HARROW SAFEGUARDING CHILDREN BOARD

ANNUAL REPORT

2016 to 2017

www.harrowscb.co.uk

Contents

Foreword by the Independent Chair

It is a great pleasure to present my first report as chair of the Harrow Safeguarding Children Board (HSCB). On behalf of the HSCB partners I want to express our gratitude to the work of Christine Hogan the previous chair whose work did much to make the HSCB the successful grouping that it is. I took up my role in December 2016 and I have spent a productive few months getting to know the staff that, across the statutory and voluntary sector, do so much to ensure the health, wellbeing and safety of Harrow's children and young people. I am glad to say that I have found the children's workforce to be motivated, determined and skilled at what they do.

This report gives an account of what the safeguarding partners have achieved in 2016-17 and also looks forward to 2017-19.

In 2016-17 the HSCB had four key priorities:

- Refocusing on Core Business
- Reducing Vulnerabilities for Young People
- Actively Incorporate the views of young people and staff
- Effective Collaboration

We can report good progress against each of these priorities. Throughout this report, you will see further evidence and information that relates to the Board's achievements in these areas. We spent some time working with the Multi-Agency Safeguarding Hub (where partners work together to share information and assess risks to children) to improve the way referrals to it were handled. Harrow Council and the Police have been very active in responding to a relatively new problem of knife crime in the borough and they have undertaken some effective joint work. The HSCB has worked with Voluntary Action Harrow to ensure the voice of the community is heard and understood. We also work with designated schools' leaders to ensure that the views of schools and their pupils are central to our thinking.

Our joint conference with our safeguarding adult colleagues was the culmination of a lot of joint planning and the beginning of some new work which will make us more insightful in the way we tackle a range of safeguarding issues.

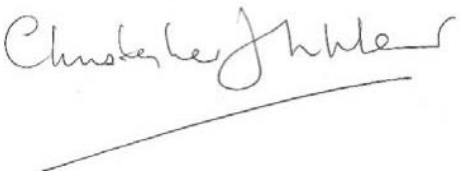
The status of safeguarding boards is changing in the next 12 – 18 months as new legislation reduces certain statutory requirements and introduces new freedoms to operate. Harrow's

partners will no longer be required to have a safeguarding board but they will still be required to deliver excellent partner services to safeguard children.

How we structure ourselves will be an important matter for consideration over the next few months. But whatever the structure that Harrow's partners decide on as their means of ensuring safety for children there will still be the need for good leadership, a vision for children and a committed workforce. The HSCB is delighted that Ofsted rated Harrow's services for children to be good and we can be sure therefore that the leadership foundations are in place. Over the next twelve months we need to build on them to ensure that our vision for excellence is maintained and that we continue to help our staff to do their work as well as they aspire to.

Ofsted also confirmed the strengths of the HSCB, identifying the impact of its reviewing and auditing activity. Areas for further development were also identified which have helped inform the business plan for 2017 to 2019.

I want to thank the many people who represent their agencies on the HSCB and who contribute to the work of the partnership. I should also like to thank our two very active lay volunteer members who ask important questions of professionals on behalf of the people of Harrow.



Chris Miller
Independent Chair, HSCB

Chair's Evaluation of the Board's effectiveness

Enquiry and Challenge

We have a programme of regular reports to the HSCB from partner organisations. Members question each other about the effectiveness of their practice and the impact they have on those they serve. We also conduct challenge panels following the completion of section 11 audits where HSCB members challenge each other about their policies and how they deliver services. We have two active and engaged lay members who question members from a standpoint of independence. MASH performance has been challenged through this process and improved.

Understanding of the impact of practice

Through the quality assurance group, we audit and enquire into practice and procedure, praise what is good and seek to change what is not. We have enquired into how children who go missing are managed on their return and we have challenged all partners to respond to an increase in knife crime. In both instances, there has a shift in performance.

Understanding performance information

We are on a journey of improvement in this area and have made progress. We have built on our mapping of CSE and now have improved knowledge of domestic violence services and outcomes thanks to a series of thematic presentations to the HSCB from partners. Our new priorities build on our better understanding of these complex issues.

Understanding early help and child protection thresholds.

We have restructured the early help service this year to tailor our response to childhood need. A combination of new financial pressures and a rethink of what we do (brought about in part by an Ofsted assessment of this service four years ago) has caused us to launch our renamed early support service. We believe that the new model will better deliver against the need we have identified.

Learning from reviews and incidents.

Our challenge panels, serious case review panel and audits have identified issues that have led to learning and change. We have published three serious case reviews in the past two years and this report details how we have taken pains to ensure that the learning from those important

cases has been transmitted to colleagues.

Over the year our robust auditing programme informed our understanding of strengths and weakness in practice across the partnership, especially in front-door services. Areas for development were monitored and challenged until significant improvements were evidenced – a clear indicator of this partnership's effectiveness and of its commitment to improving outcomes for children and young people in Harrow.

Working strategically with other partnership boards

We have improved our links with the Harrow Safeguarding Adults Board in the past year and we work with Safer Harrow on shared issues like knife crime. However, we are aware that there is more we can do in this area and have initiated a series of meetings with colleagues on other partnership boards in Harrow to make us better informed and more closely aligned.

Properly resourced

Safeguarding is a complex business and an LSCB requires resources to function. Harrow's LSCB is funded more or less at the London average. The regulations that established LSCBs invite partners to make financial contributions but do not require them to do so beyond the exhortation that the burden should not fall disproportionately on any one member more than another. The funding for HSCB falls disproportionately on Harrow Council, whose contribution ensures that the HSCB has a good level of resources. The Metropolitan Police funds the HSCB at levels well below other urban metropolitan forces and a financial commitment has not been met to cover one of the health trusts.

Conclusion

Harrow's LSCB is an effective board. It has many areas of strength. It knows where improvement is desirable and the HSCB plan for the next two years is centred on delivering for children in Harrow.

Context – Harrow's Demographics

Introduction
The London Borough of Harrow has a population of 247,000 and the number of children under 18 is 57,000. The population has grown by 12% in ten years. It is a diverse population with 70% saying they belong to a minority ethnic group; 37% being of South Asian heritage. The borough is also religiously one of the most diverse in England and Wales.

Deprivation, Poverty Education and Employment
Harrow is, on the whole, an affluent borough[1], but there are pockets of poverty and deprivation. 18.5% of Harrow children are deemed to be living in poverty but there are fewer children as a proportion of the population entitled to free school meals in Harrow than elsewhere on average in the UK[2]. In Harrow, teenage pregnancy is the second lowest for any local authority area in England.

Schools are generally very good and Harrow children perform better than the national average at Key stage 2. These results are achieved against a background of high levels of English being for pupils an additional language[3]

Unemployment rates are low and falling but 20% of residents are in low paid work.

Crime and Young People in Harrow
Police recorded crime rates in Harrow are relatively low but rose 8% last year; compared with 4% in London as a whole. In relation to children and young people of Harrow there has been an increase in knife crime. Also of concern around 16 police incidents a day involve domestic abuse in a home where there are children.

The number of young people entering the youth justice system shows a steady decrease over the year, reflecting a national decline. The illegal possession of drugs and knives are the main crime types coming to the notice of the police.

Early Help
Offering help to children when young or, quickly, after a problem has been spotted, is the essence of early help. It makes sense as it prevents situations getting difficult or dangerous for children. Four years ago, Ofsted reviewed Harrow's provision of these services and found them in need of improvement. A review has led to a renewed focus on working with whole families and particularly diverting children from crime. Children centres help families when children are small and our youth provision targets young people at risk. Harrow's Safeguarding Children's Board monitors the effectiveness of the new services.

[1] In the 2015 index of deprivation Harrow was ranked 119 out of 151 (where 1 is most deprived)
[2] 9% of primary school pupils and 12% secondary compares with UK average of 15% and 13%
[3] 66% of primary and 60% of secondary pupils have English as an additional language compared with respective national averages of 20% and 16%

Safeguarding Children

When early help does not work, there is a need for the local authority and their partners to step in and take action to safeguard those who are vulnerable. The way that this happens is for an agency or a member of the public to let Children's Services know there is a problem. Last year we received more than 8000 such referrals, with largest number coming from the police (38%) The next largest number came from local schools (19%). There are many reasons as to why someone might tell us that a child might need help. Last year the most common reasons were that the child/young person was being neglected or abused and the next was the need for parenting support.

Social Work Assessment

Before action can be taken there needs to be a full assessment of a child's need. With most referrals however (80%) there was no need for an assessment because there were already services available for the child or family capable of meeting the issues described as need. In the remaining 20% of cases an assessment of child and family circumstances was conducted.

Children In Need

An assessment may lead to a conclusion that the child referred is a child in need[4]. Figure 1 shows how Harrow compares with England and other boroughs like Harrow (statistical neighbours)

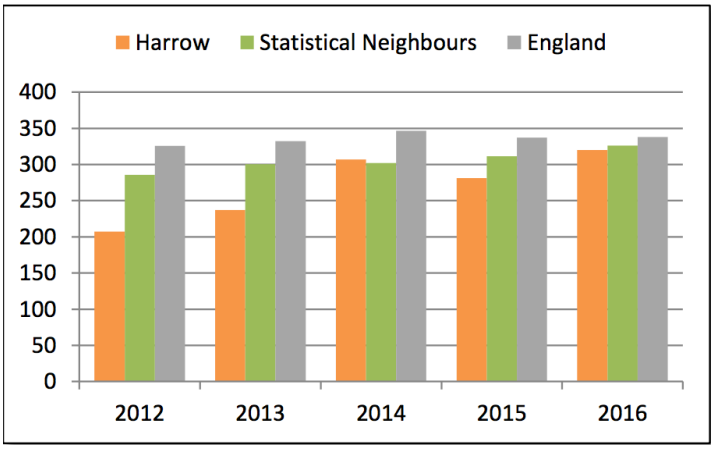


Figure 1

[4] Under section 17 Children Act 1989 a child in need is a child that needs local authority services to achieve or maintain a reasonable standard of health or development or needs services to prevent significant or further harm to health or development or the child is disabled.

