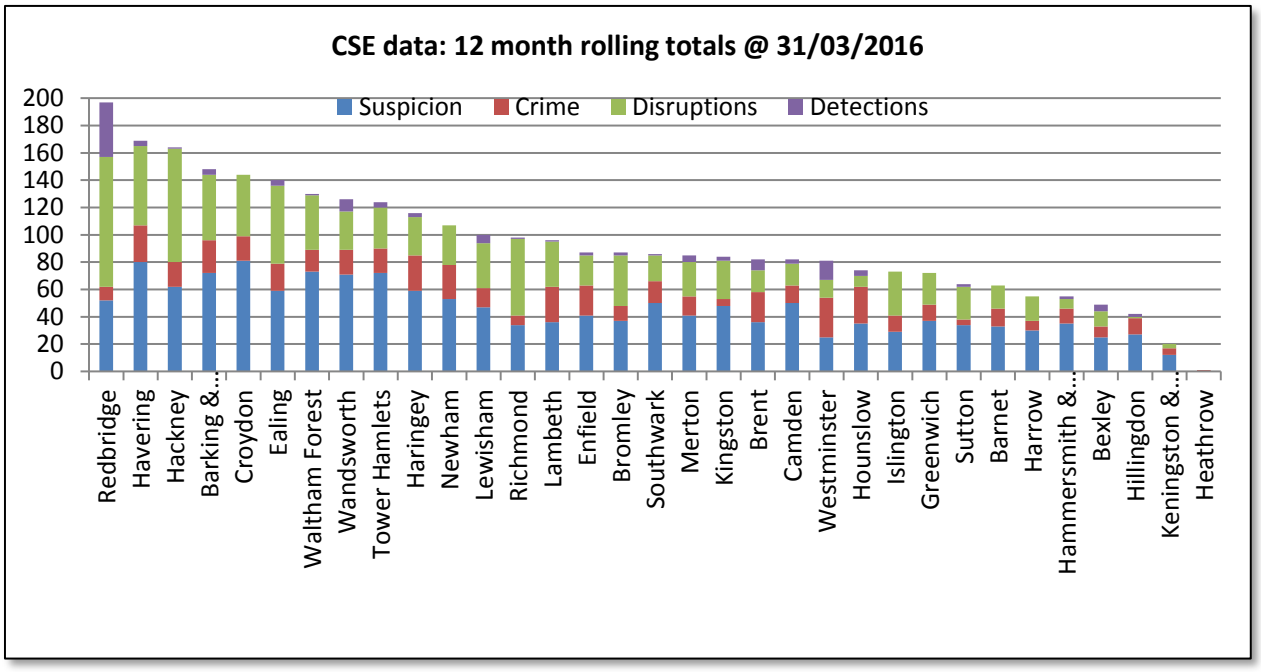
Pathways

Harrow has clear local pathways established for responding to concerns of CSE. All initial referrals will be processed through the Multi-Agency Safeguarding Hub (MASH), where the Local Authority's CSE Co-ordinator advises on identification and assessments. Those cases meeting the criteria for CSE will be referred to the Multi-Agency Sexual Exploitation Group (MASE), so

that a detailed overview of the profile of CSE in the area can be maintained. This includes the identification of any 'hot-spots' and any links between cases within Harrow and across borders.

What we know

With regard to crime generally, Harrow remains one of the safest boroughs in London. Metropolitan Police statistics on CSE are provided on a monthly basis and include a breakdown of activity in relation to detections, disruptions and crimes. With each report, Harrow is placed at the lower end of these activities.



The HSCB remains committed to understanding why the statistics are lower in Harrow and to avoid assumptions that this is purely a consequence of being one of the safest London boroughs.

So far, cases in Harrow show the majority of CSE related concerns take place within peer on peer relationships and on a one to one basis, rather than in any gang, organised or wider network context.

The ethnicity of victims and perpetrators identified in Harrow is mixed. The HSCB regularly scrutinises the profile of cases to ensure that the most realistic picture is gained and kept up to date. Work undertaken in Harrow remains informed by the local profile, but also takes into account emerging themes from London and across the country to keep abreast of potential risks.

Statistics

Since the instigation of the MASE in July 2014 and up to the end of March 2016, 65 cases were considered and 50 of these were made subject to the MASE review arrangements.

Of these cases:

- 6.1% were assessed as High Risk; 72.3% at Medium Risk; and 21.5% at Low Risk

- Females are the predominant victims (94%). This figure reflects the on-going additional challenges in recognising males affected by CSE
- 72% of cases were de-escalated over a period of 1-3 months.
- Sexual exploitation via the internet/technology established in 12% of cases
- 19 crimes were recorded by the Police in connection with CSE. A significant conviction was achieved in October 2015, when a perpetrator was found guilty of CSE related offences and was sentenced to a 12 year term of imprisonment.
- The age range indicates the most affected group sit within the ages of 13 to17, but there were two cases involving children under the age of 12:

Age at time of referral	Number/percentage
Under 12 years	2 (3%)
13	9 (13.8%)
14	8 (12.8%)
15	13 (20%)
16	21 (32%)
17	9 (13.8%)
18	3 (4.6%)

- Young people with black ethnicity had larger representation, but there was a very narrow variation across ethnicities:

Black	14 (21.5%)
White British	12 (18.5%)
Asian	12 (18.5%)
White Other	11 (17%)
Mixed Background	10 (15%)
Arabic	4 (6.2%)
Unconfirmed	2 (3.07%)

- The number of Children 'Looked After' at the time of being referred to MASE was six. Three others were considered, but categorised Low Risk due to insufficient evidence. Two further young people became 'Looked After' as a consequence of CSE being identified.
- The links between CSE and children who go missing are very strong. There were 63 individual children who had a missing or absent episode during the year. Of those, 9 were referred to MASE with concerns or at risk of CSE (see Missing Children).
- The profile in Harrow so far has not shown a strong link between CSE and gang activity, but this is being kept under careful scrutiny given that elsewhere across the country, stronger links have been established.

Findings from Second Independent CSE Review in Harrow

LSCBs are required to carry out regular reviews of the local response to CSE, as outlined in HM Government Guidance '*Tackling Child Sexual Exploitation'* March 2015. The HSCB carried out a second independent review to meet this requirement and to measure progress against the findings of the previous review undertaken in 2014. The review was also to inform the revision of the HSCBs *CSE Strategy for 2016 to 2018*.

The second review acknowledged the considerable amount of raising awareness activity that had taken place across Harrow for young people, practitioners, voluntary and faith sectors and within the wider community, including business communities.

The HSCB had commissioned the theatre company, Alter-Ego, to deliver an interactive and powerful drama on the risks of CSE to secondary schools across Harrow. This was met with considerable success, with both teachers and pupils recommending that we repeat this for others in following years. Each performance was supported by services promoting local lines of advice and support e.g. dedicated services from the local WISH Centre and the circulation of the HSCB CSE Safety card (WISH is a local charity offering support to young people who are affected by sexual and domestic violence).

