LEWISHAM SAFEGUARDING CHILDREN BOARD

ANNUAL REPORT

April 2013 – March 2014

August 2014 – version 4

Contents:

Foreword from the Independent Chair of the Children Safeguarding Board

I am pleased to introduce the annual report for 2013-14 for Lewisham Safeguarding Children Board. During this year the LSCB has continued to strengthen its approach towards audit and performance management functions, and has shown the effectiveness of its challenge and assurance functions in a number of key areas where improvements have been secured. In addition the strength of the partnership in responding to challenges is visible in this report, with improvements in initial health checks for looked after children and the securing of comprehensive DBS checks for all relevant staff in schools, on an ongoing basis, being two of many examples.

Whilst 2013-14 has been a period of considerable change in Lewisham, in particular within Health, with the merger of Lewisham Hospital with Queen Elizabeth Hospital in Greenwich and the consolidation of the new CCG role, partners have nevertheless continued to contribute effectively to the LSCB, its subgroups, and the safeguarding agenda, whilst these changes have been underway.

It has also been a challenging year in terms of demand, with marked increases in referral rates for child protection (in line with other London- wide and national trends) and consequent resource pressures. Analysis by the LSCB has shown that the referrals received remain well targeted, and the impact of the early help offer remains strong so that these increases are genuine and represent real pressures.

Although Lewisham continues to offer a challenging environment in terms of safeguarding, the early help inspection in 2014 shows that there continues to be highly effective local practice, and the LSCB has been able to contribute detailed actions in a number of areas which will improve safeguarding, whilst holding the partnership to account for its performance. These include findings from audit, management reviews, and Serious Case Reviews, which have led to action plans carried out by the LSCB, to bring about further improvements in local practice.

I would like to thank those who have contributed for the openness and quality of their contributions to the LSCB and for the hard work which has enabled us to achieve this degree of focus. This is the first Annual Report prepared in line with the requirements of the revised Working Together Guidance, and whilst there remains some further development of our performance framework in order to fully meet the requirement to analyse local safeguarding practice in the round, the style and format of this report aspires to this approach and, I believe, largely achieves it too. It also very clearly outlines the priorities for next year both for the LSCB and in terms of holding the partnership to account.

Chris Doorly
Independent Chair

1. Introduction

Working Together 2013 requires each LSCB to publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area. This report aims to provide a rigorous assessment of the performance of local safeguarding services and to show how any areas of weakness will be addressed. It will be submitted to the Chief Executive and the Chair of the Health and Wellbeing Board.

2. Context of the LSCB

2.1. National

Section 13 of the Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board (LSCB) for their area and specifies the organisations and individuals (other than the local authority) that should be represented on the LSCB. Please go to www.legislation.gov.uk/ukpga/2004/31/section/13 for more information.

The LSCB has a range of roles and statutory functions including developing local safeguarding policies and procedures and scrutinising local arrangements. The statutory objectives and functions of the LSCB are described as follow:

- 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 in the area, and
- To ensure the effectiveness of what is done by each such person or body for those purposes

The revised Working Together Guidance 2013 places increased responsibilities on the LSCB to deliver a stronger leadership role around local safeguarding practice and directly influence multi-agency and single-agency requirements as well as requiring the establishment of a single assessment approach and supporting framework. The revised regulatory framework also includes a judgement of the effectiveness of local safeguarding boards, with a focus on assessing the impact of the board's activities on frontline practice and the positive difference made to children and local communities.

2.2. Local

2.2.1. Demand for services

Lewisham has approximately 70 000 children aged 0-19 living in the borough, making up 25.4% of the total population. This compares against the inner London average of 22.7% and the London average of 24.5%. Deprivation is increasing in Lewisham, which appears to be linked to the increase in child protection rates. The 2010 Index of Multiple Deprivation ranked Lewisham 31st out of 354 local authorities in England. It is estimated that 20 335 children (ages 0-18) live in poverty in Lewisham.

There are a large number of residents from black and minority ethnic (BME) backgrounds in Lewisham and over 170 different languages are spoken by pupils in Lewisham schools. Lewisham's BME school population continues to rise.

As of December 2013, Lewisham's specialist provision showed there were 501 Looked After Children (LAC), 310 Children on a Child Protection Plan (CP) and 1 773 Children in Need (CIN). Key issues such as the

prevalence of autism are highlighted through Lewisham's special needs data, which show 1 444 children with a statement of special educational needs.

Lewisham's strategic approach of early intervention ensures that all professionals across the partnership work to identify and meet children's needs as soon as possible in order to prevent escalation. Lewisham continues to use its Common Assessment Framework (CAF) and Team Around the Child/Family as tools to improve outcomes for children and young people with the purpose that the necessary services will be in place for the earliest possible support, and to reduce the number of families and children being referred to Children's Social Care.

Lewisham has a risk based approach to safeguarding children which enables the Local Authority to ensure that appropriate support is provided to parents to ensure that children subject to a Child Protection Plan (CPP) are safe and sound in their own home.

Violence against Woman and Girls (VAWG) remains a priority for Lewisham, who has a long history of commitment to tackling domestic and sexual violence. The Safer Lewisham Partnership takes responsibility for this area of work, which is now supported by a unified and comprehensive approach to tackling violence against women and girls through a systemic VAWG Plan. A needs assessment was undertaken in the summer of 2013 to look at the prevalence of VAWG locally and to determine what the priorities should be. The partnership as well as residents and victims of VAWG were consulted as part of this process. Please see section 4.2.7 of this report for more information regarding the VAWG plan.

2.2.2. Service context

- **Health**

Health services experienced considerable changes during 2013/14. Lewisham Hospital merger with Queen Elizabeth Hospital in Greenwich in October 2013. One of the implications of this was that safeguarding services also merged across the two hospitals. Some areas for improvement in safeguarding arrangements at Lewisham Hospital midwifery and health visiting service were identified and the LSCB continues to track the implementation of the action plan to ensure service improvement. A robust maternity safeguarding pathway was put in place by Lewisham & Greenwich NHS Trust.

Lewisham Clinical Commissioning Group (CCG), which was established following the NHS reforms, assumed the responsibility of Lewisham Primary Care Trust in April 2013. Key legislations have been amended through the Health and Social Care Act 2012 in order that the NHS Commissioning Board and CCG have the same duties as those previously applying to the Strategic Health Authorities and Primary Care Trusts in relation to having regard to the need to safeguard and promote the welfare of children and to be members of the Local Safeguarding Children Board.

There have been some changes to the South London and Maudsley NHS Trust (SLAM) safeguarding services during 2013/14. The Trust Named Doctor for Safeguarding Children retired in February 2014. The Assistant Director of Nursing Trust Named Nurse for Safeguarding Children left his role in December 2013 to take up his position as Deputy Service Director for CAMHS. In light of these changes, SLAM had to review their representation at LSCB Main and Executive Boards.

- **Probation Service**

The LSCB has been briefed regarding the significant changes regarding the London Probation Trust Reforming Rehabilitation. London Probation Trust will be dissolved on 31 May 2014 and the work will be transferred to two new organisations, the National Probation Service and Regional Community Rehabilitation Companies (CRCs). The CRCs will manage the majority of offenders under probation supervision until a contract for this work is awarded in October 2014. The LSCB will remain sighted on the Probation changes to ensure that all the necessary safeguarding links and processes are clearly defined within the new structure.