Child Protection Enquiries

Sometimes children need more than extra services and are in need of protection. Last year 8% of referrals led to the initiation of child protection enquiries. These enquiries may then lead to a child protection plan (CPP). This is a local authority led plan that is designed to keep children safe and is contributed to by other agencies through the provision of services and information. Figure 2 shows how the rate per 10,000 children of CPPs in Harrow is greater than it was five years ago but remains below London and England rates as well as that of our statistical neighbours. On 31st March 2017, there 309 children on CPP

The majority of children on child protection plans are 5-9 years (109) or 10 -15 years (106) and of all CPPs 190 were cases of emotional abuse[5]

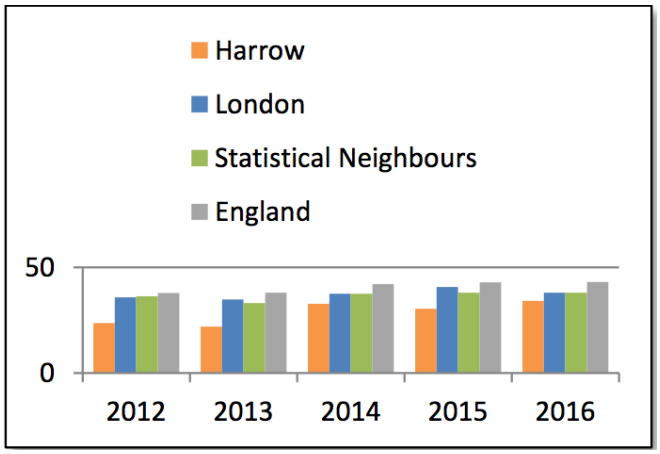


Figure 2

Because CPPs are designed to manage family situations where children are deemed to be in need of protection from harm it is important that the plans do not last too long. If the plans need to carry on it means that the child may not yet be safe and that cannot be allowed to last to continue. So, the Local Authority monitors lengthy CPPs and also monitors cases where a child returns onto a plan having been discharged from one. Last year there were four plans that lasted beyond 24 months. And as a proportion of all plans about 8% involved a second (or more) plan within 2 years of a previous plan. These cases are scrutinised by a multi-agency panel to prevent drift and ensure good outcomes for children.

Children are invited to attend their own planning conferences. Where they cannot an advocate usually speaks for them.

Children Looked After

In some instances, children need to be taken from their families because life with their parents is simply not safe, healthy or parents may not be able to cope. Sometimes children are voluntarily looked after because their parents have realised that they cannot cope and agree to

[5] This is a difficult issue to quantify because often children suffer multiple forms of abuse and it is not always easy to determine which category is the most appropriate.

allow them to go into another home. These are known as children looked after (CLA). Children in custody are also looked after. Harrow's CLA rate is rising slightly but is lower than London, England and our statistical neighbours (Figure 3)

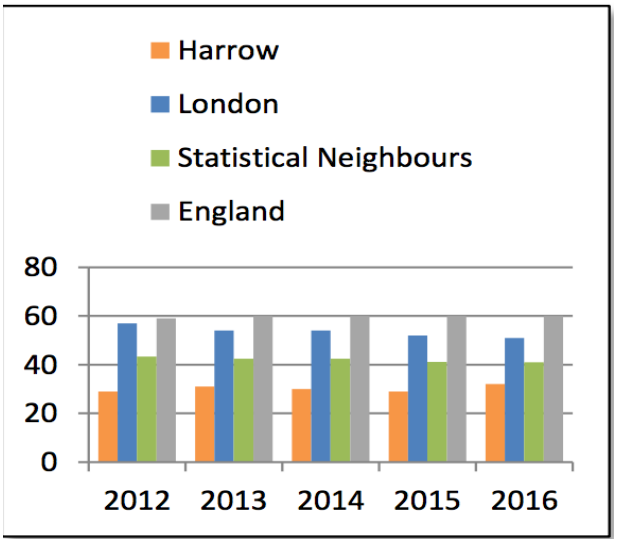


Figure 3

There are a number of matters concerning Children Looked After that the HSCB is concerned with:

- 6% have a disability
- 13% of CLA go missing at least once but
- 45% of all episodes of a child going missing involved a CLA
- 7.7% go on to be adopted
- More Harrow CLA offend than the national average (but the cohort is small)
- Fewer CLA are placed 20 miles from home than was the case 2 years ago.

Key achievements for CLA:

100% of Children and young people had information about their entitlements from the local authority – e.g. grants for education or setting up home or getting a job

14% of young people are in higher education and provided with vacation accommodation or money towards it

98.98% of Looked After Children Reviews took place within the statutory timescales

89.76% of children and young people participated in their Reviews (attending or contributing to their Review)

HSCB Priorities 2016 - 2017

Four areas of priority were identified and agreed by the HSCB at it Business Planning day in the spring 2016. The following report describes why these priorities were chosen; what was done under each priority; and most importantly, what was achieved through this activity to improve outcomes for children and young people in Harrow.

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

Why did we choose this priority?

At the beginning of 2016, the HSCB carried out an audit of Harrow's Multi-agency Safeguarding Hub (MASH). We also carried out an audit of the way that partners worked together to protect children by co operating in the conduct of an enquiry in those children's needs. What we found in these audits and how we responded to them is described in our audit section (page 25). These particular audit findings led us to make core business our first priority.

Progress on all areas requiring improvement was carefully and regularly monitored by the Quality Assurance Sub committee, the Board, as well as the Chief Executive and Lead Members.

What was achieved/what difference did it make?

In January 2017 Ofsted inspected the Local Authority under its Single Inspection Framework. Amongst a wide range of practice areas across Children's Social Care, this inspection included in-depth scrutiny of Harrow's MASH and its front door services.

The Local Authority received an overall grading of 'Good' from this inspection, which confirmed the considerable advances made over the past year. The following findings were made in the inspection report:

"Services for children and young people in Harrow are good. Most children and young have the support that they need when they need it".
"The local authority acts quickly and effectively to protect children when they are at risk of significant harm. The multi-agency safeguarding hub (MASH) provides an effective single point of contact that transfers child protection concerns promptly to the first response team (FRT).

This team holds strategy discussion and undertakes child protection enquiries when this is appropriate".
"When children are at immediate risk, social workers and other adults, such as police officers and teachers, work together well. They act quickly to protect children".

The inspection identified that children with lower levels of need do not routinely receive such a prompt response and that for these children performance management systems in the MASH do not provide enough information to accurately track the progress of cases to ensure the timeliness of assessments and service provision. Consequently, the HSCB has oversight of the new Early Support Service as one of its priorities for 2017 to 2019.

The inspection identified that children with lower levels of need do not routinely receive such a prompt response and that for these children performance management systems in the MASH do not provide enough information to accurately track the progress of cases to ensure the timeliness of assessments and service provision. Consequently, the HSCB has oversight of the new Early Support Service as one of its priorities for 2017 to 2019 to help ensure that sufficient progress is made.

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

Why did we choose this priority?

This priority was continued from the previous year as the HSCB wanted to ensure that collectively we became more proactive in responding to the growing national concerns regarding Child Sexual Exploitation, Children who go missing, gang association, trafficking, violent crime and on-line abuse.

Whilst Harrow has amongst the lowest crime rates in London, the Board wanted to ensure that this did not make us complacent with regard to the safety of young people who are exposed to the kind of risks described above. In fact, we have seen a gradual increase in these risks occurring in Harrow. We recognise that for each affected child and their family, the impact is no less distressing that it is when the prevalence has been greater e.g. Rotherham, Oxford and the Midlands.

In each area of risk, the HSCB will ensure that attention is given to children with disabilities, so that these children are not seen as unaffected by the risks faced by other young people in Harrow.

What did we do?

The HSCB reviewed and refreshed the existing CSE Strategy to ensure that it reflected the learning from more recent national reviews and to respond to the local profiling that was beginning to take place, for example, the cohort of children most affected, some geographical 'hot spots' and emerging characteristics of perpetrators.

The HSCB commissioned a repeat independent audit of our local arrangements for prevention and responding to CSE. This audit was used to measure progress against the previous CSE audit findings and the following strengths were identified:

- There were many stakeholders who were committed to working in partnership to tackle CSE across Harrow
- There was committed leadership within the HSCB
- There was a strong commitment to develop services, the CSE training programme and in particular to embedding the SAFGUARD Risk Assessment Tool.

A key area for development was to strengthen the analytical capacity to support the profiling work taking place and ensure that the Multi-agency Sexual Exploitation Panel (MASE) process applied a systematic application of the risk assessment tool.

What was achieved/what difference did it make?

Over the year, the HSCB partnership expanded the number of CSE Champions, including within the voluntary sector, which helped us reach a much wider population of community groups and some groups which traditionally have been more difficult to reach.

For a second year, our CSE training was delivered to the business communities with cooperation from our partners in the Licensing Service. This work also included expanding licensing contracts to include a requirement to raise awareness of CSE amongst staff and encourage referral of concerns.

A very successful conference for parents was led by police colleagues to raise their awareness of sexual exploitation and related on-line abuse. Attendance was very encouraging and the event was supported by Harrow Independent School which provided the venue and the local authorities CSE Co-ordinator; - A good example of partnership working across police, schools and local authority. Following the level of interest from parents, the police planned a similar event for raising awareness of knife crime for 2017.

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

Why did we choose this priority?

Ensuring that our work is informed by the views and experiences of service users and front lines staff remains an on-going priority for the Board. The findings of our audits and our serious case reviews have been enriched by the perspective of those best placed to tell us what is working well and what needs improvement.

What was achieved/what difference did it make?

The HSCB's Serious Case Review of 'Family F' highlighted the need for practitioners to be more flexible in gaining an understanding of a child's views and experiences, especially when they are young and have limited verbal skills. Interactions of the child needed to be better interpreted. The Review of 'Child R' also identified a need for practitioners to show greater curiosity about the history and motivations of troubled young people. Subsequent audits have revealed much more focus from practitioners in gaining and responding to the wishes and experiences of children of all ages and abilities. Some very good examples of working with young people, previously not wanting to engage were identified, as well as good observations of non-verbal children (See page 17).