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"It has given me more confidence to say no**"** **Female aged 15**

"The idea that pictures online are no longer your responsibility was stressing – I'm more aware on online safety" – **Female aged 15**

"The statistics shocked me but gave me a better idea about what others think. I also understand how to spot if someone is being sexually exploited" **Female aged 16**

The HSCB produced an additional CSE training package for delivery at school assemblies. This followed a successful pilot run with year 11s. 100% of pupils said this gave them a better understanding of rape and sexual assault 98% said they understood more about safety online; and 96% said that as a direct result of the assembly, they had a more positive attitude about non-violent and healthy relationships.

The independent review in spring 2016 also found that the appointment of a local CSE Coordinator and a good number of CSE Champions across all agencies was a strong point. These practitioners have helped to embed CSE training and provided a point of advice and support to colleagues across the partnership.

CSE Champions are also identified and active across the HSCB's commissioned services for the voluntary sector. All Champions promote the HSCB's website advice pages and the '*Make-Safe'* materials (posters, films and leaflets) produced by the *Metropolitan Police*.

Continued work was needed in keeping a clear and realistic profile of CSE in Harrow and in particular its links with missing children, gangs and trafficking. The HSCB is keeping these important links under scrutiny as well as the performance of MASE in evaluating local risks. The findings of a wider *London CSE Review* in April 2015 reinforced the HSCB's commitment to maintain a strong focus on information sharing, training and raising awareness activity.

7. Missing Children

Some 140,000 children go missing from home or care in the UK each year and it has been estimated that running away places around a quarter of these children at risk of serious harm. Children and young people who run away may be 'pushed away' following abuse or other factors or 'pulled away' wanting to be near friends or family or because they are being exploited by adults.

A missing child is a vulnerable child. They face many risks including sexual exploitation, gang exploitation, becoming involved in crime or becoming a victim of crime. These children are also at significant risk of underachieving and becoming NEET (not in education, employment or training.

In Harrow, a multi-agency Missing Panel ensures that intelligence is effectively coordinated and that adequate plans are put in place to keep children safe. It is informed by 'return interviews' which try to establish why each child goes missing and where they went. In recognition of the multiple risks faced by children who go missing, this panel coordinates its work with the Multi-agency Sexual Exploitation panel (MASE) and the CSE and Gangs Coordinators. This helps to ensure a joined-up approach and promotes early sharing of local intelligence.

The borough has a small missing persons unit within the police which oversees all low and medium risk cases of missing persons. All missing persons under the age of 18 attract a risk rating of medium by virtue of their age. Any case of immediate risk of serious harm will have a high risk rating attributed to it. These cases are overseen by the CID.

The Local Authority introduced a new 'in house' Runaways Worker at the beginning of 2016, who undertakes the return interviews. The focus of this work is diversion and prevention.

Unaccompanied Asylum Seeking children

All actions and laws which apply to missing children in general equally apply to unaccompanied children. Despite the enormous risks to which unaccompanied migrant children are exposed, their disappearance is usually under-reported. In the UK, the *British Asylum Screening Unit* reported that 60% of the unaccompanied minors accommodated in UK social care centres go missing and are not found again (Frontex, 2010)

What we know

In November 2015, the HSCB undertook a 'What we know' mapping exercise in relation to missing children.

In Harrow, there were 63 individual children who had missing or absent episodes between May 2015 and April 2016. Of those, there were five that were known or suspected to be at risk of sexual exploitation during the same period.

Looked After children: The majority of children that are reported missing in Harrow are 'Looked After' (89%), with the rest going missing from their family home. 'Looked After' children accounted for 77% of the episodes. Just over a third of cases referred to the police were attributed to seven individuals who each had a number of repeat missing and absent episodes. 75% were missing for one day or less. 5% were missing for more than a week.

Gender and ethnicity: More females went missing; Black or Black British children and young people accounted for 42% of all children going missing in the period, with White children and Asian children each accounting for 15%.

Age: 42% of children reported missing were aged 16/17 years, 46% aged 10-15, and a smaller cohort of younger children that were reporting missing with parent/s.

During 2014 to 2015, 513 cases were reported as 'Missing', i.e. they were missing from their home residence and their activity was out of character. 220 were reported as 'Absent' i.e. they were not believed at risk of harm (generally the young person is at a friend's house or they have ignored their curfew times). Of the overall figure of 733 episodes, some individuals were

responsible for the bulk of them e.g. Seven children had between 19 and 91 missing or absent episodes each.

Recording missing children instances has been revised to distinguish children in care who go missing and those who are absent from placements. The number of children reported missing from home has been dropping, but the number of children 'looked after' who went missing or who were absent increased.

Missing Children	2014/15				2015/16			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of instances of children reported as missing from home (whereabouts unknown)	6	13	4	11	20	10	15	13
Number of instances of children in care reported as missing from placement (whereabouts unknown)	22	68	77	117	61	47	35	48
Number of instances of children in care reported as absent from placement without authorisation (whereabouts known)	7	15	33	38	21	15	31	35

Oversight, Scrutiny and Impact:

Children reported missing children remains a priority focus. The profile of these children is subject of multi-agency oversight through daily operational monitoring and monthly overview meetings.

A new local authority Runaways Worker was introduced at the beginning of 2016 to undertake return interviews with young people following missing episodes. This post sits within the new Violence, Vulnerability and Exploitation Team to help strengthen local intelligence regarding the overlapping cohort of young people affected by Gangs and CSE.

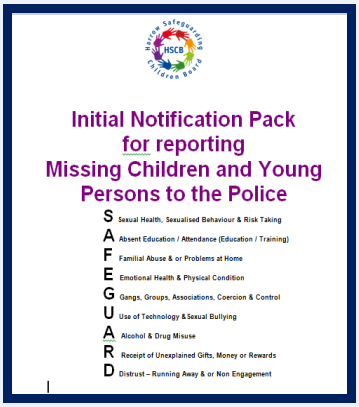
Prior to the new Runaways Worker post being in place, return interviews were undertaken through the Local Authority's commissioning arrangement with a charity. For the period of this report, 96 referrals were taken by the charity relating to 27 children. 22 interviews took place; 14 interviews were declined. 30 interviews took place with parents/carer or key worker. The new in-house service has been raising performance in relation to return interviews and establishing reasons for young people going missing:

18 of the 19 high Risk Young people were interviewed within 72 hours of being located (from start of new service to end April 16)

Reasons given by young people for going missing:

- Family breakdown
- Pull towards gangs
- Not complying with curfew

New Multi-agency Missing Children Notification Pack (Grab Pack)
The Metropolitan Police developed a 'Grab Pack' for use by themselves and Local Authorities to help gather essential information when trying to identify and locate missing children and young people. The HSCB adapted the pack for multi-agency use, so that any agency, school or voluntary sector service could contribute quickly to the process of describing and locating the child/young person. This can be used when it is anticipated that a child/young person might go missing or in response to an unexpected missing or absent episode.