2.2.3. Increase in Children subject to Protection Plans

There has been a significant increase in children becoming subject to Child Protection Plans during 2013/14, which has been a London and National trend. A report into this matter concluded that these plans were appropriate and there were a need to protect these children by making them subject to Child Protection Plans. The report further found that the Local Authority had maintained services of a high quality, despite increase in the quantity of work. Extra resources had been brought in through the creation of an extra social work team despite the financial difficulties in a time of austerity. The LSCB will be keeping it under review. Please see section 4.2.1 of this report for more information on this matter.

2.2.4. Inspections

Lewisham's latest Safeguarding and Looked After Children inspection took place in February 2012 whereby the Local Authority was rewarded an 'Outstanding' grading by Ofsted for its safeguarding services. The inspectors commented that children and young people in Lewisham are very effectively safeguarded through a combination of initiatives lead by partner agencies and some directly influenced by young people. The inspection highlighted that partnerships between agencies are strong and mature with a robust focus on improving outcomes for children and young people in all aspects of their safeguarding and child protection work. Lewisham has been rated 'excellent' in the past three Children's Services inspections. No priority actions were identified within either of the two unannounced inspections preceding the safeguarding and looked after children inspection in February 2012. Inspectors' findings during the latter inspection was that a strong focus has been maintained to address the areas for development following the unannounced inspection in November 2010. Inspectors saw clear evidence of these areas having been fully addressed and embedded within practice.

The overall effectiveness of services for looked after children received a 'good' rating. The inspection revealed rigorous and routine performance management which is strengthened by a wide range of audit activity. During the inspection the quality of pathway plans were identified as a weakness (although outcomes for care leavers were in the main very good). The inspectors commented on the fact that placement stability is improving but the ability to monitor progress effectively is hindered by a lack of measurable actions and objectives in case work plans.

Ofsted conducted a thematic inspection of Lewisham's Early Intervention Service during February 2014. It was overall a very positive inspection with a lot of strengths identified, as well as a few areas for development. Some of the strengths included sound decision making, strong partnership working across agencies and commitment to early intervention, frontline staff feeling supported by managers, strong decision making by Children's Social Care, appropriate closure of cases, child focussed work with evidence of taking views of children into account.

A few areas of improvement were highlighted. These were mainly around being clearer regarding the outcomes achieved by early intervention. All action identified are being followed up within the Children and Young People Strategic Partnership Board and under the scrutiny of the LSCB. The Local Authority welcomes this helpful feedback from inspectors which will support with improving early intervention work across the partnership.

2.3. The LSCB and its governance arrangements

The LSCB has conducted a comprehensive governance review in 2012 whereby the structure of the board and its sub groups were established. The LSCB is a statutory board in its own right under regulations and guidance. It operates within the matrix of the local structure of partnerships and its own structure must be seen in this context (Appendix A). The main board coordinates the main work of the LSCB. The work programme and tasks of the LSCB main board are laid out in the Business Plan 2012-15, which has been developed through a consultative process and is designed to address the collective priorities of the partnership in terms of safeguarding. The LSCB Business Plan 2012-15 coincides with Lewisham's Children and Young People's Plan 2012-15 and the LSCB task groups are responsible for driving this work. Please see section 4.6 of this report for information regarding the work and activities of the task groups during 2013/14.

The LSCB main board feeds into the Executive Board, whose main responsibilities are to direct and oversee the business of the LSCB and to ensure there is a focus on monitoring the strategic horizon and taking into account, understand and respond to the opportunities and threats posed by the national and local policy and resource changes.

Lewisham has benefitted from good partnership working and strong leadership in the children's services arena. There has been good feedback from inspections of Children's Social Care in relation to inter-agency case management.

The LSCB continues to have a close relationship with the Children and Young People Strategic Partnership Board. The LSCB Chair attends all meetings to provide updates on the work of the LSCB. Part of the Chair's role on the board is to hold members to account for ensuring that safeguarding is central to all its activities. Please see Appendix B for a breakdown of the LSCB's budget for 2013/14.

2.4. Chairing and Membership

The Lewisham LSCB has been chaired by Chris Doorly since 2011. The Chair is funded for 20 days per financial year to fulfil her role. This includes chairing both Executive Board and LSCB main board, as well as representing the Board on the Children and Young People's Partnership Board and at external events. Chris also chairs the Adults Safeguarding Board in Lewisham.

The composition of the board is in line with statutory partners listed in Working Together 2013. The LSCB has succeeded in continuing partnerships across the various agencies and agreeing governance arrangements. The LSCB welcomed three lay members to the board in 2013/14. They are local residents who have good links with the community. The lay members attend the main board as well as some of the task groups.
Please see Appendix C for a full list of LSCB members.

3. Report of the LSCB's work

3.1. Outcome of key priorities from last year (2012/13)

The LSCB has undertaken the following work during 2013/14 in respect of each priority:

3.1.1. Reduce child abuse and neglect

- Local Management Reviews identified neglect as an area to focus on in 2013/14 and a neglect audit was conducted to improve practice in this area. The audit included cases where neglect was a feature, but did not reach the threshold for Children's Social Care involvement and was managed via a Team Around the Child (TAC) approach. The audit indicated that early intervention can be a robust mechanism for children's services to manage complex cases where neglect is a feature, but does not meet the threshold for Children's Social Care involvement. However, the audit also indicated that some professionals need ongoing support to increase their confidence to appropriately manage cases where neglect is apparent. The audit made a number of recommendations which will be implemented and tracked by the Neglect task group until complete. Please see section 4.6.2 of this report for more information on the outcome of this audit.
- The rate for child protection cases was fairly stable during 2012/13. However, in 2013/14, there has been a significant increase in child protection cases which led to work being undertaken to understand the reasons for the increase and to evaluate the ongoing effectiveness and capacity. A report was presented to the LSCB. The report indicated that these children were all in need of protection and that appropriate action was taken to ensure these children's safety. Please see section 4.2.1 of this report for more information.
- The LSCB has ongoing oversight of the thresholds for early intervention services, by which means children receive support to prevent harm. The LSCB monitors the uptake and approach to the CAF on an ongoing basis. Please see section 7.2 for CAF data for 2013/14. The need to both review thresholds and analyse the effectiveness of the Early Help offer was identified during 2013/14 as a task for the LSCB.
- Lessons from management reviews and national serious case reviews have been shared with the partnership by means of briefing sessions as part of the LSCB's training programme.

3.1.2. Reduce Bullying of children at school

- Bullying will always be a priority for the LSCB and it will always want to ensure itself that bullying is dealt with effectively.
- The LSCB revised and updated the bullying strategy and established a Bullying task group to consider the consultation on the strategy, analyse the findings and put in motion any appropriate actions. The LSCB Business Plan 2012-15 has been updated to reflect this work strand.
- Bullying data is reported to the LSCB on a quarterly basis. This will be reviewed once the bullying strategy has been implemented to measure the impact this has had on children being bullied in Lewisham.

3.1.3. Reduce harm to children and young people caught up in domestic violence

This area remains a priority for the LSCB due to the known harm caused to children exposed to domestic violence. Statistics in Lewisham are high and it therefore remains a priority area.