Interviews with front line practitioners provided invaluable feedback for the HSCB's audits of child protection enquiries, disability services and multi-agency case audits. These helped us pinpoint why previous learning had not been fully embedded, as well as where further amendments to systems were needed (See page 22).

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

Why did we choose this priority?

The HSCB recognised that several of its key priorities connected with those of other multi-agency strategic partnerships and that we could be much more effective if we collaborated on relevant topics. This would mean that our key messages would reach a wider audience and that the direction of many local initiatives could be influenced to help achieve our main objective of keeping children safe.

Limited resourcing for all public and voluntary services has meant that we have to be more efficient and effective with what we have. The HSCB continues to seek opportunities to maximise its impact, so that those children and young people in most need are supported by several lines of coordinated activity across the community.

What was achieved/what difference did it make?

Harrow Safeguarding Adults Board (HSAB): Through regular Business Coordination meetings, the HSCB and HSAB have continued to identify areas of mutual interest such as Female Genital Mutilation, Sexual Exploitation, Forced Marriage, Gangs and Trafficking. This has led to the Boards running a number of training/briefing events together to reach the widest possible audience in fewer sessions to achieve efficiencies in resourcing. In addition, such joint activity has helped to reinforce the **Think Whole Family** approach, by alerting the children's and adult's workforce to each other's issues and consequently supporting each other's work.

With similar objectives, the HSCB and HSAB agreed to run an annual conference together on the subject of domestic abuse. Attendance and engagement on the day from both workforces was excellent, with enthusiasm expressed for combined conferences in future (see page 29).

Two multi-agency case audits have also been undertaken involving Adult Services to see if learning from Serious Case Reviews was being reflected in improvements to practice. Initial learning included the need for Adult services to share concerns about adult vulnerabilities e.g. mental health, substance misuse with Children's Services, so that the impact on parenting could be evaluated. Audits revealed considerable progress in this respect. In response, the HSCB made a commitment at the HSAB's Business Planning Day to ensure that children's services reciprocate by promoting the need to safeguard vulnerable adults.

Safer Harrow: Both domestic abuse and Violence, Vulnerability and Exploitation (VVE) sit within the priority work of the Safer Harrow partnership, for which it takes a strategic lead. The HSCB contributes to the same priorities through its evaluation of services for children and young people in Harrow who are affected by domestic abuse or VVE (see pages 28 and 33).

Safer Harrow also takes the strategic lead on addressing Extremism and Hate crime. The HSCB continues to take an active interest in 'Prevent' training attendance across the partnership on the basis that young people are amongst the most vulnerable to grooming in this respect.

Sharing data and related reports across the two strategic partnerships helps to ensure that planning takes advantage of all available information across Harrow and any unnecessary duplication of activity can be avoided.

Brent Safeguarding Children Board: The HSCB began its collaboration with Brent LSCB in 2015 when a joined up approach to relevant auditing was agreed. This applied to auditing of safeguarding arrangements where an agency covered both London boroughs. As well as strengthening collaboration and our understanding of cross border work, these arrangements reduced the need for these particular agencies to provide more than one audit for the different LSCBs.

The positive working relationship across the two LSCBs has led to suggestions for other joint work such as a shared training programme, which is currently under consideration.

New Priorities for 2017 to 2019

The annual business planning day for the HSCB was held in spring to measure progress against the existing priorities (as outlined above) and to plan for the next two years. The new plan builds upon existing work and incorporates areas for further development. It takes into account important emerging themes and trends for Harrow and the findings of the Ofsted Inspection which took place in January 2017 – see Appendix B.

Learning from Serious Case & Learned Lessons Reviews

In 2016-17 HSCB concluded one serious case review (SCR) while continuing to learn from two previous SCRs and another local Learned Lessons review. It is vital that agencies embed the learning from these reviews to improve practice and to avoid the issues that gave rise to the reviews in the first place.

To check whether agencies have learned the right lessons and embedded them into their practice the HSCB's multi-agency case auditing programme gathers evidence of improvement against key learning points e.g. how well we engage fathers in assessments and planning and how well we challenge each other to achieve better outcomes for children and their families.

Following the Learned Lesson Review for 'Family E' case HSCB produced a DVD to explain the long term impact of neglect and domestic abuse on all members of a family; the story being told from the children's perspective. This has proved to be a successful way of embedding learning because the DVD is remembered by practitioners long after they have seen it. Demand for copies of the DVD continues to come from across the country, producing a small but helpful income, which is used to fund other learning and improvement activity.

IMPACT – "The DVD is remembered by practitioners long after they view it " (General Practitioner)

(i) Learning from Serious Case Review: 'Young Person R'

Concluded in 2015 this SCR identified challenges for staff working with young people who have very complex needs and who are placed away from their home area. We explained in last year's annual report how we had we had embedded some particular learning points from this review:

- The need to ensure continuity in the planning for health care and education needs of children in order to prevent a disjointed 'stop-start' approach to programmes of care that are driven by crisis intervention, rather than a balanced assessment of longer term strengths and needs.
- The need to understand the perspective of migrant families who may mistrust 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.

Outcomes / Impact
Children Looked After - Health Assessment Service

- In June 2015 the CCG and LA set up a new integrated, Children Looked After health assessment service. This is person centred and therefore more responsive
- The HSCB's scrutiny of this new service revealed that targets were being met for timeliness and quality.

"As a carer I feel very informed. During the visit I received good advice which I believe will aid me in the upbringing of my child. The visit was not too long or too short…just right and I am grateful for the time spent discussing the healthcare of my child" (Carer)

"It was fun and very easy and got good advice"(11 year old)

"I really enjoyed it and the lady is kind and taught me how to keep healthy and I can stay fit" (10 year old)

"It was great – the lady was a good listener and supportive" (17 year old)

(ii) Learning From Serious Case Review: 'Baby F'

This SCR involved the death of an 11 month old baby whose parents were known to agencies for substance misuse and domestic violence.

'Baby F' who was on a child protection plan drowned in a bath.The mother, who had left the baby unattended was found guilty of manslaughter.

The family moved a lot and were often difficult to locate; making assessing their needs very difficult. But the review uncovered a lack of professional ownership of the case as the family moved in and sometimes out of Harrow. The additional vulnerability of families in temporary accommodation was a significant factor in this case.

Other important learning points from the review were:

- Practitioners should not make assumptions based on stereo-types of family backgrounds e.g. Traveller families and their lack of engagement with services
- Practitioners should always make further enqurieis in relation to referrals from the community, including anonymous calls
- There should be less reliance on using the police for protecting children and for assessing their welfare; using local authority powers would sometimes be more appropriate and more effective
- 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 across all agencies. The learning from this review strengthened the content of the HSCB's multi-agency course on Neglect.

- Midwives were trained to recognise and respond to their individual safeguarding responsibilities. A recent HSCB audit confirmed the effectiveness of this training by finding good practice in front-door midwifery service

  The HSCB sought assurance that when assessed for temporary accommodation families with children on Child Protection were prioritised by Harrow's Housing Services. Like other London boroughs, Harrow is facing unprecedented demand for temporary housing, but the HSCB is

- The HSCB developed a course, 'Working with Fathers' to ensure that fathers have opportunities to contribute to assessments and planning for their children.

- HSCB reinforced the London Procedures for case transfer across boroughs and a subsequent sample of cases was audited by the Local Authority, which evidenced improved compliance for timescales when handing over cases to other areas or receiving cases in to Harrow.

(iii) Learning Generally From Serious Case Reviews

The HSCB drew learning from other review material that has not been published in Harrow. We dicovered when we focused on this review material that we had the following learning that we need to embed.

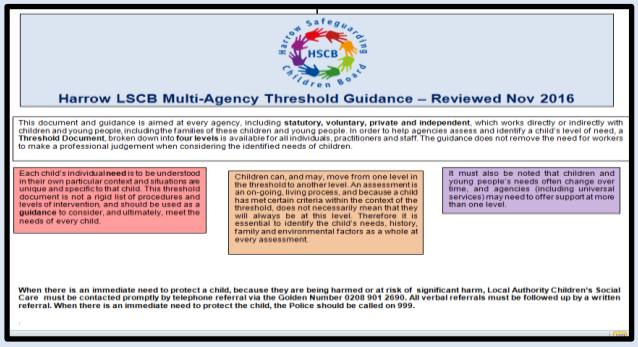
- When cases are transferred across borough boundaries sometimes in Harrow as elsewhere we find that delay and poor management can be a problem. In our previously mentioned Family F case we found similar issues.
- When a parent has a medical condition that impacts their parenting capacity that information may need to shared with non medical professionals. We want to make sure that we are better aware of this need
- When fathers seem to be absent from the home or apparently disconnected from his family professionals need to be vigilant and curious about what level of involvement there really is. Otherwise decisions about children's welfare are taken with inadequate information.
- When professionals get involved with a family there is often an immediate improvement in outcomes. It is important for practitioners be remain realistic about their long term sustainabilty and are robust in ensuring that any changes are not simply short term compliance but are followed through on a long term consistent basis.
- Where practitioners in one organisation feel that those from other organisations are not progressing some aspect of a case at a reasonable speed or with appropriate purpose it is important that the partnership is strong enough to encourage and react to an escalation of concern.
- London has many diverse cultures and it is important that professionals are aware of cultural practices that impact the welfare of children so any assessment of risk is properly informed
- The views and experiences of children need to be sought in any case that affects them. That seems in Harrow, as elsewhere, to happen less often that we would like.

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.

Outcomes / Impact

- The HSCB refreshed its existing Thresholds document to incorporate cultural practices as a factor to be considered in assessing thresholds for intervention.

- Updated training also incorporates the need to be curious about a cultural practices



- The continuing theme of insufficient engagement with fathers led to a challenge to all Board members to ensure that relevant front-line staff attend the HSCB's course on 'Working with Fathers'. Applications for the course were seen to rise in response to the challenge.