8. Gangs, Youth Violence and Vulnerability

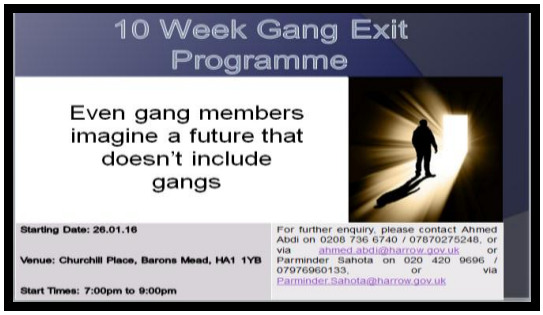
In 2011, the Government published '*Ending Gang and Youth Violence'* a report which set out the measures needed to tackle gang and young violence, together with a series of national actions. The central message was that such violence can only be addressed by a coordinated approach, based on early intervention as well as enforcement and the active involvement of every local agency to share information, resources and accountability.

What we know

There are two identifiable gangs within the borough of Harrow; one largely in the Wealdstone area and the other in Rayners Lane. They are both known to have links to neighbouring areas in Brent.

There are also lower profile gangs in Harrow, involving younger people and these groups are believed to act as 'feeder' groups into the more established gangs mentioned. Inter-school rivalry is sometimes a feature.

Information on gang members is shared across relevant agencies via strategic and operational partnerships e.g. Safer Harrow and the Multi-agency Safeguarding Hub (MASH). The Local Authority's Gangs Coordinator helps to ensure that a preventative and diversionary service for young people is accessible via the *Exit Path Gang and Support Programme*. 18 young people (aged 15 to 16) have accessed the Exit Programme over the year. Of these, 13 were from BAME background (Black Asian Minority ethnic).



Research undertaken by the *Office of the Children's Commissioner 2013 ' Inquiry into Child Sexual Exploitation in Gangs and Groups'* revealed the prevalence of sexual violence within or between gangs, including the use of rape as a weapon in gang conflict or punishment. . The research found that many professionals fail to regard such violence as sexual exploitation.

So far, the profile of cases in Harrow has not established the same clear link between young people affected by CSE and gang activity, but the pattern remains under constant scrutiny. The co-location of the Local Authority's Gang's, CSE and Missing Coordinators has strengthened the intelligence sharing in this respect.

The HSCB carried out a 'What we know' mapping exercise in relation to gangs in Harrow in February 2016. All relevant agencies and voluntary services submitted intelligence and data to inform discussion and analysis. Discussions were also informed by feedback and consultations with young people, which the HSCB shared with the Safer Harrow Partnership to inform their new strategy.

Monitoring and Scrutiny:

- The Gangs Coordinator is supported by the Morning Lane Programme for gang affected families and by key voluntary partners: Ignite, WISH, Xcite and Plus 16. The Coordinator ensures good connectivity with and between MASH, MASE Panel, the Risk and Vulnerability YOT Management Panel, Children at Risk of Missing Monthly Meeting, the Serious Incident High Schools Group Meeting, and Wealdstone Gangs Partnership Meeting.

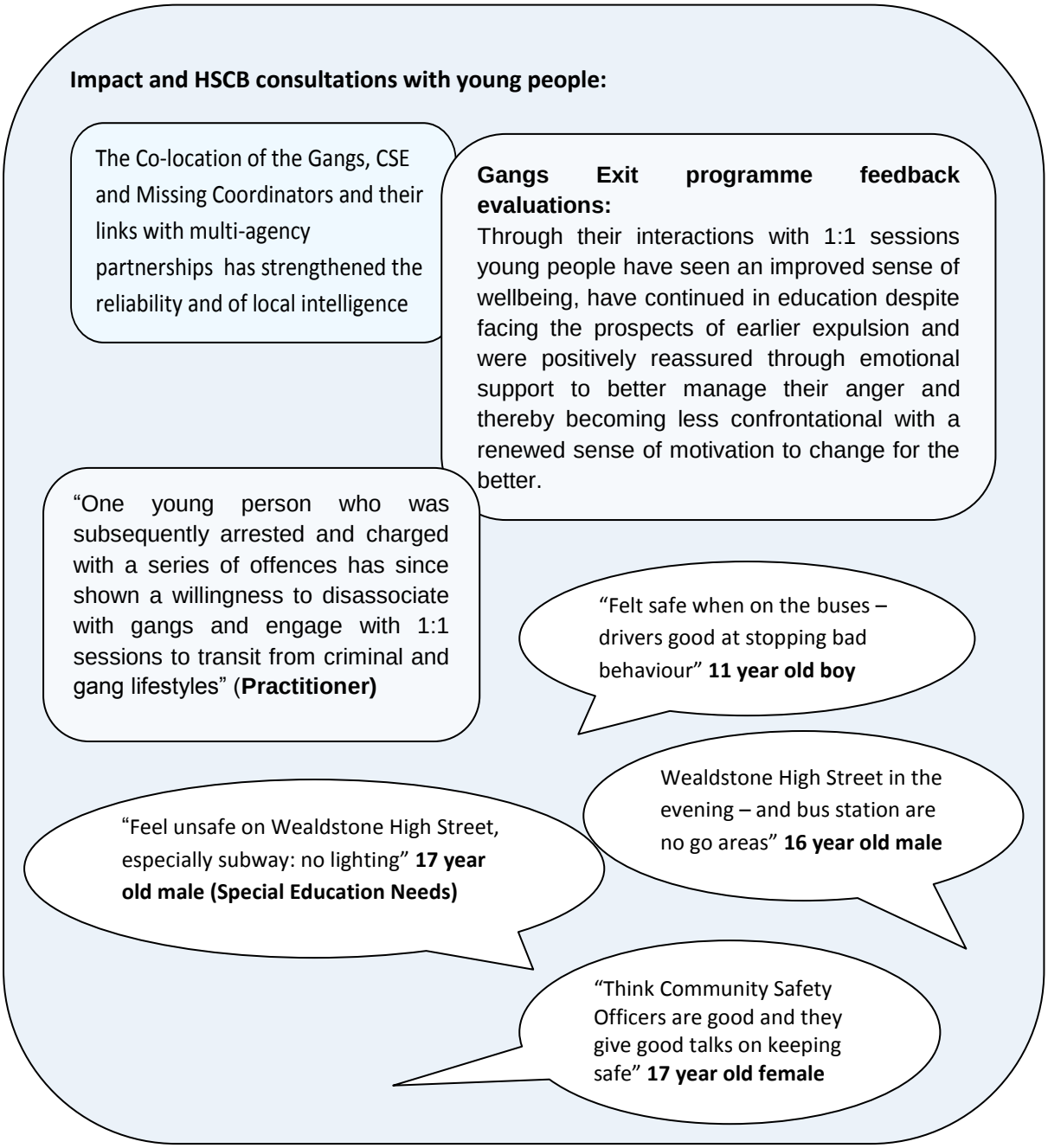
- 18 young people accessed the Gang Exit Programme in the year with the source of referrals mainly from YOT and schools, then Early Intervention and Children in Need Services. The main support has been through 1:1 sessions usually taking place in school settings or at the civic centre – depending upon the needs of each young person.