- As a result, the LSCB facilitated training courses on domestic violence as well as a Multi-Agency Risk Assessment Conference (MARAC) briefing session during 2013/14. Feedback on this training has been

extremely positive and courses will be commissioned again as part of the next training programme.

- Lewisham Safer Partnership board completed two Domestic Homicide Reviews by 2013/14. These made some recommendations for action by the LSCB, which had been converted into SMART action plans. The LSCB will review these action plans to ensure completion.
- Lewisham's Crime Reduction service has developed a Violence against Woman and Girls plan (VAWG) which has been presented to the LSCB and implemented across the partnership. The LSCB will monitor the safeguarding aspects of this plan.
- The LSCB Executive challenged the lack of availability of police Merlin reports in respect of domestic violence issues to health partners such as health visitors. As a result of this challenge, reports will now be shared to ensure professionals are aware and offer appropriate support when working with these families so children can be protected from coming to harm as a result of domestic violence.

3.1.4. Develop a coherent multi agency strategy to reduce the incident of sexual exploitation

During 2012/13, Child Sexual Exploitation (CSE) has been identified as an ongoing priority for the LSCB.

- LSCB Sexual Exploitation training has been delivered to services across the partnership, including Youth Workers, Independent Reviewing Officers, Safeguarding leads for schools, Sexual Health nurses and school nurses. The training specifically focussed on helping professionals to identify and respond to CSE appropriately.
- Lewisham was part of a pilot for implementing the Police Sexual Exploitation Protocol. Multi Agency Sexual Exploitation (MASE) meetings takes place monthly and are designed to look at data and develop a local profile of CSE to support the work of the board. Please see section 4.6.1 for more information regarding the LSCB's approach to sexual exploitation.

3.1.5. To work with other partnerships to reduce incidents of youth gun and gang violence

- The Community Safety Partnership leads on this area of work. There is innovative and effective practice in Lewisham which includes the Youth MARAC. The LSCB contributes to this area of work through its training courses, which aim to equip professionals with signposting to appropriate services for young people at risk of involvement in this area.
- The LSCB has included this area of work as part of its performance framework, which will be monitored on an ongoing basis to ensure services are making a positive contribution to keeping children safe from gun and gang violence.

3.1.6. Reduce road traffic accidents involving children and young people

- Having identified this as a priority in 2012/13, Lewisham council continued to deliver a number of initiatives via the Road Safety and Sustainable Transport team to reduce the number of fatal and serious accidents with a clear reduction over the past decade.
- Lewisham's next Local Implementation Plan (LIP) comes into effect in 2014 and LIP money is continuing to help fund the road safety programme of safety measures in Lewisham. Please see section 4.4.6 of this report for more information.

3.1.7. Provide secure and consistent support for looked after children, particularly placement stability

Placement stability remains a priority for the LSCB, which is driven by data that shows performance to be lower

than Lewisham's Statistical Neighbours. This data is monitored by the LSCB on an ongoing basis. A report was presented to the LSCB in December 2013 which informed the Board of the reasons for placement breakdown and assurance was given that the Local Authority puts a lot of work and consideration into ensuring children are placed according to their needs and that every effort is made to avoid a placement from breaking down. Please see section 4.2.5 of this report for more information on this.

3.1.8. Support families at risk of being in crisis

Generally in Lewisham the Early Help offer and Early Intervention approaches are seeing to work well, using the Common Assessment Framework (CAF), Team Around the Child (TAC) and Early Intervention services. However, the LSCB decided in 2013/14 that the threshold would benefit from review and outcomes from the Early Help offer should be more strongly evaluated by the LSCB. This has been identified as an action within the 2014-15 business plan of the LSCB. Please see section 3.2.4 of this report for more information regarding the outcome of the Early Help inspection during February 2014. The work of the Early Intervention and Access Service during 2013/14 is further explained in sections 6 and 8.1 of this report.

3.1.9. Ensure that children and young people feel safe

The LSCB monitors information in this area. Agencies have demonstrated through their section 11 audits how they will improve practice in relation to ensuring the child's voice is heard. Examples of outcomes in this area include improved child friendly complaints procedures and greater involvement of children and young people.

The Communications and Publications task group of the LSCB will establish links with the Lewisham Youth Council and other youth forums and driving forward the work towards ensuring children's voices are heard and at the forefront of the LSCB's work. This will form part of the LSCB's priorities for 2014/15.

3.2. Analysis of key reports and findings/activities by the LSCB

3.2.1. Report on increase in children subject to Child Protection Plans (CPP)

The number of children subject to child protection plans in Lewisham have seen a steady rise during 2013/14. In March 2012, the number of children subject to a child protection plan was 198, increasing to 235 children by March 2013, a 19% increase over the period of a year. In October 2013, this figure had risen to 327 children, which is a further increase of 37% over a period of six months.

The report explored whether there were evidence to suggest

- Children are remaining on child protection plans for longer than they should be
- The rising number of children subject to child protection plans can be linked to changes in Children's Social Care (CSC) thresholds
- Whether there are national trends or demographic changes that might explain the increase in child protection plans in Lewisham

None of these three factors were found to have occurred and it was concluded that numbers have risen appropriately due to actual demand.

The report concluded that the number of children subject to CP plans has continued to rise apparently in line with national trends and there was no evidence from the investigations undertaken, to suggest that there has been a decline in the quality of the work or to suggest that children are not being protected because of the volume of work. Action has been taken within Children's Social Care (CSC) to increase the number of social workers and address increased workloads. CSC has continued to undertake quarterly audits of children who have been made subject to CP plans to ensure appropriate thresholds are maintained and these are evidencing that responses are appropriate.
The LSCB will continue to monitor the increase in the number of children subject to CP Plans and the quality of service to these children.

3.2.2. Report on attendance at Child Protection Conferences

The LSCB requested a report to look into agencies attendance at child protection conferences as there has been a decrease in this performance indicator reported to the LSCB.

There is a local arrangement in place for agencies to provide written reports or to send deputies if they are unable to attend the conference. A number of key agencies were identified which needed to improve their attendance or reporting. These agencies have been made aware of this concern and future attendance will be tracked by the Quality Assurance Team. The LSCB will monitor this data on a quarterly basis and ensure that improvements are sustained.

3.2.3. Lewisham Healthcare NHS Trust safeguarding arrangements (LHT)

In June 2013 three cases were made know to the LSCB in relation to weaknesses in Lewisham Healthcare Trust (LHT) in respect of safeguarding. The primary areas of concern were midwifery and health visiting. LHT undertook a review of processes within midwifery and health visiting services and an action plan was agreed and implemented. This action plan has been monitored and reviewed by the LSCB and evidence of implementation has been provided. The LSCB was therefore satisfied that the issues has been appropriately addressed to ensure LHT fulfil in its safeguarding duties towards children.

3.2.4. Healthcare needs of Looked After Children (LAC)

Lewisham is responsible for approximately 500 LAC with over 40% of them residing within the borough. Lewisham Public Health conducted a needs assessment for Looked After Children (LAC) and informed the LSCB of the findings in September 2013. The LSCB Executive was especially concerned at the arte of completion of Initial health Assessments for Looked After Children. Urgent management action was taken on this matter which resulted in significant improvements.