- Monthly tracking of cases transfers has been implemented by the Local Authority to ensure compliance with the London Procedures – with outcomes reported to the HSCB.

- The HSCB took steps to ensure that awareness of the multi-agency Challenge and Escalation policy was better understood across the partnership: Board members were reminded of their responsibility to embed learning in this respect within their organisations and all relevant training and dissemination events now promote the use of the expected pathway to address professional disagreements. All subsequent multi-agency audits conducted by the HSCB seek evidence of compliance and recent audits have shown appropriate challenges taking place.

- The HSCB produced new guidance for schools in relation to maintaining and transferring safeguarding records. This guidance places an onus on schools receiving new pupils to chase records from the pupil's previous school – in addition to the statutory guidance for schools to send on safeguarding records when a child leaves their school. This guidance also reminds schools not to dispose of any safeguarding records (despite existing regulations specifying minimum timescales), whilst the National Sexual Abuse Inquiry is on-going.

- New information systems have been introduced into LNWHT to enable safe and appropriate information sharing across health disciplines and to other agencies where appropriate.

Learning Lessons Activity

The HSCB's Review Sub committee also considers cases which do not meet the threshold for a Serious Case Review, but nonetheless it is felt that important lessons can be learned to improve practice. Work in this respect has initiated a number of improvements:

- Production of a joint protocol between Mental Health Services and Children's Social Care for children with complex emotional and behavioural needs and require specialist placements
- The Review Sub-committee sought a response from the Safer Harrow Partnership and the Local Authority to a growing number of knife crime reports – and in particular to one fatal incident involving young people from Harrow. An immediate review of the situation was instigated and the HSCB was consulted on the development of Safer Harrow's new Violence, Vulnerability and Exploitation Strategy
- Following previous management review, the Review Sub committee sought improvements for children with special needs having timely access to appropriately trained intermediaries when involved in criminal proceedings. Recent reports confirm that service has much improved and children gain support within acceptable timescales.

HSCB'S Auditing activity

1- Auditing the effectiveness of the 0-25 Disability Service

This service is a single service for disabled children and adults which ensures a good transition between children's and adult's services. The HSCB commissioned an independent audit of this service to ensure that it was meeting statutory requirements and locally identified needs for disabled children and young people in Harrow.

Nine cases were selected which included children and young people of different ages, including those going through transition to adulthood. The cases also included a range of disabilities, ethnicities and social circumstances.

In many or most cases the following strengths were found:

- Detailed and timely assessments.
- Good practice and child-centred work taking place with disabled children
- There was timely identification and action in relation to child protection concerns – leading to appropriate child protection plans
- Good engagement with children to take account of their views
- Appropriate challenge by Child Protection chairs and Independent Review Officers to keep plans on track

- A stable and committed workforce, providing continuity of care for children, young people and their families

In some cases, the following developmental issues were found:

- Missed opportunities to obtain information from other agencies and historical information was not always taken into account
- Children were not always seen on their own (this was also the case for Children in Need and those with Child Protection Plans).
- The views of children and young people were not routinely presented at Children Looked After or Child in Need Reviews
- There was no evidence that alternative means of communication were explored. The use of advocates were not always considered (not evident in recordings)
- Insufficient change over a long period of time – with little action to address this.
- Variable quality of child protection, CIN, LAC and plans for transition with a lack of clear and measurable outcomes and timescales.
- A lack of critical reflection and challenge by managers.

Outcomes – Impact

As a result of the audit The Service has:

- Set up monthly internal audits to monitor progress:
- Embedded practice guidance: 'Establishing Wishes, Views and Feelings' – reinforced with training from **Triangle:**
- Incorporated routine discussions with IROs to ensure that where a child has little contact with family the services of an Independent Visitor are considered;
- Introduced SMART 'step up' and 'step down' plans to minimise risks following the cessation of child protection plans;
- Put in place pathway plans for disabled young people going through transition to adulthood;
- Developed a **'Think Whole Family'** approach with the offer of an Independent Advocate
- Built in the requirement to consider an assessment of carer needs

Short breaks are linked to child/young person's preferred leisure activities to provide them with positive social interaction in the community to enhance life skills and support inclusion in main-stream activities

"A stable and committed workforce in the team which provides continuity of care for children, young people and their families"
Independent Auditor

2- HSCB Repeat audit of the Multi-Agency Safeguarding Hub (MASH)

The MASH acts as a single point of contact in Harrow where multi agency information is shared to ensure that the best decision can be taken about a child's needs. In January 2016 the HSCB audited this service.

In some cases the following issues were found

- Gaps in gathering information (particularly from schools and GPs)
- Not establishing parental consent for information sharing;
- Cases not being processed within the agreed MASH timescales;
- An inconsistent approach to assessing levels of risk and need.

Because the MASH is such an important service, quarterly reports to the HSCB on progress were introduced and the Quality Assurance Sub-committee re audited it in the summer of 2016 to see whether its weaknesses had been rectified. Considerable improvement was identified and HSCB's findings were endorsed by Ofsted

Outcomes– Impact of the MASH audit

"The findings of this audit show that there has been a great improvement in the operation of the MASH from the previous audit, meaning that children are better safeguarded and families better supported. In particular, there is now greater consistency in assessing levels of risk and need; an individualised and more comprehensive approach to information-gathering; good adherence to guidance relating to parental or child consent; and a sharper approach toward keeping to timescales." **Independent Auditor**

*The multi-agency safeguarding hub (MASH) provides an effective single point of contact that transfers child protection concerns promptly to the first response team (FRT). This team holds strategy discussions and undertakes child protection enquiries when this is appropriate. Thresholds of need are well understood and consistently applied***.**
'Inspection of Services for Children in Need of Help and Protection, Children Looked After and Care Leavers' - Ofsted Inspection 2017

HSCB Audits of Child Protection Agency Checks

Local authorities need to carry out thorough enquiries in cases where a child appears to at risk of significant harm[6]. A very important element in these enquiries is checking with other agencies to see what they know. HSCB's audit of this activity in September 2015 discovered that these partner checks were either not done as often as they should be or were not done to a good standard.

A further audit was undertaken six months later. Progress was insufficient; therefore a strengthened action plan was launched. A checklist of the agencies to be contacted was incorporated into the Council's electronic recording system, supported by staff briefings.

A third audit was undertaken in the autumn 2016 and the findings were disappointing in that little improvement was discovered. Personal interviews with operational staff revealed that they found some instructions confusing. More importantly they made assumptions about what the results checks might reveal, therefore they didn't always do them and as a result were less thorough than was required.

Outcomes – Impact

'CHECK, CHECK AND CHECK AGAIN!'

A rapid further follow-up audit in spring 2017 signalled the importance of this at needed to be challenged. This revealed that some good progress was evident. There were indications that recent briefings were starting to have a positive impact on practitioners' understanding:

"Towards the end of the audit period, a front-line practitioner spotted (his/her) weakness in their own entries on Framework-i (the Council's electronic case management system) and said that recent training had helped (him/her) understand what was required and why. This indicated that the LA's briefing sessions were beginning to make a difference in a way that they had not done before." **HSCB Quality Assurance Auditor**

3- Multi-Agency Audit of Cases involving Domestic Abuse – Joint Audit with Harrow Safeguarding Adults Board

The HSCB's multi-agency audits sit within and form a critical part of its overarching Quality Assurance Framework. The purpose of the HSCB multi-agency case auditing process is to provide a robust and reliable approach to assessing work undertaken across the partnership with a child/young person and their family. In particular, we seek to identify how effectively

[6] Sec 47 Children Act 1989

agencies work together and how well they have embedded learning from previous reviews and audits.

As part of the HSCB's drive to embed a '**Think Whole Family'** approach, recent case audits have been conducted jointly with Harrow Safeguarding Adults Board (HSAB). Recently we jointly audited a number of cases where domestic abuse was involved.

In many cases the following strong performance was found:

- Pre birth assessments were effective (demonstrating improvement following a recent serious case review)
- Agencies were acting early and appropriately
- Risk was identified and cases escalated and shared appropriately
- Good record keeping concerning family details
- Good evidence of listening to and acting on the views of children
- Good inclusion of fathers and wider family in case planning
- Good use of data sharing provisions
- Appropriate inter agency challenge and support
- Good levels of supervision

In some cases the following development areas were found

- The risks posed by female perpetrators were treated differently from those posed by men
- Chronologies were not up to date
- Issues concerning parental consent in cases involving mental health and some other conditions were not routinely discussed by the children's workforce with adults services.
- The whole family (which includes adult siblings) were not always considered.
- Some multi agency challenges were left unresolved.

The Quality Assurance Sub-Committee will re audit this area of work in the future to see whether strengths have been built upon and areas for development have improved.

Auditing of agencies' compliance with their statutory responsibilities

The HSCB audits all the agencies that attend it to seek assurance that children and young people are being effectively safeguarded and their welfare promoted. Prior to the audit each agency submits a self assessment. This is followed up with 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. The programme of audits this year found all or most agencies:

- Had the required statutory arrangements in place, including having effective lead roles for safeguarding in place

- 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.

  Provided evidence of their awareness and activity in relation to embedding learning from recent Serious Case Reviews and auditing

- Provided evidence of their internal auditing in relation to how well their front-line practitioners understood their safeguarding responsibilities. The HSCB has reminded agencies to make the findings of these audits open to external scrutiny through the HSCB's Quality Assurance Sub-Committee

- Provided good evidence of effective inter agency working.

Report to Harrow LSCB
Harrow Child & Adolescent Mental Health Service
August 2016:
Service User Activity
"Harrow CAMHs has a strong service user base, Harrow User Base (HUB) and employs a variety of different approaches to seek feedback and to involve service users and families in day to day work as well as more strategic planning/development for the service"

Royal National Orthopaedic Hospital – Annual Safeguarding Report 2016:

"As a commitment to high standards a Section 11 audit is worked continually, highlighting areas for development. This is on track, with all key areas of development being implemented in practice."