- The Exit Programme helps young people learn and explore issues in relation to peer pressure, why they join gangs, anger management and the law. Building resilience is a key objective.

- Those accessing the Exit Programme have had a range of associated concerns including selling illicit drugs; carrying a weapon; poor performance at school and at risk of permanent exclusion; and staying out late with known gang members

- Currently no young females are on the Police Gangs Matrix – although there is low level anti-social activity in one known girl's gang

- HSCB consultations with young people have identified "no go areas" at certain times in Harrow



Home Office Review in Harrow – Ending Gangs and Youth Violence (EGYV)

The HSCB recognised the important role it has in supporting the development of a gangs and young violence strategy by Safer Harrow and was therefore very keen to support the Home Office led *Peer Review* in October 2015. This review was organised by Safer Harrow and a wide range of agencies participated to inform its findings.

The review found that Harrow's needs were very specific and that there was a strong commitment to take early intervention in order to prevent escalation from what is currently a serious but not high profile issue in the borough.

The need for a clear overarching strategy from the Safer Harrow Partnership was identified, but many examples of effective operational activity and partnerships were found e.g. the MASH; the schools and community police initiative in the *Serious Incident Group* (where local intelligence

about gangs, youth violence and exploitation is shared at an early stage across the partnership); and drug enforcement days:

Links with the HSCB's CSE Strategy.:" *This is well recognised in the CSE Strategy of the LSCB which identified a strategy structure to ensure accountability and governance to the highest level; understanding the scale of the problem; raising awareness; identification of those at risk; support for victims; and information analysis to enable disruption and prosecution"*

The LSCB is ideally placed to pose reflective questions and to challenge thinking about the systems and processes of the 'Youth violence, vulnerability and exploitation' Strategy"

Serious incident Group: *"There was a clear awareness of the drivers of violence and vulnerability and the risks, particular to young people schooled in Harrow. There was an evident sense of the group's real willingness to understand and support joint work"*

***Police led Drug enforcement day: "…**offered the public the chance to see how agencies work together to tackle community safety issues…helping to create a hostile environment for criminality and make a strong statement that drug misuse, gang and youth violence are not acceptable within Harrow".*

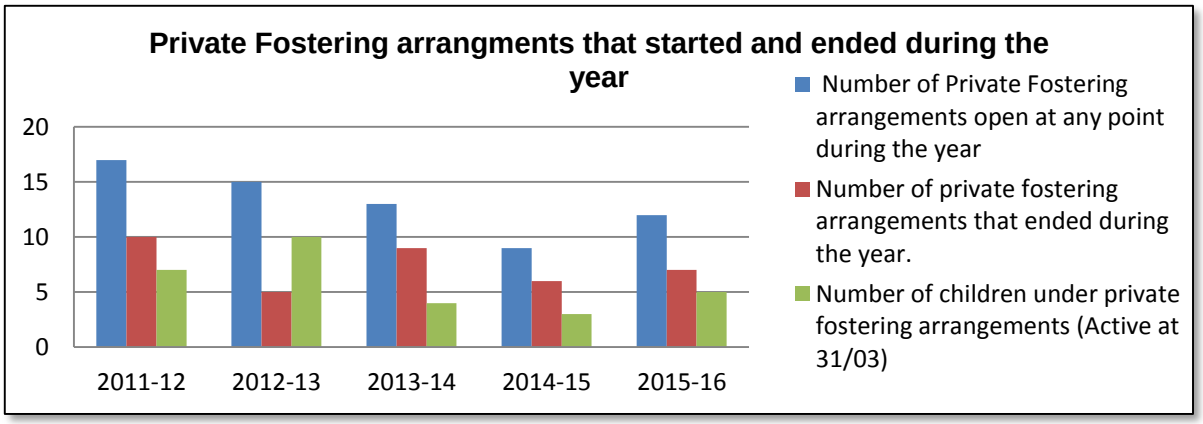
Mapping the problem: *"Staff, especially on the front line, from a number of different agencies have detailed, current and important knowledge and information about issues on the ground in relation to serious youth violence, current and emerging vulnerabilities and patterns. This information if collected, collated and analysed will be an essential foundation for the growth of an effective strategy based on a Problem Profile".*

9. Private Fostering

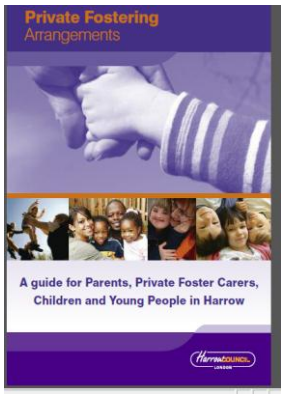
Private Fostering arrangements are made privately by agreement with the birth parent(s) and concern the care of children under the age of 16 (under 18 if disabled) by someone other than a parent or close relative with the intention that this care arrangement should last for 28 days or more.

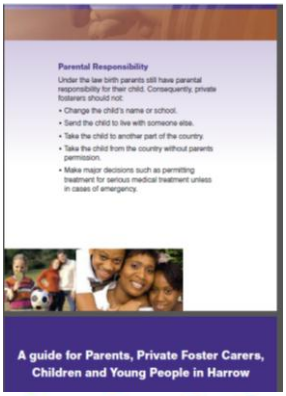
The Local Authority has a written plan, which sets out its duties and functions in relation to private fostering. It also promotes awareness of the notification requirements.

Whilst the number of private fostering notifications has increased, it is acknowledged that there is significant under reporting across the country and therefore efforts to raise awareness must be continuous.



Based on a comprehensive marketing programme, Harrow has developed its own leaflets, posters and information packs and has distributed these to schools, local community groups, statutory partners and other colleagues within Children and Families and the Council as a whole. Local agency and HSCB websites have been used to promote this information, as well as communications through the local media, based on the national campaign *"Somebody else's child".*





Somebodyelse'schild

Specific information sessions have been provided to a wide range of agencies, schools forums and community/faith groups.