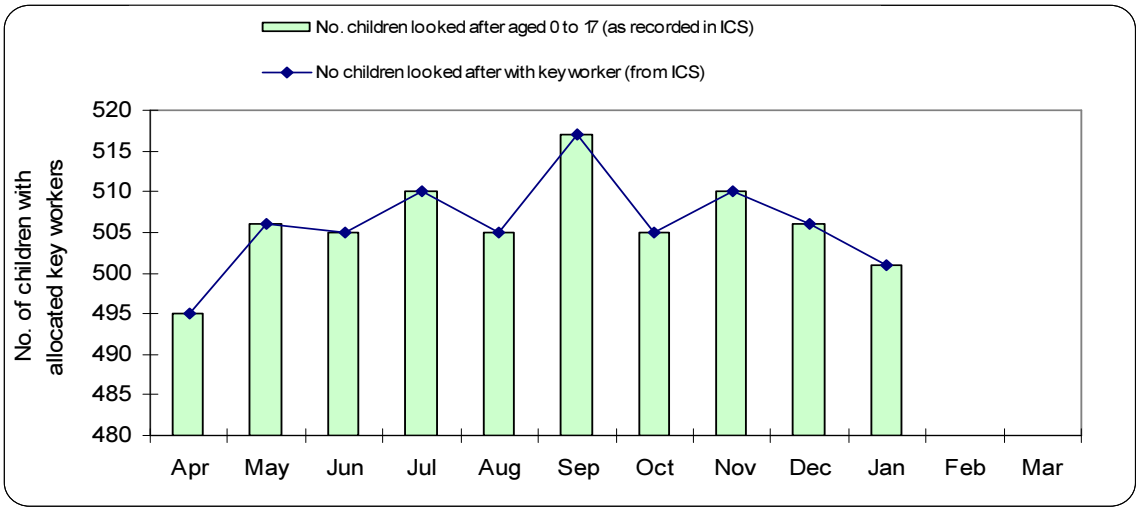
This comprehensive report concluded, on the basis of the evidence presented, that Lewisham's looked after children cohort face a range of obstacles placed in their way by often tumultuous early years in precarious home environments. Despite this, and responding to these problems, Lewisham's services are performing in a largely robust manner. Moreover, with careful oversight, these services are continuing to improve. From this review a n action plan was developed which is being tracked by the LSCB.

3.2.5. Looked After Children Report (LAC)

Following the presentation of the annual LAC report to the LSCB in September 2013 (please see section 4.4.7 of this report), a further report was requested in relation to placement stability, LAC missing from their

placement and LAC who has substance misuse problems or for whom there is a concern they may develop such a problem. The health and wellbeing of LAC remains a priority for the LSCB., which wanted to review this area in more depth. This further report was presented in March 2014. The purpose of this second report was to examine in more detail the three areas of :substance misuse of LAC, the distance of placements from home and the placement stability of LAC. The LSCB's findings in these 3 areas are summarised below.

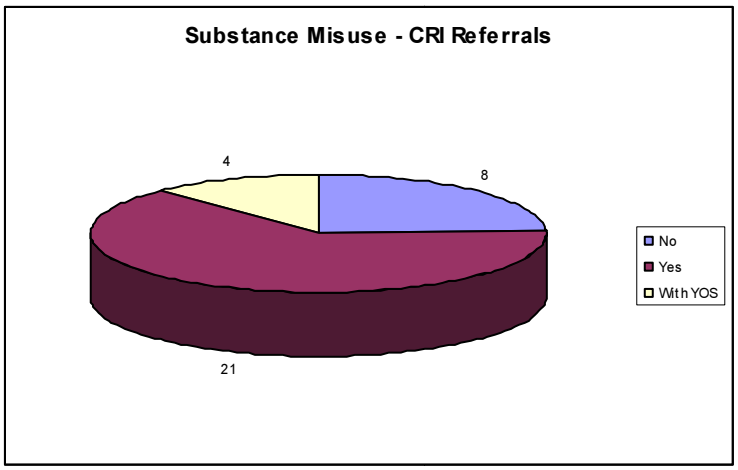
The graph below illustrates the total number of children looked after from April 2013, which was 495, the overall figure rose during the year hitting a peak of 517 in September 2013. Since then (with the exception of October 2013) the number has been decreasing and on the 31st January 2014 there were 501 Children looked after by the borough.



- **Substance Misuse**

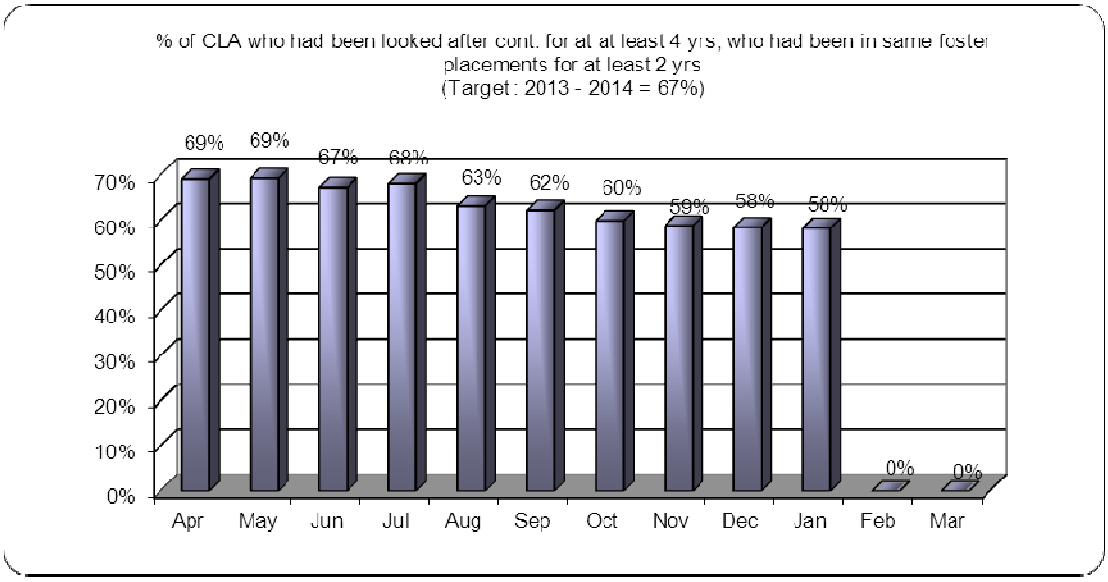
The number of LAC with an identified substance misuse problem was 33 in December 2013. 23 of the cohort are aged 16 and above, 8 are aged 15 and one aged 14 and the other 12. The 12 year old was in fact referred for support as a result of his level of cigarette smoking given his age. The intervention has been positive and he has been discharged from the service.

The Leaving Care Service has access to a specialist worker whose role it is to provide assessments and interventions to minimise the use of substances by these young people. The graph below shows the number of young people who have been referred to the specialist worker. Those who were not referred were either newly identified at the time or young people who were refusing to accept a service, some because they have been working with CAMHS and did not wish to work with another agency. Four of the young people were also allocated within the Youth Offending Service and were receiving services to reduce both their offending and associated substance misuse directly from the Youth Offending Service. The LSCB was therefore assured that appropriate services and responses were made to young people in respect of substance misuse.