NWLHT: Staff 'You Said- We Did" survey:

Full Action Plan in response to staff feedback was reported to HSCB August 2016: identifying measures put in place to strengthen a learning and improvement culture across the organization.

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".

Children's Social Care – social worker survey:

- SWs feel able to make a difference to people's lives and feel a sense of achievement
- They are able to use their professional judgement effectively
- Reflective practice is encouraged
- Practice is influenced by input from other agencies
- SWs feel confident to show their work to inspectors

Themed Focus

Domestic Abuse

The strategic lead for Domestic Abuse sits with the Safer Harrow Partnership, but the HSCB recognises this is an area where collaboration is essential.

In Harrow, domestic abuse features as one of the main reasons for a referral to the Multi-agency Safeguarding Hub totalling 473 for the year. This figure does not capture the many cases where domestic abuse is a common secondary factor to the referral and can be linked to concerns of parental mental health and substance misuse.

The harmful impact on children who are exposed to such abuse is well known – both immediate and long term. To reflect our concerns about the effect of domestic abuse on children, the HSCB dedicated three of its main Board meetings to understand the local picture and scrutinise the quality of service response across the partnership, particularly with regard to making a positive difference for affected children.

Harrow has invested £552,000 over two years in domestic and sexual violence services to provide

- A six unit refuge for women and children fleeing domestic abuse;
- Practical and emotional support, advice and advocacy to women and their children on housing benefits, legal options, health, education, training, childcare;
- The offer of an independent domestic violence advisor

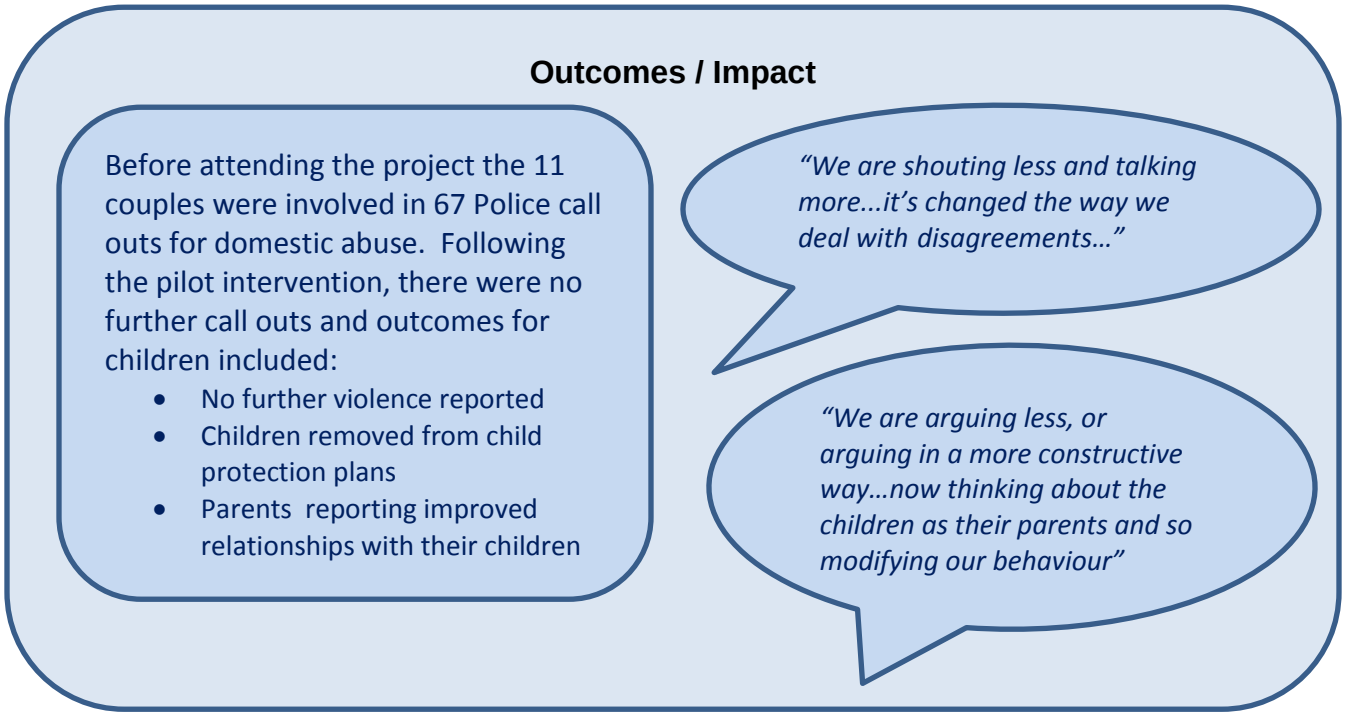
As a partnership on a monthly basis we assess the risks and safety plans for domestic abuse victims through our Multi-Agency Risk Assessment Conference (MARAC). At this meeting information is shared between professionals about the highest risk cases. Over the last year they considered 211 cases (a 19% annual increase) of which 27% were repeat cases. A total of 281 children were in the households considered.

Most cases heard at MARAC involve female victims. But 6.2% were male – higher than the national and statistical neighbour averages.

Harrow Couples Domestic Violence Programme

Over the past year, the Harrow Couple's Violence Programme was set up through a partnership between Children's Services and Tavistock Relationships and funded by the Department for Education (DfE) This provides a therapeutic intervention for the parents of one or more Children in Need, where there has been situational violence. Its aim is to improves the couple relationship and outcomes for children. It helps parents recognise and better respond to the triggers for conflict and focuses them on the negative impact of exposure to domestic abuse on their children.

Initial successful indicators has led to further funding from the DfE for another 18 months.. This will allow more families to benefit from the project.



The HSCB annual conference was dedicated to the topic of ***'Domestic Abuse – a journey through life'*** and was delivered in partnership with the Harrow Safeguarding Adults Board. Local expertise and perspectives from national research helped to ensure the day was both challenging and relevant for practitioners in Harrow. The conference was also supported by lively presentations from the Eyewitness Theatre Company to help exemplify the service needs of victims, carers and perpetrators.

A very clear message emerged from the whole day for Harrow in relation to the need to develop effective services to address the behaviours of perpetrators (of all ages) in order to make a positive difference for children and families affected by such abuse. This message has been translated into new priorities for the HSCB (see new priorities in Appendix B).

NB. The findings of the HSCB's multi-agency audit of cases involving domestic abuse are covered in the Auditing Activity (page 25).

Impact - Outcomes

"..I feel that before the conference, I had never properly considered the impact on other family members who live with DV, but were not themselves the target of it"

"..I feel able to approach the subject of DV with service users more openly. Now more aware of the impact of historical and current DV on individuals and other family members"

"The conference made a strong point about the advances made in the area of multi-agency work/information sharing that has allowed the identification of DV and appropriate interventions. MARAC featured as a key forum and this onus on joint work will be of mutual benefit to all agencies and my practice"

Female Genital Mutilation (FGM)

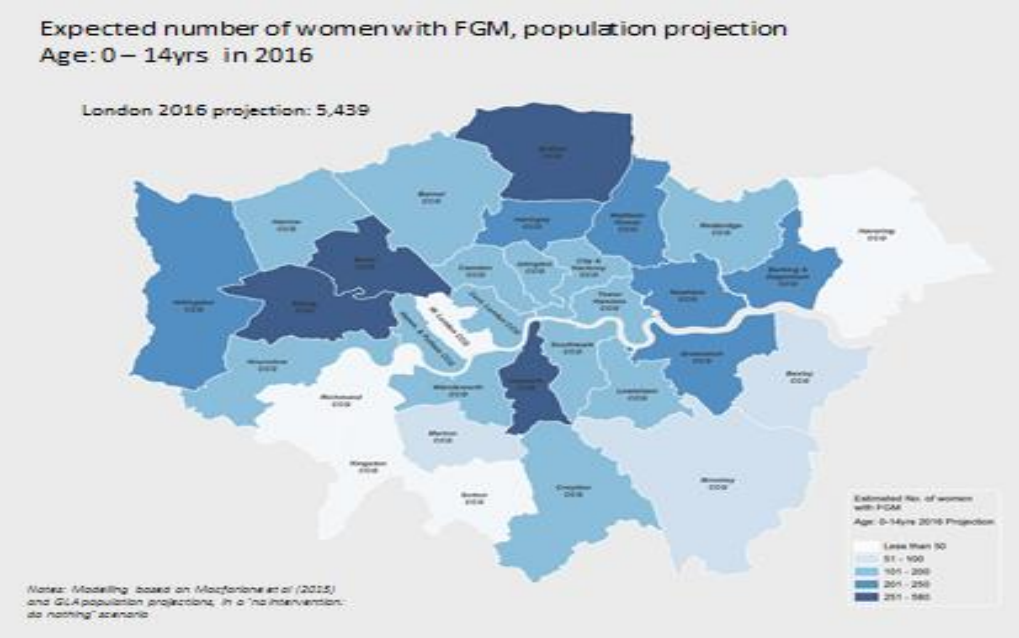
In 2015 it became mandatory for regulated professionals[7] to inform the police when they come across a child who they suspect of having undergone female genital mutilation. The HSCB ran a number of briefings to alert relevant practitioners to their new duties and to inform all staff of the effects of FGM. There was an initial increase in referrals, mainly from schools at school holiday time about girls potentially at risk of FGM, when any planned time away from school can raise the risk for some girls.

Our main objective in Harrow is to work with families and communities so that they understand the law and the significant harm that FGM causes. As well as ensuring that information and advice is available the HSCB's voluntary sector arm, Voluntary Action Harrow incorporates awareness-raising of FGM in all of its training and outreach activities.