Oversight, Scrutiny and Impact:

In 2015 to 2016 all 12 notifications in Harrow were visited & assessed within 7 working days – meeting the statutory requirement

7 cases were monitored regularly - meeting statutory requirements. 5 cases were just outside of the required visiting schedule due to families rearranging appointments (dates were booked within the required timescales)

A Lead Private Fostering Officer has been established to keep raising the profile of PF and to offer support & advice to carers & professional colleagues

Parents are also provided with information & support. A guide for parents has been produced to help them understand key issues, responsibilities and available support

Children and young people are provided with direct advice and support.
They are all seen alone to ascertain their wishes, feelings & any concerns they may have.
Additional support is also provided by the Children's Participation Coordinator and the Advocacy Service.

Post private fostering consultations confirm that children & young peoples' wishes & feelings contributed to the development of their plans

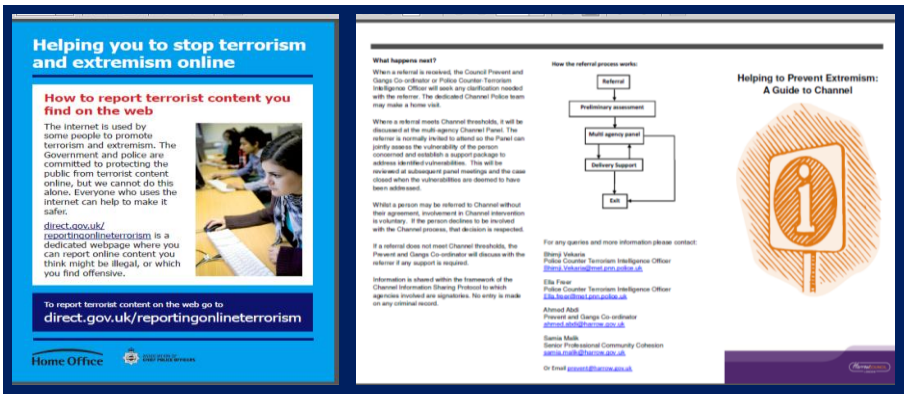
10. Preventing Radicalisation and Extremism

Young peoples' vulnerability to extremism is primarily a safeguarding issue rather than a counter-terrorism or policing issue, particularly with regard to securing early help. The HSCB has a key role therefore in ensuring that the local response supports the Government's Prevent agenda in raising awareness and identifying vulnerable young people at risk of radicalisation at the earliest stage.

The HSCB supports the Local Authority in running regular multi-agency *Workshops to Raise Awareness of Prevent (WRAP)*. The HSCB also monitors attendance to ensure that all agencies engage their staff in the training. Additional reports are received from the health sector with regard to accessing the Department of Health's bespoke training for health staff.

The HSCB website provides information and advice for professionals, young people and parents to alert them to the possible signs and where to obtain help. These pages include useful and sensitive films to help respond to the needs of a wider audience. The Prevent e-learning courses can be accessed via the website and the face to face training is booked through it.

Harrow has an established a multi-agency '*Channel Panel'* set up to discuss any cases of concern and to take action to divert children and adults from being drawn in to terrorist related activity. It addresses all forms of extremism.



Oversight, Scrutiny and Impact:

For the period 2015 to 2016 50 cases were referred to the Multi-agency Safeguarding Hub where initial concerns of possible radicalisation were raised – most did not reach the threshold for a referral to the Channel Programme

More than 40 training/briefing sessions on Prevent were delivered (multi-agency & single agency) by Lead Prevent Trainers

The HSCB's section 11 audit for schools seeks confirmation that Prevent policies and training is in place. All returns in 2015 to 2106 provided evidence of compliance

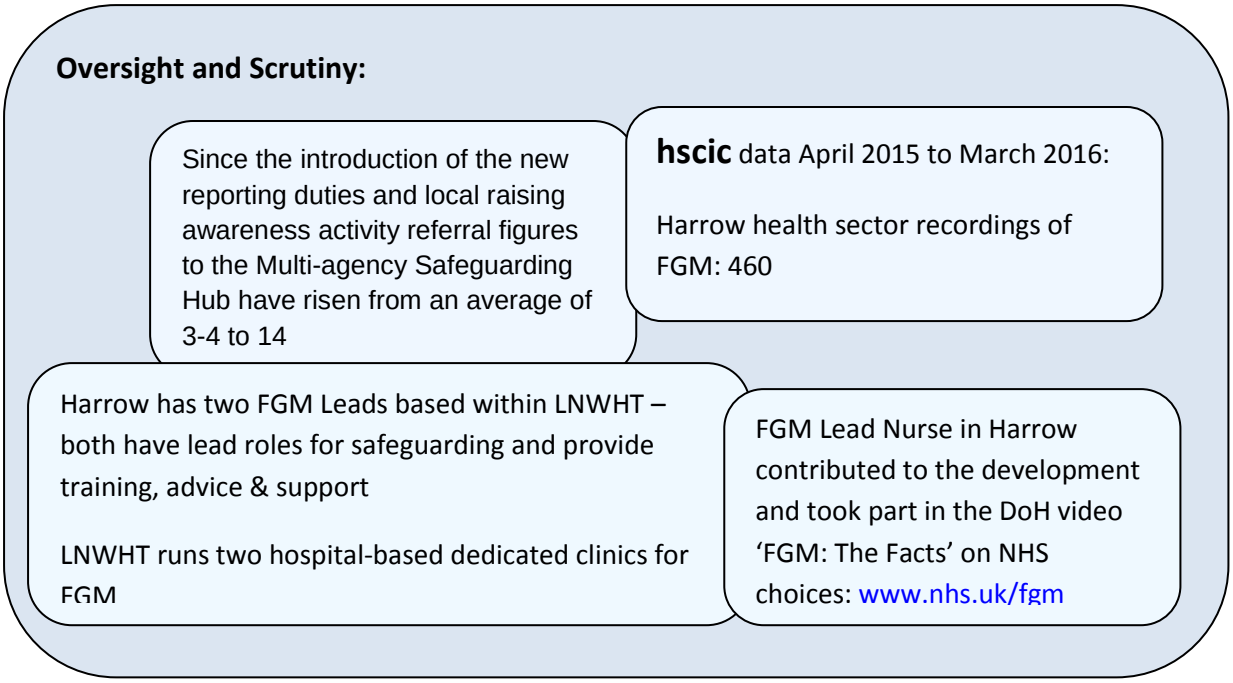
11. Female Genital Mutilation (FGM)

A new mandatory reporting duty for FGM came into force on 31st October 2015 and was introduced via the *Serious Crime Act 2015*. The duty requires regulated health and social care professionals and teachers in England and Wales to report known cases of FGM in under 18-year-olds to the police.