- **Stability of LAC placements**

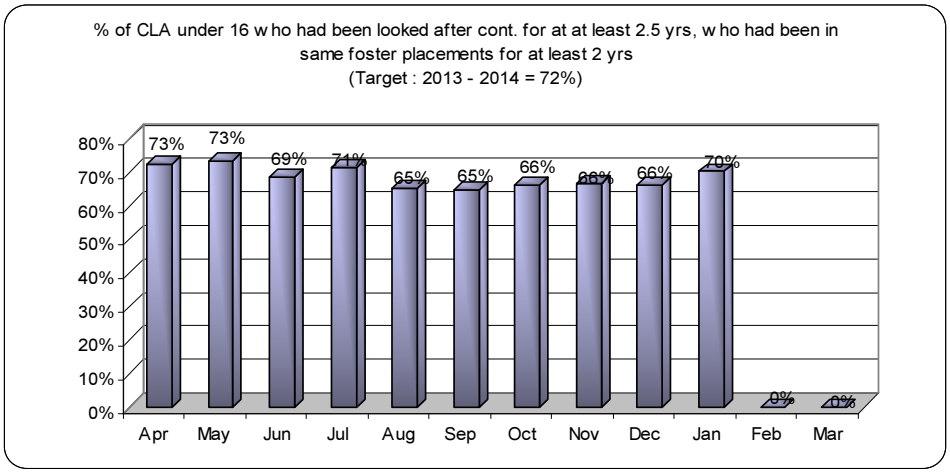
The stability of the LAC cohort is measured in three different ways. The table below shows the percentage of LAC who had been looked after continuously for at least 4 years, who were currently in a foster placement where they had spent at least 2 years.



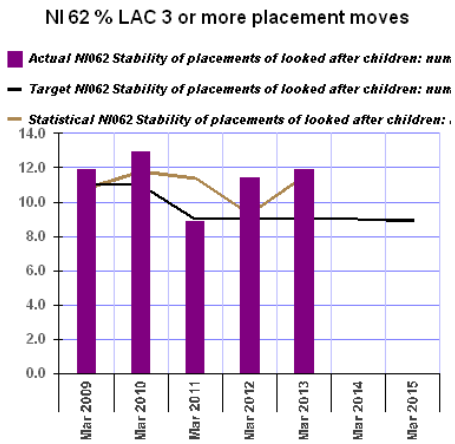
As the chart suggests there has been a concerning downward trend in terms of the average length of foster placements reducing in time span in this cohort. Some initial analysis suggests the reasons for this are both varied and complex. Placements breakdowns are not only attributable to the needs and difficulties of the young people but also the life circumstances of the foster carers including divorce, serious life threatening illness, pregnancy and bereavement. The LSCB has therefore referred this matter to the Corporate Parent Board with a request that they investigate the possibility of developing some support to foster carers to improve their capacity for stability.

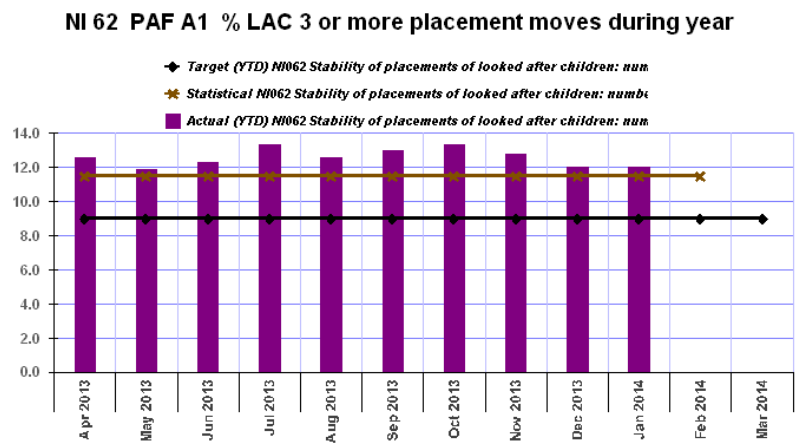
Further and ongoing audits of individual cases designated as ‘unstable’ by Independent Reviewing Officers (IROs) are required to ensure appropriate resources are targeted and every effort is made to reduce further instability and breakdown. An additional resource has been secured to undertake both this analysis and other related audit to provide a more comprehensive overall understanding. An update on this will be presented to the LSCB during 2014/15.

The second measure of stability measures the number of LAC under 16 who have been looked after for at least 2.5 years and who have been in the same placement for at least two years. This indicator captures both residential and foster placements. Residential placements are only used for the most complex and challenging children. These behaviours are often attributable to their earlier experiences of abuse and trauma. Unlike the first cohort which is predominately concerned with older children, this group also captures younger children who may have been looked after throughout protracted care proceedings. For this cohort changes in placement may have occurred as a result of court directed assessments of both family and other extended family. It can therefore also include children placed for adoption for whom the move is a positive social work decision. No actions were therefore deemed to be needed by the LSCB in response to this area of concern.



The third measure of placement stability looks at those Children and Young people who have had more than three placements in twelve months. This cohort includes all children with a variety of care plans. It can for example include young babies in court proceedings for whom a third move to an adoptive placement within twelve months is excellent for that individual child. Lewisham is in the top quartile for this measure on the adoption scorecard. This measure has been changed in year, to include young people who are missing for more than 24 hours. This has contributed to the Local Authority's difficulty in meeting its target. Whilst the LSCB understands that some of these factors may be positive in respect of their impact on the child, it was agreed that the Corporate Parent group should be charged with investigating how the number of unhelpful moves per annum could be reduced through good practice.





An audit has been conducted on where Lewisham Looked After Children reside. The national indicator on this

looks at children placed more than 20 miles from Lewisham. The outcome of these findings were shared with the LSCB**,** providing assurance that these children have all been placed appropriately and in accordance with their needs, wellbeing and safety.

3.2.6. Domestic Homicide Reviews

This work is led by the Safer Lewisham Partnership Board. Two domestic homicide review reports were presented to the LSCB in March 2014 to share the learning and recommendations from these reviews with the partnership and to take account of any actions for the LSCB.

The key findings for **case 1** was in relation to the lessons to improved information sharing by agencies. It was not possible to determine if this person's death could have been avoided.
The key theme arising from **case 2** was around awareness raising of domestic violence and abuse, better training and culture of questioning especially in relation to vulnerable adults. Other key recommendations involve taking a closer look at the risk assessment procedures across all agencies and the understanding of the toxic trio of mental health, substance misuse and domestic violence and abuse.

SMART action plans have been put in place based on the recommendations from these reviews. Actions will be tracked by the Lewisham Community Safety Partnership, supported by a task and finish sub group. The LSCB will monitor completion of these plans.

3.2.7. Violence against Woman and Girls Plan (VAWG)

This work is also led by the Safer Lewisham Partnership Board. Lewisham Council has a long history of commitment to tackling domestic and sexual violence. This work is now supported by a unified and comprehensive approach to tackling violence against women and girls through a systemic VAWG Plan.

A needs assessment was undertaken in the summer of 2013 to look at the prevalence of VAWG locally and to determine what Lewisham's Saver Partnership's priorities should be. Council partners were consulted as well as residents and victims of VAWG. The aim is further to have focus groups with local resident women and girls, to ascertain wider feedback.