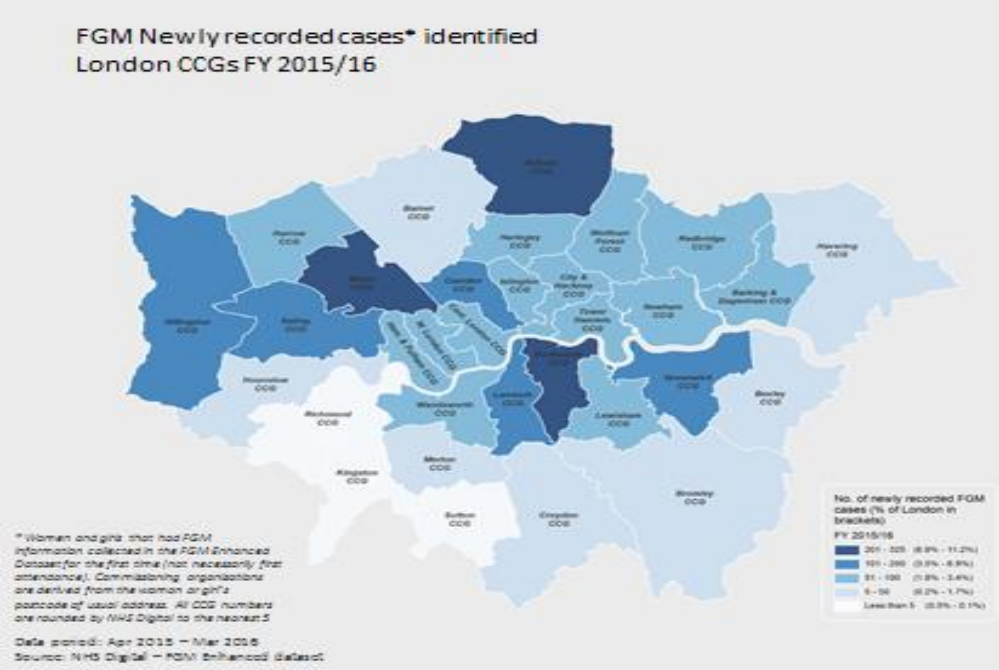
[7] A regulated professional is a health care worker, a teacher, or a social worker.

The HSCB's multi-agency training programme includes regular FGM courses. Attendance of all agencies is monitored to ensure that knowledge is kept up to date. In addition, Norbury Primary School continues to deliver its innovative courses to staff and pupils at other schools. With the involvement of their own pupils and women from local communities who have experienced FGM, they have produced some very powerful training packages which remain in demand across Harrow and beyond.

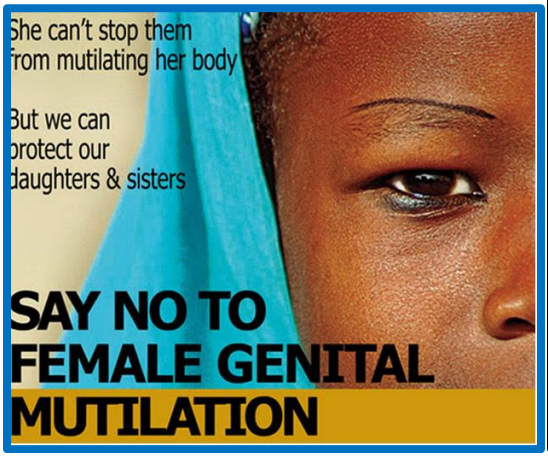
However, London-wide data indicates that in a population as diverse as Harrow, we should be seeing higher referral rates for initial concerns and for those cases requiring statutory intervention. A total of 14 cases (fear of FGM taking place) were made during 2016 to 2017.

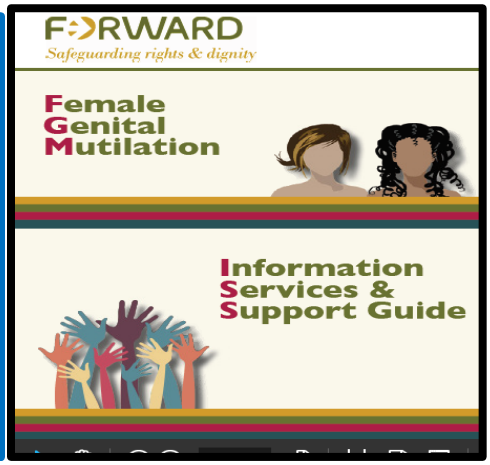


Health practitioners are also required to record any case where an adult woman has been found to have been mutilated in this respect. In Harrow, these reports do reflect the local demographics. Many of the women affected live in households where there will be younger females and so it is imperative that both practitioners and communities remain vigilant about any beliefs that promote FGM taking place.



Harrow has two FGM Lead Officers based at Northwick Park Hospital who act as a source of advice and training for the multi-agency partnership. LSCBs across London were also asked to confirm FGM Lead Officers within the Local Authority to help strengthen responses to cases where the risks have been identified. The additional leadership will help to drive forward our commitment to educate, prevent within our diverse communities and where necessary, prosecute offenders.





HSCB's FGM courses are supported by FORWARD (Foundation for Women's Health, Research and Development), which is a leading charity dedicated to tackling FGM and child marriage. Their programme strategies include campaign and policy work; public education and training, advice and support, information and research; and community engagement.

Private Fostering

Private Fostering is a private agreement which places a child under 16 (under 18 for disabled young people) into the care of someone who is not a close relative for more than 28 days.

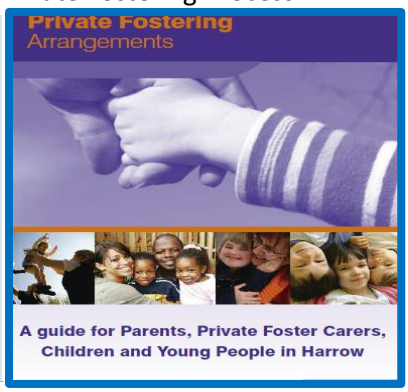
The Local Authority (LA) has a duty to assess private fostering arrangements to ensure they meet each child's individual needs. But the LA can only do their job if the public identify private fostering and report it.

There was a small increase in new notifications to the Local Authority during 2015 to 2016, but the number dropped again during 2016 to 2017 to just 5. The number of active fostering arrangements at the end of March 2017 was four.

There is significant under reporting across the country and so efforts to raise awareness have continued. The Fostering Team have taken the following action over the year to try and address this:

- Regular advertisements in the Harrow People Magazine
- Regular leaflet drops
- Leaflets with medical centres, places of worship, dentists and Northwick Park Hospital
- Stalls in community shopping centres and leisure centres
- Information on Council and HSCB websites
- Briefings for voluntary agencies, teachers and social workers

Inductions for new social workers on the Private Fostering Process.



VIOLENCE, VULNERABILITY AND EXPLOITATION

In recent years, the HSCB has been strengthening its understanding and overview of the multiple risks faced by young people in Harrow, especially where these risks link with each other, for example, children and young people who are known to go missing and are exposed to risks of Child Sexual Exploitation, gangs, youth violence and/or trafficking.

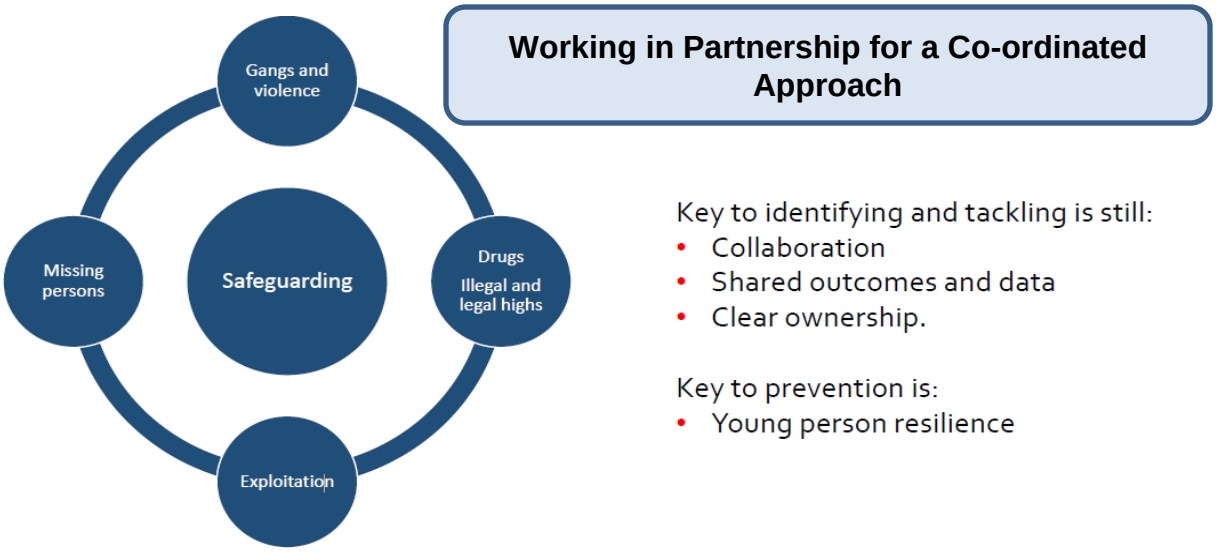
To reflect this approach, the HSCB changed the title and terms of reference for its existing Child Sexual Exploitation Sub-committee to the wider focus on Violence, Vulnerability and Exploitation (VVE). Our focus on these areas of vulnerability which was based on local need is similar to the Mayor of London's Police and Crime Plan which was based on the broader picture across London. The MOPAC plan for 2017-21 puts more focus on crime involving or affecting young people; its key themes being:

- Neighbourhood Policing
- Keeping Children and Young People Safe

- Tackling Violence Against Women and Girls
- Criminal Justice that Works for London
- Hate Crime

Locally these themes are driven largely through the Safer Harrow strategic partnership. Where the priorities of the HSCB and Safer Harrow converge we seek opportunities to support each other to make a positive impact for children and young people in Harrow.

In April 2016, we recognised that some young people are vulnerable in more than one way and so Harrow Council established a Violence, Vulnerability and Exploitation Team comprising a CSE Coordinator, Missing Children/Runaways Family support Worker and a Gangs/Prevent Worker. This Team works closely with other operational groups across the partnership, including Community Safety and the Channel Panel (part of the local activity for the prevention of extremism).



The following sections provide an overview of the activity undertaken and its impact over the last year.