As part of its ongoing commitment to protect young girls from the practice of FGM, the HSCB ran briefings for staff on the new duties and to reinforce understanding about the harmful initial and long term effects of FGM. The Lead Outreach Officer from the *Home Office* presented at a HSCB event in October 2015 to help embed an understanding of the new duties across the multi-agency partnership.

Historically, referral figures for concerns relating to FGM have been low in Harrow (3-4 a year), given the local demographics and women coming from countries and cultures where there is a high prevalence of FGM. Since the introduction of new legislation, making reporting mandatory for certain professions and the associated local raising awareness activity, referral figures increased.

In addition, new data collection by the Department of Health draws figures on health recordings on women who have presented for services and FGM has been identified. As well as gathering intelligence on the profile of those affected by FGM across the country, it provides local services with opportunities to consider future risk for any children in the household and to provide preventative education and advice. The process of gathering this data is new and caution is advised in any interpretation, but the *Health & Social Care Information Centre* report April 2015 to March 2016 shows that health staff in Harrow are complying with recording responsibilities and there were 460 attendances in health settings, where FGM was recorded.



HSCB supporting local initiatives

Norbury Primary School in Harrow has taken a lead role in developing training for its pupils on FGM and taking their training programme to other schools across the borough and beyond. It has a large population of children from countries known to practice FGM. Their initiative is cited in the Government's latest guidance as a good practice example: *'Multi-agency Statutory Guidance on Female Genital Mutilation'* (2016).

The School's programme has been promoted through a number of HSCB briefings and at the HSCB's Annual Conference, where the children presenting left a powerful and positive impression on the delegates. To celebrate the voice of the child, the school created a working party of Year 3- Year 6 children to raise awareness of FGM across their borough.

"Norbury School recognised that it needed to bring communities on board with the work rather than have a 'top down' approach. They also wanted to be open and honest about facts, based on an educational approach, rather than 'blame' and 'lecture' ".

They used the NSPCC PANTS programme as a basis for their FGM awareness programmes. The PANTS programme sets out a simple message for children that parts of their body covered by underwear are private, their body belongs to them and that no-one has the right to make them do anything that makes them feel uncomfortable.

The school had six months of regular meetings with stakeholders including health services, children's services, their parent group, the voluntary sector, the police, cluster schools and charities to understand the facts, the various educational approaches, training and engagement with communities

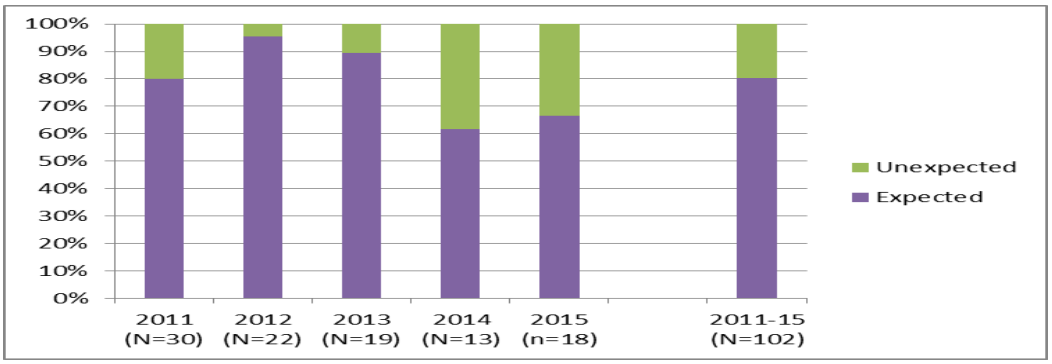
12. Child Death Overview Panel 2015-16

The Harrow Child Death Overview Panel (CDOP) has the responsibility to review all deaths in children up to the age of 18 years and to establish whether there were any modifiable factors. A key element of the process is to identify any lessons to prevent similar future child deaths.

The Panel held four meetings during the year in which 18 cases were discussed compared to 13 cases in 2014.

Due to the low numbers involved, it is difficult to provide a robust trend analysis. However summary data for the previous five years is included in this report for comparison. Regardless of the small numbers, CDOP continues to act as advocate for families to improve the health and wellbeing for infant and maternal health.

Expected Vs Unexpected Deaths: Over the past five years, only 20% of child deaths are classified as unexpected. In the past two years this proportion is higher although the small numbers make it impossible to say if this is an ongoing trend. Of the 20 unexpected deaths occurring in the past five years, almost all had a rapid response meeting or visit.

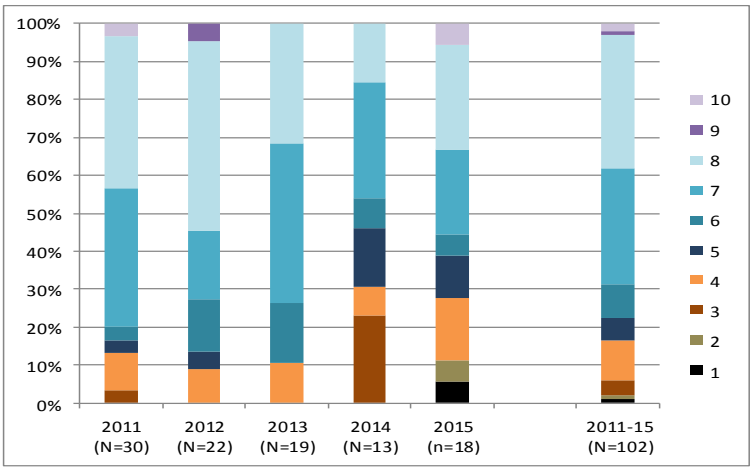


Between 2011 and 2014, deaths were higher in males than in females. In 2015, female deaths accounted for 56% of cases reviewed by CDOP.

Due to small numbers the pattern of deaths varies by ethnic group. On average over the past five years, the number of deaths in children from BAME groups is slightly higher than might be expected given the makeup of the Harrow population.

In almost half of all child deaths, religion was not known or not recorded. No conclusions can be drawn from this data.

In common with that national data, both in 2015 and over the past five years, the most categories were that of perinatal/neonatal events and chromosomal, genetic and congenital abnormalities.



Key:

Category	**Name & description of category**	Category	**Name 7 description of category**
1	Deliberately inflicted injury, abuse or neglect	6	Chronic medical condition
2	Suicide or deliberate self-inflicted harm	7	Chromosomal, genetic and congenital anomalies
3	Trauma and other external factors	8	Perinatal/neonatal event
4	Malignancy	9	Infection
5	Acute medical or surgical condition	10	Sudden unexpected, unexplained death

Over the year, there were three cases that were unusual for Harrow. Two cases were subject to serious case reviews and both were assessed by CDOP to have modifiable risk factors. 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.