The needs assessment identified gaps in local knowledge in a number of areas; and proposes 3 key strands for local focus and priority:

- Domestic violence and abuse
- Rape and sexual violence
- Sexual exploitation with particular focus on children

As with all partnership intelligence development documents it is likely priorities may be revised as further information on all strands of VAWG becomes available. All local partners are committed to dealing with any aspects of VAWG and will be reviewing and reassessing areas annually. The plan includes areas such as Female Genital Mutilation, Forced Marriages, Honour Based Violence, Child Sexual Exploitation, Stalking and Harassment.

VAWG is a multi-faceted issue that links to, and impacts on, a range of other social issues including poverty, unemployment, youth crime, homelessness, child abuse, health, and problematic substance use. A multi-

agency, integrated approach to tackling these issues is therefore required. The Plan sets out four important objectives and goals for Lewisham:

- To develop a better understanding of VAWG and its impact in our borough;
- Early intervention and prevention of VAWG;
- To ensure an improved access to the support and protection of women and girls in our borough;
- To hold perpetrators to account and consideration of rehabilitation provision.

The LSCB will hold to account progress in this area of work by means of regular reports and data sets to be provided by the lead body, the Safer Partnership Board.

3.2.8. MAPPA LSCB Protocol

The protocol agreed by London MAPPA Strategic Management Board (SMB) and the London Safeguarding Children Board provides a high-level framework to guide borough-based arrangements designed to enhance co-operation and communication between safeguarding children and MAPPA structures.

The LSCB is required to provide a formal link between the LSCB and MAPPA, to enable the MAPPA to refer issues to the LSCB for its advice and comments and to enable the LSCB to receive, at least once a year, a formal performance report from the MAPPA to ensure LSCB scrutiny.

The Probation representative on the Lewisham LSCB has been identified as the most appropriate service to act as link between the LSCB and MAPPA and the MAPPA performance report has been placed on the LSCB annual reports rota.

3.3. Key activities and campaigns for the LSCB during 2013/14

3.3.1. Working Together 2013

In March 2013 the much anticipated revised Working Together 2013 Statutory Guidance was published. It was, as expected, a significantly reduced set of guidance which established a set of 'good practice principles' that underpin good safeguarding practice. The key aim of Working Together 2013 is to reduce prescription in local safeguarding arrangements, however at the same time it strengthens the role of the LSCB in monitoring and evaluating the effectiveness of local safeguarding arrangements.

A gap analysis document has been derived to address any developments as a result of the new Working Together 2013 document and to ensure Lewisham is in line with government guidance. This is a standing item on the LSCB agenda and actions will be tracked until complete.

The single assessment framework has been implemented in Lewisham by Children's Social Care in November 2013. LSCB partner agencies have been informed regarding the changes and process, and the LSCB will continue to monitor the effectiveness and timescales of practice in this area.

3.3.2. Lewisham Hospital

Lewisham Healthcare Trust has integrated with Greenwich Healthcare Trust on 1 October 2013. This meant joined up services between Lewisham Hospital and Queen Elizabeth Hospital, including safeguarding services

and staff. The LSCB has been kept informed regarding any safeguarding risk that might arise as a result of these changes, and is monitoring this on an ongoing basis.

3.3.3. Voluntary Action Lewisham (VAL) Safeguarding Training Project

With funding received from the LSCB, and in partnership with Safe Network, Educare, the NSPCC and Children's Society who helped to shape the bid, Voluntary Action Lewisham successfully delivered a programme of safeguarding training for up to 250 people, from 84 voluntary and community organisations in the borough. Designed to ensure that everyone who works or volunteers with children and young people from the voluntary and community sector knows how to keep them safe, the project also offered intensive support to up to 6 agencies to help them develop their organisation's safeguarding policy and practice.

This Safeguarding Children Project was very successful in engaging with the faith sector and 27 faith-based organisations were trained on the Essentials of Safeguarding, the highest overall attendance of any of the single courses offered. This was important as Faith based groups have access to hundreds of children and young people each week through their many and varied programmes. The projects interventions led to some of the following outcomes:

- Increased confidence in their role in safeguarding children and improved joint engagement on this issue
- Improved engagement among Black, Asian, Minority Ethnic and Refugee (BAMER) Faith Groups with difficult issues around safeguarding children and
- Beginnings of better established links between the faith sector and strategic safeguarding bodies such as the LSCB and other safeguarding agencies

A second tranche of support for this initiative has been approved in principle by the LSCB, conditional upon evidence that it will produce hard outcomes in terms of safeguarding referrals or use of the CAF/TAC by agencies in this sector.

3.3.4. Lewisham Bullying Strategy

All children and young people living, working, being educated or socialising in the London Borough of Lewisham have the right to go about their daily lives without the fear of being threatened, assaulted or harassed whether physically, emotionally or through technology. The LSCB is committed to providing safe environments for children and young people, and therefore to effectively addressing bullying behaviour so that the incidence of all forms of bullying is minimised.

During 2013/14 the LSCB commissioned work to be undertaken in relation to updating Lewisham's standing bullying strategy. The document is intended to provide a strategy for effective management of bullying within organisations working with children and young people as well as to supplement and support the work both of Lewisham's Safeguarding Children Board and the objectives of the Children and Young People's Plan.

The revised Bullying strategy was presented to the LSCB in March 2014. It was recommended that a Bullying Task group is established to consider the consultation of the strategy, analyse the findings and put in motion any actions. The LSCB Business Plan 2012-15 will be updated to reflect this work strand.

3.4. Annual reports considered by the LSCB and key issues identified

During 20113-14 the LSCB identified a comprehensive list of annual reports which it wishes to receive in order to fully hold to account all those services which contribute to effective safeguarding. A rolling schedule for the presentation of these reports was designed, so that the LSCB could challenge both performance and reporting coverage in these areas. Due to the timetabling some annual reports are presented in the year following the one which they are concerned with, nevertheless, this approach enables the LSCB to gain a comprehensive view across the partnership. The purpose is for the Board to scrutinise safeguarding arrangements and to ensure that safeguarding matters have been addressed appropriately throughout the year and services are contributing to positive outcomes for children**.** A full list of the annual reports covered is attached at Appendix E and the LSCB tracks any actions which derive from these in the MESI sub group.

The following annual reports have been added to the rota for 2014/15:

- Children missing from education
- Safeguarding children with complex needs
- MAPPA update

These will help to inform the LSCB's understanding of the bigger picture for safeguarding in Lewisham

3.4.1. Annual report on Disclosure and Barring Systems (DBS)

Arising from an Individual Management Review which identified the coverage of DBS/CRB checks as an issue of concern the LSCB agreed to receive an annual report on this particular issue in order to assure itself that the actions put in place to rectify the identified shortcomings were being used on an ongoing basis, and that they are effective.

Since the reviews of the DBS system a number of changes have been implemented. As a result of those changes the council can provide much more assurance that robust DBS processes are in place across the Council. The LSCB is therefore satisfied that the Local Authority is protecting children through safe recruitment of staff. This will be kept under LSCB scrutiny on an ongoing basis.

3.4.2. Private Fostering

Working Together to Safeguard Children 2010 set out a policy and procedure function for the LSCB in relation to private fostering. This has now been superseded by the revised 'Working Together to Safeguard Children (2013) The LSCB role includes its usual roles of co-ordination, monitoring and quality assurance, and a specific role with regard to awareness raising. The LSCB has a statutory duty to report annually on children who are Privately Fostered.