Child Sexual Exploitation

Problem Profiling

Children who are at risk of sexual exploitation require all agencies to work together to protect them, pursue and prosecute those who exploit them and support those who care for them. Between April 2016 to end of March 2017 a total of 103 contacts and referrals were made by practitioners across the partnership and the public as having possible CSE issues. Of these, 66 were identified as having a CSE concern following assessment.

In Harrow as elsewhere in London this multi-agency activity is coordinated by a panel called the Missing and Sexual Exploitation (MASE) Panel. 28 cases were discussed by MASE this year; fewer than the

previous year. Harrow's figure remains lower than other London boroughs and we continue to explore the reasons for this.
A further 8 cases relating to possible offenders or persons of interest were also discussed by the MASE Panel, where the subject was also a young person.

The MASE Panel is responsible for identifying the characteristics of victims, perpetrators and relevant locations in order to inform local activity to combat CSE. The following picture has been collated:

- The majority of victims are females (26 out of 28)
- The majority of children/young people reviewed by the MASE Panel were assessed as 'Medium' Risk
- The types of exploitation varied, but almost a third involved peer-on-peer exploitation; a quarter has some associated gang involvement; and just over a quarter involved abuse through internet/social media (NB some young people were exposed to more than one type
- Some key locations 'hot-spots' for CSE were identified and as a consequence, the multi-agency partnership, including the Licensing Body were able to effectively pursue adult perpetrators; apply closure orders on certain properties; enhance CCTV coverage; and limit free wifi to discourage anti-social gatherings.

Analysis of MASE data now steers our preventative work. Good intelligence helps agencies collaborate in tackling CSE:

- Schools featuring regularly in reports are offered an opportunity to work in partnership to help them understand and deal with issues of exploitation.
- Where locations, including hotels, have been identified as being places where children are at risk of being exploited multi agency approaches will be taken to reduce the opportunity to take effective preventative action.

In London a recent review of CSE cases has shown that there is a greater reluctance for victims to pursue allegations than elsewhere in the UK. This tendency is true also in Harrow where of the 28 MASE cases nine victims declined to provide information about the perpetrator.

From July 2016, cross-borough working was strengthened , with CSE coordinators and analysts with the West London Alliance (Harrow, Brent, Ealing, Hillingdon and Hounslow) meeting to share themes, trends and cross borough intelligence. This is an essential development in response to the movement of young people and perpetrators across the West London region.

The HSCB requires each agency to have a CSE Champion who is responsible for raising awareness across their organisations of the signs and indicators of CSE and how to respond. The commitment to this arrangement has been encouraging, but lower referral rates in Harrow indicate that this activity must be maintained, leaving no room for complacency.

CSE Conference for Parents and Carers

Harrow Police held a spring conference on the subject of CSE for parents and carers at Harrow School. The keynote address was given by Lorin LaFave of the Breck Foundation. The purpose of the day was to:

- Raise awareness of CSE
- Provide advice on the available support in Harrow if concerns arise.
- Introduce parents to organisations who were able to provide them help

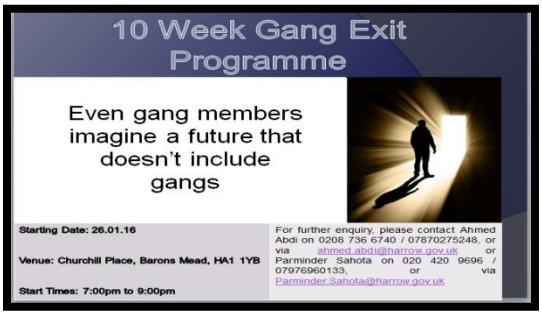
The conference also included an exhibition of organisations focused on the welfare of children and young people, e.g. Pace UK (Parents Against CSE), HSCB, Compass, Mind in Harrow, Wish Foundation and the Volunteer Police Cadets.

Gangs and Youth Violence

Prior to the summer of 2016 Harrow experienced very little knife crime involving children or young people. However from the summer onwards that changed with a number of such reports being made. In response to a fatal incident, the HSCB's Review Sub-committee asked the Youth Offending Board and the Safer Harrow Partnership to work together with HSCB to identify issues that could be worked on in partnership to protect children.

The response was impressive. A wide range of professionals came together and supplied information, ideas and contributed to an action plan. As a consequence the quality of information sharing across the operational groups listed has been strengthened.

- A Safer Streets initiative in crime hot spots has been set up to reassure the public.
- A cross border forum has been set up by the Community Protection to manage links between Harrow gang members and those in neighbouring boroughs.
- A dedicated data analyst was recruited .
- Work with schools and parents was prioritised. Later in the year Harrow police planned a conference for parents on knife crime.



Harrow's Gang Exit Programme helps young people learn and explore issues in relation to peer pressure, why they join gangs, anger management and the law, with a view to them making positive decisions and building personal resilience.

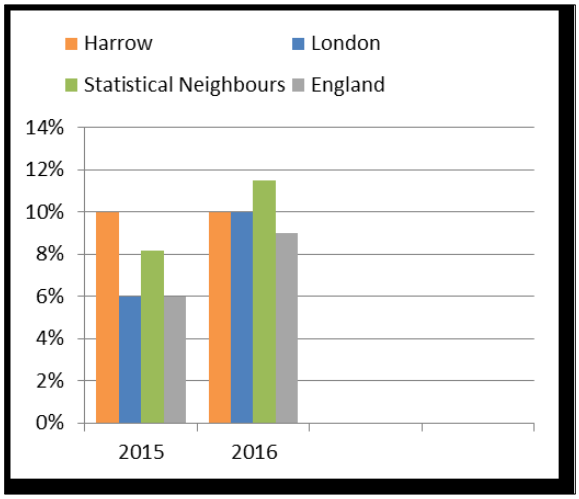
Children and Young People who go missing

Children and young people missing from home or care are a high priority for the HSCB and are the subject of multi-agency oversight via a dedicated Missing Children Meeting.

When a missing child returns it is important to find out why they have run away, where they have been and who they have been with. A dedicated worker undertakes an interview on return to offer support and establish where they have been and why. We aim to do this interview within 72 hours. This time frame is a challenge and it was the appointment of a dedicated worker that saw an improvement in timeliness. Now most are done in time. That makes the information gleaned more useful.

- Those at higher risk due to CSE or gang association have been more reliably identified.
- The local understanding of the profile of young people who go missing has improved.

Some children go missing regularly and some of the most frequent runaways are Looked After. 10% of Children Looked after by Harrow had a missing incident during the year. This reflects the national and London picture. A common feature of these young people going missing is that they want to be in contact or proximity to family and or friends. A smaller proportion are being pulled towards risky behaviours including exploitation and gang association.



	2015	2016
Harrow	10%	10%
London	6%	10%
Statistical Neighbours	8%	12%
England	6%	9%

Percentage of Children Looked after who had a missing incident during the year

Trafficking and Modern Day Slavery

Human trafficking and modern day slavery is the fastest growing international crime and world wide is the second largest source of illegal income. The Modern Slavery Act 2015 now places a statutory duty on the police and local authorities to identify potential victims and refer them for help via the National Referral Mechanism (NRM).

There may be 10-13,000 victims trafficked into the UK. Only a small percentage of them are actually identified. From 2016 to 2017 eight referrals concerning children in Harrow were made.

In some poorer counties it is customary practice for parents to transfer the care of their child to a relative or community member who is seen as better able to provide for the child. Traffickers exploit such practices, with children being brought to the UK and other countries in order to be domestic servants or for benefit fraud, or otherwise exploited rather than to receive education.

Trafficking can also involve children and young people born in the UK being moved across the country and beyond. Its association with CSE must be kept in focus. The Board realises that much more work is needed across the partnership and with our communities to identify and support potential victims.

Doing More in Harrow to identify and support potential victims of Trafficking and Modern Day Slavery

Strengthening engagement with Children and Families Across Borders (CFAB) – sharing training and development between Local Authority, CFAB and HSCB

Harrow's new Training course is shared across the HSCB and HSAB. Its content has been updated to promote a fuller understanding modern day slavery. The link between adult and child victims is emphasised as part of both Boards' commitment to the **Think Whole Family Approach.**

Health and Local Authority Trafficking and Modern Day Slavery Champions are in place in Harrow to provide training and advice.

Voluntary and Faith Sectors – Training and Outreach

Voluntary Action Harrow Co-op

Helping you achieve.

Following two years of successful partnership , the HSCB continued to commission Voluntary Action Harrow (VAH) to work with the Board in reaching smaller and more remote voluntary sector and faith groups across Harrow. Their reach into Supplementary Schools too has grown over the past two years.

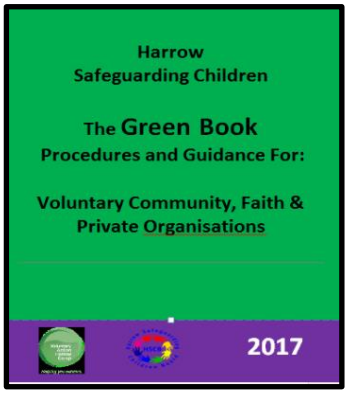
VAH provides training and support to many voluntary groups and has also created a network of nominated safeguarding leads to help embed safeguarding standards in these groups across Harrow.

During 2016 to 2017 a total of 81 organisations accessed VAH's safeguarding training. This helps to equip practitioners and volunteers to identify and respond to children in need of help and protection. VAH relationship with these organisations helps the HSCB's to talk to communities about such difficult issues as Child Sexual Exploitation, Gangs and youth violence, Female Genital Mutilation, Private Fostering, Forced Marriage and Radicalisation.

Post course evaluations demonstrate the high regard that organisations place on the training provided by VAH.

VAH also supports the voluntary and faith groups with their recruitment arrangements. This ensures that both paid staff and volunteers are carefully vetted to work with children and vulnerable groups.

VAH has updated and refreshed the 'Green Book'. This contains the HSCB's standards and useful guidance, tailored for the voluntary and faith sectors on a wide range of safeguarding topics. The 'Green Book' can be accessed via the HSCB and VAH's websites.