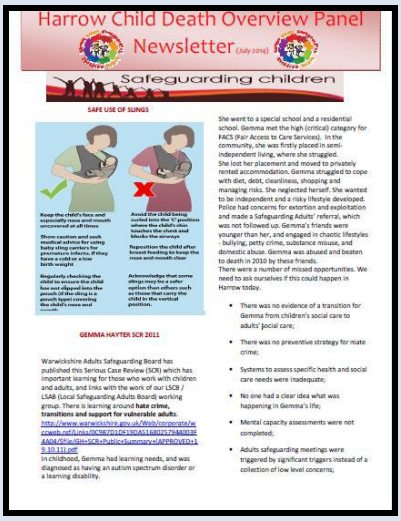
The third case of note was a sudden unexplained death in infancy, the first in Harrow since 2011. An unexpected death of a child is defined as death that was not anticipated as a significant possibility 24 hours prior to the occurrence. The case had no modifiable risk factors but the panel suggested that thought should be given to refreshing awareness about reducing the risk of SUDI/ SIDS.

There were believed to have been four modifiable deaths in the cases examined in 2015. Due to the small numbers of child deaths in Harrow, further information related to individual cases cannot be made available.

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 case reviews which will determine future learning.

Lessons Learnt:

- All unexpected deaths were managed appropriately using Rapid Response Procedures
- As in previous years, infant deaths are the highest proportion of all child deaths; therefore measures to improve the health of pregnant women are vital. Early booking gives the best chance of identifying problems, implementing any changes in the woman's management and making lifestyle changes such as stopping smoking
- As a result of the SUDI case, a programme of training for early years workers in children's centres, private nurseries and private child minders has been initiated in collaboration with the Lullaby Trust. The training on safer sleep practices includes information on referral to stop smoking services, the use of child slings and the availability of support for bereaved parents.



13. Voluntary and Faith Sectors – Training and Outreach for the HSCB

Following a very productive year in 2014 by Voluntary Action Harrow (VAH) and Ealing CVS, the HSCB decided to re-commission these services as the training and outreach arm for the Board. The HSCB has very good representation from some of the larger and more established voluntary groups, so this commissioned arrangement helps to reach some of the smaller and more remote groups with advice and support.

The outreach team have successfully delivered safeguarding training to the community voluntary, faith and private sectors in Harrow, engaging some of the harder to reach minority ethnic groups, organisations and communities. Their reach has been broadened into a much wider range of faith groups over the past year, helping to ensure that Safeguarding messages are communicated to minority faith groups/organisations in Harrow e.g. Afghan Association Paiwant; Harrow Association of Somali Organisations; Harrow Bengali Association; Pakistani Women's Association; Rayners Lane Islamic Centre; Harrow Central Mosque, as well as a range of supplementary school settings.

The outreach team also provide advice and support to smaller organisations with regard to developing their safeguarding procedures, supporting their safer recruitment processes and advising on specific concerns they may have. They have formed a much valued focal point for the community, voluntary and faith groups, as well as a bridge between these groups and agencies which strengthens partnership working.

As well as supporting the general work of the HSCB's sub-committees and the annual conference, VAH have responded to specific requests from the HSCB in addressing concerns raised about possible deficiencies in safeguarding arrangements within organisations. Their involvement has led to improved understanding, better relationships and more robust safeguarding arrangements being put in place.

The new commissioning arrangement included an added brief in helping to embed an understanding of signs and support in relation to CSE, gangs radicalisation, private fostering, Honour Based Violence, Forced Marriage, and FGM. These topics have been delivered alongside key learning from the HSCB's reviews; with neglect being a key focus.

Feedback from VAH and Ealing CVS indicated that some community groups are easier to access with safeguarding training if titles of the courses are more tailored and sensitive to their needs. For example, an understanding of CSE and radicalisation has been successfully incorporated into training on 'Grooming', without avoiding or diluting the intended messages.

Oversight, Scrutiny and Impact

VAH succeeded in achieving target number of bespoke training sessions with good attendance rate

Sessions have resulted in organisations identifying a Nominated Safeguarding Person

VAH and Ealing CVS have trained CSE Champions who deliver the CSE face to face training programme

Safeguarding briefings have been incorporated into the Inter-faith Forums – including WRAP training

Training Impact Assessments:

"Prior to the training I would have investigated any allegations and now know that this is not my role and that I need to make a referral to the MASH team"

"We now log and record concerns no matter how minor so that we can go back if we have concerns"

"We decided to print our child protection policy out so it is easily accessible to staff, volunteers and parents"

"It has made me more aware of the dangers of sexual exploitation of children – I am now more determined to involve parents in our church to make them aware"

Safeguarding news and the VAH training programme is promoted via the quarterly Safeguarding Newsletter
VAH's website also promotes its DBS checking services for local organisations

Voluntary Action Harrow Co-op

14. Learning, Development and Training

The main objective of the Learning and Development Sub-committee is to support the HSCB's *Learning and Improvement Framework*, so that multi-agency learning strengthens working relationships and improves outcomes for children. This means that our focus remains on identifying improvements for the child's journey through local multi-agency systems.

This was another very busy year for the HSCB training programme, with a marked increase in the take up of courses on the previous year. The most important aspect of our training is the evaluation of what difference it makes to practice and the impact this has for children and young people in Harrow. In this respect processes for capturing evidence have been strengthened.

Delegates are required to complete pre course questionnaires to establish a base line of their understanding; an evaluation immediately following the course gathers information about whether the course met training needs; and finally, a follow-up evaluation with delegates and their managers seeks evidence of how the training has impacted on practice and outcomes for children.

In addition to the annual training programme, the sub-committee have been very active in running a range of briefings and dissemination events to keep staff up to date with emerging themes and local initiatives e.g. learning from our serious case reviews; FGM; Belief in Spirit Possession, Prevent, and a re-launch of the *Neglect Toolkit*.

HSCB's Annual Conference : 'Reducing Vulnerabilities for Young People in Harrow'

This year the focus of our conference was on two of the HSCB's key priorities: to reduce vulnerabilities for young people and to incorporate the voice of the child.

We were fortunate to be supported by the Lucy Faithful Foundation with key note speaker Lisa Thornhill, who focused on young people who exhibit harmful sexual behaviour. A powerful presentation was also given by the Director of the WISH Centre, Rowena Jaber, who runs a Harrow based charity for young people affected by exploitation and self-harm. Rowena's presentation brought the voice of the child via a survey of over 150 young people in Harrow, as well as through an impressive new film involving young people themselves. The final key note speaker came from the charity Ms Understood, George Curtis who gave a very thought provoking presentation about peer on peer abuse.

The day included a range of well received workshops relating to local drugs services, travel risks for young people, FGM, sexual health, and girls and gangs. Pupils from Norbury Primary School presented a learning activity regarding FGM and responded to questions about their understanding of how to keep safe and how they talk about sensitive issues with friends, teachers and family.