Under Standard 7 of the National minimum standards for private fostering the local authority should report annually to the Chair of the Local Safeguarding Children Board on how it satisfies itself that the welfare of privately fostered children in its area is satisfactorily safeguarded and promoted, including how it co-operates with other agencies in this connection.

The latest private fostering annual report indicated that there is a year-on-year increase in privately fostered children being referred to the Local Authority for assessment and support. The majority of notifications are

received from other local authorities and education (schools and education admissions department). A large number of referrals were received from TWIN who are an organisation based in Lewisham that provides training courses to children/young people from abroad in the UK and places them with host families.

The promotion of private fostering has continued to be a area of significant development for the team who deals with private fostering and links have been established and maintained with key agencies and departments whom large numbers of referrals are being received from. In addition, the steering group has continued to meet quarterly with members of key agencies present to help improve the number of notifications and service provision for privately fostered children.

Feedback and evaluation forms have continued to be distributed to children and young people in private fostering arrangements in order to ensure that the Local Authority is catering its service to the needs of the children. Feedback forms have been developed for carers.

The LSCB is satisfied that annual reviews, as part of the transfer meetings, have continued to be implemented before the case moves to the Looked After Children team for three monthly visits after the first year. The LSCB is further assured that assessments, records and checks will be rigorously monitored through the team manager peers audits, using the specialist audit form, which has been tailored specifically for private fostering cases.

A number of challenges have been identified. These include:

- Financial hardship for private fostering parents/carers, including No Recourse To Public Funds families
- Emerging theme of children whose parents have passed away or became severely unwell and unable to care for them
- Continued theme of children whose parents are serving a custodial sentence and having to make alternative childcare arrangements
- Large increase in private fostering notifications results in less capacity to promote and raise awareness
- Difficult to engage faith groups

The report highlighted a number of recommendations to take forward to ensure privately fostered children receive adequate support and services according to their needs. Recommendations have been transferred into an action plan, which will be tracked by the Referral and Assessment Team Service Manager until complete.

3.4.3. Child Death Overview Panel (CDOP)

Chapter 5 of Working Together to Safeguard Children 2013 places duties on Local Safeguarding Children Boards to review deaths of all children who normally reside in the Area. This has been a statutory duty since April 2008. The LSCB must collect and analyse information about each death with a view to identify:

- Any case giving rise to the need for a SCR
- Any matters of concern affecting the safety and welfare of children in the area of the authority.
- Any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area.

The function of the Child Death Overview Panel continues to be funded from the Public Health budget. Since 1st April 2013, Public Health Lewisham is a part of Lewisham Council, and the department's budget continues to be

used to fund this service.
It is clear from the CDOP annual report that the team has made good progress in its work and improved its functions, ensuring that child deaths are reviewed in a timely, rigorous manner. Helpful meetings have been had with the Coroner and relationships with the Coroner's service improved. A very helpful meeting has also been had with the Youth Offending Service and improvements are planned in the way violent deaths are reviewed.

The most common cause of the deaths reviewed was extreme prematurity. Of the 37 deaths reviewed by the CDOP, nine were identified as having modifiable factors. The proportion of deaths with modifiable factors was comparable to that of the previous year. A full review of all deaths that have occurred since April 2008 has been recommended to identify any equity issues as well as modifiable factors.

The CDOP identified a number of issues as a result of the deaths reviewed by the panel. The most important of these was the degree of chaos in the lives of mothers of some children who died because of prematurity.

The panel further emphasized the importance of the Coroner's team to respond with empathy and sensitivity when communicating with bereaved parents. Equipping GPs to deal with bereaved parents has formed part of the CDOP workplan for 2013/14.

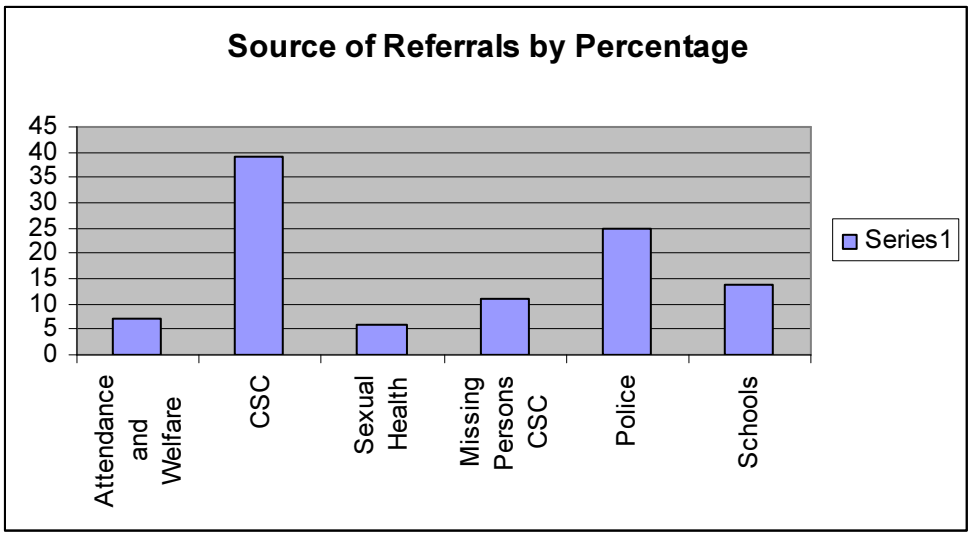
The LSCB will continue to monitor the work and functioning of the CDOP to ensure any areas of concern will be challenged and appropriately addressed, as well as learning any lessons from the death of a child in the case where this might have been as a result of neglect or abuse.

3.4.4. Child Sexual Exploitation (CSE)

The Lewisham Safeguarding Children Board (LSCB) has been tasked with leading on CSE in the borough. An update report on the CSE action plan and other developments was presented to the LSCB in June 2013. This follows on from the scoping document and action plan derived by the CSE task group, which was presented to the LSCB in September 2012.

The report highlighted that in 2012, the Quality Assurance Service collated the best available data in the partnership, which was by no means complete or reliable. Lewisham Children's Social Care was aware of 20 cases of children who were being sexually exploited or at risk of sexual exploitation between 2006 and 2012. A database was set up in Children's Social Care in January 2013 and since then 37 cases of Child Sexual Exploitation have been identified. This is a significant improvement and evidence that the workforce are more aware of the warning signs of possible CSE and therefore making appropriate referrals for support.

A breakdown of the source of referrals can be found in the graph below:



Evaluation of information on the 37 cases collated since January to May 2013 shows that:

- The victims are overwhelmingly female
- Just over 50% of victims of child sexual exploitation are aged between 13 and 14.
- Legal status of victims:

  10 out of 37 children are LAC to Lewisham.