Post VAH course evaluations:

- **96% felt confident to make a referral to Harrow's Multi-Agency Safeguarding Hub**
- **96% had improved understanding of safeguarding responsibilities**
- **99% felt the learning materials catered for diverse groups and learning styles**
- **98% would recommend the training course to others**

"The training was very interactive and concise"

"The training was very good the way it was developed and delivered"

"I feel more able to recognise issues and report them"

Extracts from the Child Death Overview (CDOP) Annual Report for 2016

The CDOP is an inter-agency forum that meets regularly to review the deaths of all children up to the age of 18 normally resident in Harrow. It functions as a sub-group of Harrow Safeguarding Children's Board.

During the review process, the CDOP may identify issues that need to be addressed such as:

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

The Panel held four meetings during 2016 in which 26 cases were discussed compared to 18 cases in 2015.

It is important to note that as the number of child deaths is small, it is difficult to make any comparisons with other National data.

The key principles underlying the CDOP are:

- Every child's death is a serious matter and should be reviewed to see what can be learned
- Where we can we should learn lessons to prevent future child deaths
- We take a joint agency approach
- Where appropriate we make recommendations to the HSCB to ensure that positive action to safeguard and promote the welfare of children is taken

Expected and Unexpected Deaths - Over the past 6 years, 20% of child deaths have been classified as unexpected. Of the 20 unexpected deaths occurring in the past six years, almost all had a Rapid Response meeting or visit. This is a multi-agency meeting held to identify any necessary enquiries into the death and to identify initial support for the family.

Characteristics of Cases - On average, between 2011 and 2016:

- a slightly higher proportion of deaths were seen in males than in females; in 2016, 70% were males.
- the number of deaths in children from Black and Ethnic Minority groups is slightly higher than might be expected given the makeup of the Harrow population[8]
- There is no reliable data on religion
- the most categories were that of perinatal/neonatal events and chromosomal, genetic and congenital abnormalities

Modifiable Risk Factors

From 1st April 2010, CDOPs were asked to identify whether or not there were 'modifiable factors' in a death. 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. However, there are difficulties in distinguishing between these categories, i.e. of factors which definitely contributed to the death and of factors which may have contributed to the death, and ensuring a nationally consistent approach.

Last year four deaths with modifiable risk factors were identified. Due to the small numbers of child deaths in Harrow, further information related to individual cases cannot be made available.

[8] Ethnicity is not recorded on death certificates and so the data on ethnicity of CDOP cases has been gathered from hospital records and/or based on the recorded ethnicity of the parents or mother where father's details are not available. Due to small numbers the pattern of deaths varies by ethnic group. On average over the past six years,

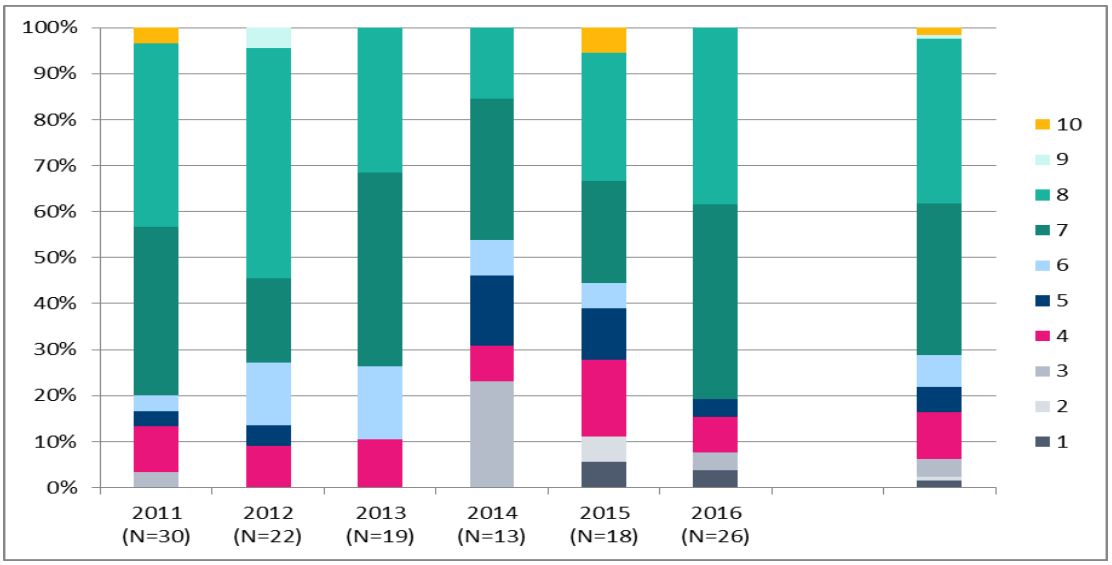


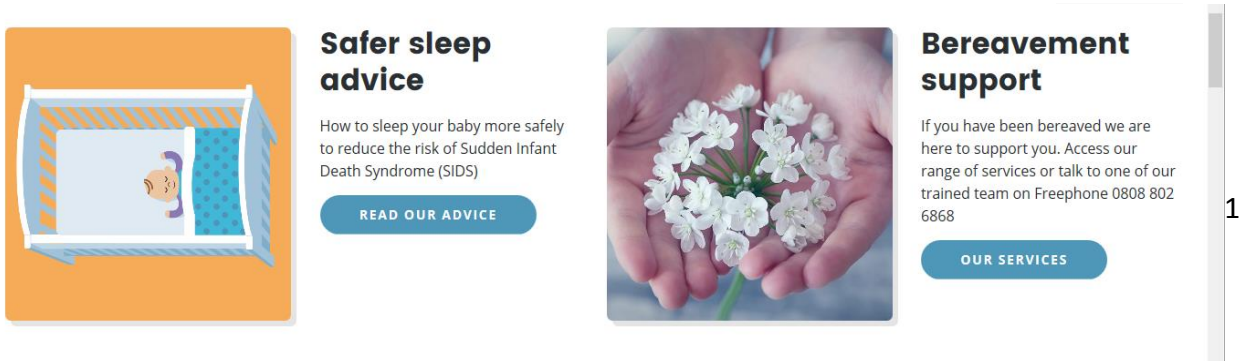
Figure 1 Harrow CDOP cases by Category 2011-16

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

Consanguinity (parents related to each other) In the past five years 10% of Harrow child deaths were identified as being in consanguineous families. This is not a modifiable factor in these child deaths.

Lessons Learnt: Due to the low number of deaths identifying trends or wider lessons is very difficult. However all unexpected deaths were managed appropriately using the rapid response process.

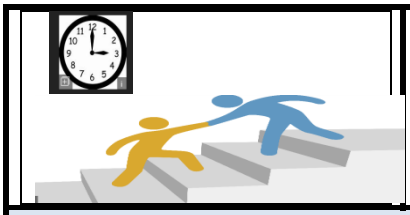
- Following a child death in 2015, CDOP and HSCB have developed guidance for schools to support children with epilepsy.
- CDOP has continued work with the Lullaby Trust to deliver training on safe sleeping and reducing the risk of cot death. More training sessions are planned in 2017.
- CDOP supported the Safer Sleep Week national campaign in March 2017 providing a free training session for parents and carers.



HSCB Financial Summary 2016-17 Appendix A

HSCB Income 2016-17	£
Harrow Council including Business Support	163,020
Police / MOPAC	5,000
National Probation Service	1,000
Royal National Orthopaedic Hospital	5,000
Cafcass	550
Harrow Clinical Commissioning Group	11,000
London North West Healthcare NHS Trust: Acute Services & Community Services	22,000
Training Income	7,020
Sale of USBs	350
Total Income	**214,940**
Staff & Consultancy Expenditure:	
LSCB Chair	17,850
Professional Support (full time BM; part time L&D co-ordinator)	91,762
Business Support	39,630
Training Admin (.5 FTE) + p/t admin	8,285
SCRs and Independent Auditing	26,410
Voluntary Outreach work Revision of Green Book	13,900 2,000
Staffing & consultancy expenditure Total:	**199,837**
Delivery costs:	
Annual Conference	6,455
Training Providers	8,250
Venue Hire	3,585
LSCB Website	1,500
Publications, Printing, USB Production	619
Other Admin Overheads	4,968
Catering & Misc	3,040
Delivery Costs Total:	**28,417**
Total Expenditure:	**228,254**

HSCB Priorities 2017-19 Appendix B



Priority 1: Early Help/Support:
To ensure a clear understanding of what help is available across the partnership, where it is delivered and how to access it.

- ***Developing and implementing a communication strategy to promote a clear understanding of the referral process and the range of services available***
- ***Monitoring and evaluating front-line practice in relation to the identification, referral and impact of early help – Drawing upon regular single and multi-agency data analysis and auditing***

Priority 2: Understanding Risk:
To achieve a reliable understanding of the risks faced by children and young people in Harrow, so that preventative and responsive actions are informed by up to date and relevant information.

- ***Reviewing the focus and breadth of the HSCB's data set and identifying priority areas for further scrutiny***
- ***Compiling problem profiles and ensuring they are continually fed by data and intelligence from the <u>whole</u> partnership***
- ***Identifying best practice in preventing and addressing risk; drawing upon local learning from reviews and audits - and evidenced based practice (local and national)***

Priority 3: Engagement:
To ensure that the work of the Board is regularly informed by children, young people and their families – and to harness new support from the wide range of communities in Harrow

- ***Broadening the methods of communication with children, young people and families – and furthering their involvement in service development and evaluation***
- ***Seizing opportunities to involve local communities in safeguarding and promoting the welfare of children***

Working Together

Priority 4: Effective collaboration:
To ensure that the priorities of the HSCB are supported by other strategic partnerships within Harrow and that relevant collaborative work takes place with other LSCB's

- ***Building on existing collaboration with other strategic partnerships and identifying new external alliances to strengthen practice and achieve efficiencies***
- ***Ensuring that the HSCB promotes robust scrutiny, transparency and accountability in all of its monitoring activity***
- ***Developing 'in-house' auditing and reviewing skills to ensure efficient allocation of HSCB's financial resources***