Feedback from delegates was very positive and confirmed that the issues addressed were all very relevant to Harrow and that the presentations and workshops inspired and equipped delegates to strengthen practice.

Oversight, Scrutiny and Impact:

The HSCB ran 72 multi-agency learning sessions and 3 Designated Teacher Forums

Activity reached **one thousand, seven hundred and two** practitioners – an increase of **508** on the previous year

15 new practitioners were trained to join the HSCB training pool.

60 new CSE Champions were trained to cascade a minimums of two face to face CSE courses per year – reaching a wide range of statutory and voluntary sector organisations

There was in increase in the number of practitioners accessing **e-learning courses**:

- 309 undertook the Level 1 baseline Safeguarding course
- 159 undertook the level 2 Introduction to safeguarding
- New e-learning courses were introduced during the year for CSE, Prevent, and FGM. The HSCB website also signposts staff to the DoH bespoke courses for health practitioners on these topics

Impact statements:

"Team are more inquisitive during health assessments – evidenced in health assessment paperwork**" Health Practitioner**

" We have joined the travel ambassador programme, 12 student involved this year and again in future years - to empower themselves to feel heard and also to advocate for the rights of young people with disabilities travelling in the borough" **Teacher**

"I have utilised some of the resources identified by the Lucy Faithful Foundation in relation to CSE" **Social Worker**

"She is more vigilant and active in this aspect of her practice (risk assessments)" **CSC Manager**.

"This training has been successfully cascaded to all support staff including Teacher Assistants and SMSAs', and will now be given to Teaching staff" **Headteacher**

15. Business Co-ordination with Harrow Safeguarding Adults Board

To ensure that where relevant, the strategic plans between the two safeguarding Boards are co-ordinated, members of the two bodies meet on a quarterly basis, as well as having representation on each other's Boards. This arrangement recognised that since the *Care Act 2014* (implemented in 2015), Safeguarding Adults Boards across the country became

statutory bodies. This created new opportunities to combine some activities for greater effectiveness and efficiency.

Together the Boards have run events on topics including FGM, Sexual Exploitation, trafficking and Preventing Radicalisation. Joint meetings are held with the London Ambulance Service to assist with efficiencies for that service and to share good practice and members of each Board participate in each other's Business Planning Days.

Members of the Adult's Board have participated in auditing activity for the HSCB's multi-agency case audits. Their own auditing activity incorporates scrutiny of the '*Think Family Approach'* and findings have been presented to the HSCB's Quality Assurance Sub-committee, confirming good practice in identification of needs and risks to children by adult services and appropriate referrals to Children's Social Care.

Appendix (i) HSCB Budget 2015-16	**£**
Harrow Council including Business Support	149,173
Police	5,000
National Probation Service	1,000
Community Rehabilitation Company	1,000
Cafcass	550
Central and North West London NHS Foundation Trust	11,000
Harrow Clinical Commissioning Group	11,000
London North West Healthcare NHS Trust: Acute Services & Community Services	22,000
Training Income	14,985
Sale of USBs	220
Total Income	**215,928**
Staff & Consultancy Expenditure:	**£**
LSCB Chair	19,840
Professional Support (full time BM; part time L&D co-ordinator)	91,203
Training Admin (.5 FTE) + p/t admin	18,279
SCRs	21,102
Voluntary Outreach work	18,600
Staffing & consultancy expenditure Total:	**169,024**
Delivery costs:	**£**
Annual Conference	5,920
Training Providers	9,795
'Chelsea's Choice' production on CSE	8,100
Venue Hire	4,827
LSCB Website & 3 year Chronolator™ Licence	7,650
Publications, Printing, USB Production	1,174
Catering & Misc	4,168
Delivery Costs Total:	**41,634**
Total Expenditure:	**210,658**

Appendix (ii)

HSCB Quality Assurance Sub Committee – Scrutiny Calendar 2015

date	meeting	Activity / Report for scrutiny
28 April	**QA sub cttee**	• Police dataset • HSCB dataset • CIN Deep Dive Action Plan
12 May	Mulit-Agency Case Audits – spring 2015	Scrutiny Panel feedback, 2nd session. Theme – CIN, CP, LAC
23 June	**QA sub cttee**	• Health referrals into social care • HSCB Dataset Q4 14/15 • Multi agency case audit report – Spring 2015
9 July	S11 Challenge Panel	Harrow Borough Police - a.m. CAIT – p.m.
28 July	**QA sub cttee**	• CRC Safeguarding Improvement Plan • YOT annual report • Public Health - YP D&A needs assessment review & templates •
19 Aug	S11 Challenge Panel	Adults Services
27 Aug	S11 Challenge Panel	Community Health
22 Sept	**QA sub cttee**	• HSCB Dataset Q1 15/16 • LADO report • Draft local gangs strategy (SHP) • Multi agency audit action plan – Spring 2015 • Missing Children report (CS) • Sample s47 enquiry checks (HSCB report following audit)
30 Sept	S11 Challenge Panel	Children's Services
27 Oct	**QA sub cttee**	• CP Conference Chairs' Report • IRO Annual Report • Early Help assessment report • Verbal report: learning from CP Challenge Panel • Probation performance report
5 Nov	S11 Challenge Panel	Community Rehabilitation Company

8 Dec	**QA sub cttee**	• CS audit of CLA health reviews • HSCB Dataset Q2 15/16 • Allegations Management training attendance
15 Dec	Multi-Agency Case Audits Autumn 2015	Scrutiny Panel Feedback. Theme: Neglect CP cases; accomodated visa EPO or PPoP
17 Dec	S11 Challenge Panel	CNWL
19 Jan	**QA sub cttee**	• CAMHS report • QA Framework draft • Children & Families QA Framework
23 Feb	**QA sub cttee**	• Virtual School • Maternity perinatal m/h report • WISH Centre Annual Report • HSCB Dataset Q3 2015/16
24 March	Sec11 audit	Acute Services
5 April	**QA sub cttee**	• Social work health check report • Adults – Think Family • MASH Audit (Janis Lloyd)

Appendix (iii) New HSCB Priorities for 2016 to 2017

Priority 1: Refocus on core business: knowing that systems and practice are fit for purpose in **identifying, assessing** and **responding** to **risk.**

Safeguarding children from abuse and neglect - Robust and reliable quality assurance for:
Thresholds and multi-agency 'front-door' responses – Early Help - MASH – MASE

Priority 2: 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

Children with Disabilities/Special needs -Missing Children - Child Sexual Exploitation - Gangs - Trafficking - Female Genital Mutilation - Radicalisation - Forced Marriage – Cyber & Homophobic Bullying - Self harm

Priority 3: 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 4: Effective collaboration: ensuring that the priorities of the HSCB are **acknowledged and supported** by other strategic partnerships within Harrow and that opportunities to work in collaboration with neighbouring LSCB's are sought and initiated

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