  6 out of 37 are under a Care Order to London Borough of Lewisham

  4 out of 37 children are Looked After under Section 20 of the Children Act 1989

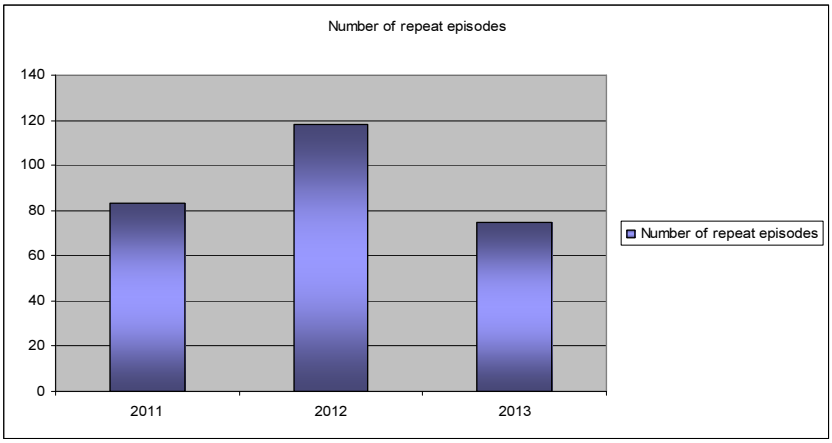
Lewisham has been chosen for a pilot by the Metropolitan Police. This pilot arose from recognition that multiagency intervention in cases of child sexual exploitation needed to be radically overhauled following the highly publicised case in Rochdale. The pilot started on 7th May 2013. The pilot requires the police to set up specialised child sexual exploitation units. These units hold monthly interagency meetings, known as MASE meetings, attended by Children's Social Care, Education Lead, Youth Offending and Sexual Health Services to share information on cases of child sexual exploitation plans and track actions.

The Lewisham MASE meetings have been hugely productive with a 'hot spot' being identified where children are at risk of CSE. The police are now working with the Safer Neighbourhoods team as well as the Youth Service to target this area to prevent children and young people from being sexually exploited.

CSE training courses will continue to target workers such as youth workers, social workers, learning mentors as well as foster carers to ensure suspected CSE is identified at an early stage and appropriate action is taken to safeguard the child.

3.4.5. Missing Children

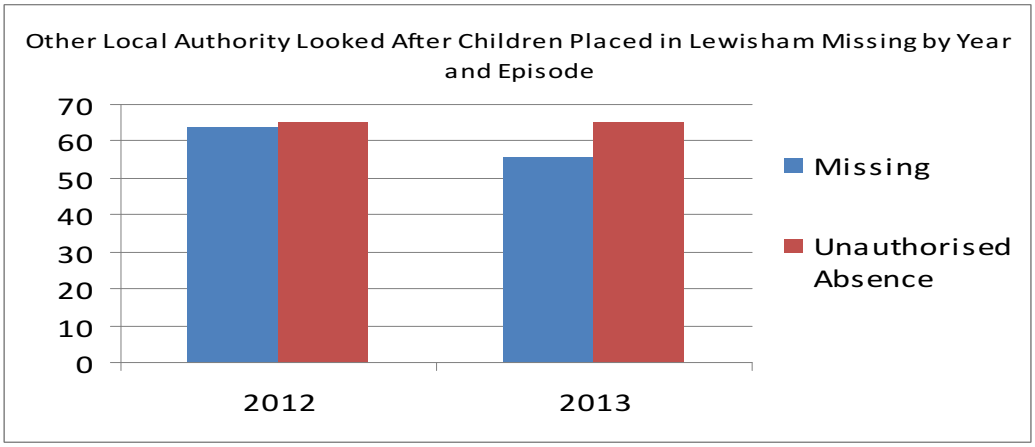
The data in the missing children annual report only goes up to August for 2013. The data collected enabled a provisional forecast to be made for the end of year. Month on month comparison showed that it was likely for the figures for 2013 to return to the 2011 levels of repeat missing episodes, which will represent a reduction of 20 children compared to the numbers from 2012.



An audit has been undertaken to satisfy the LSCB that strategy meetings are convened for Lewisham Looked After Children (LAC) who goes missing from residential care (please see section 4.4.7)
A reduction in missing episodes and unauthorised absences for Looked After Children has been anticipated for 2013 compared to statistics from 2011 and 2012. this reduction is believed to be attributable to professionals recording unauthorised absences more accurately. An unauthorised absence is when a child has gone out without permission but their whereabouts are known. These used to be wrongly included in the missing figures thus wrongly inflating them.

There has been a year on year reduction of non LAC being reported missing. However, it is not clear if the reduction is as a result of fewer children going missing or whether mistrust of the authorities had led to fewer reports to the police. The data available will be interrogated further to establish the underlying reasons for the reduction. This exercise will be completed by May 2014.

The Local Authority forecasted that the number of missing episodes for LAC placed in Lewisham by other boroughs will remain roughly the same in 2013 as for 2012 and a reduction in unauthorised absences will occur. The police has conducted a lot of work to explain the difference between unauthorised absence and missing children with foster carers and residential care providers in Lewisham which might contribute to the correct data being collected in the future, but more importantly, for genuinely missing children to be located as soon as possible.



A number of actions for the Missing Children Liaison Officer has been identified to take forward in 2014/15, which includes comparison of data with statistical neighbours, which will enable Lewisham to establish the scale

of this problem for Lewisham children compared with surrounding areas.

3.4.6. Road Traffic Safety in Lewisham

This report is presented to the LSCB by Lewisham Public Health to look at the what measures have been applied to prevent children from being seriously injured or killed as a result of road traffic accidents and to establish if these measures have been successful and if alternative methods are needed.

Since 2001, six child road traffic accident fatalities were reported in Lewisham. Three in 2002, one in 2003 and two in 2008. It is evident that, in the last decade, the continuing work to reduce the number of fatal and serious casualties on the roads of Lewisham is helping to achieve the reduction in casualties. This has been achieved by the targeted work of the Road Safety and Sustainable transport team.

In 2012, the overall lowest ever total of injuries for people of all ages was recorded in Lewisham with 998 people injured on the roads. At this time there were 3 fatalities, 99 serious and 896 slight injured recorded. Despite the general reduction, it was noted at this time that certain road users remain vulnerable on Lewisham's roads and are still highly represented in the casualty figures. The most vulnerable road users by mode of transport remain to be cyclists, pedestrians and motorcyclists. Children aged fifteen years and under were found to be highly represented in the pedestrian figures, with those aged between 12-15 years deemed most at risk. This is similar to patterns noted both throughout London, and described nationally in the Department for Transport 2007 'Child Road Safety Strategy'.

It has been possible to map the collisions in Lewisham by looking at road traffic accidents resulting in child Killed or Seriously Injured (KSI) casualties. Collisions occur on major roads, with increased concentrations of incidents taking place on the A20, the A2 and the A209 (South Circular), as well as in Lewisham and Catford town centres.

The use of traffic engineering measures as targeted local safety schemes remain an important method of reducing collisions. A comprehensive relighting of the Borough has jointly begun with the London Borough of Croydon, with the installation of new lighting to be finished by 2015. Maintenance works is also continually on-going and effort is made to ensure that work associated with road safety, such as the renewal of anti-skid materials, replacement of traffic signs, School Keep Clear marking and other safety markings are prioritised. The age range of children at increased risk of involvement in KSI accidents in Lewisham have previously been suggested to be those aged 12-15 years. However, recent statistics suggests a wider age range, with increased numbers of accidents occurring in children aged 10-15 years. This may indicate that road safety education should take place at an even earlier age, as by later ages, risk-taking behaviours may already have developed in children leading to KSI casualties.

The number of KSI casualties, in children and young people aged between 0 and 17 years old between 2007 and 2012 is shown in the figure below:

Accident Severity	2007	2008	2009	2010	2011	2012	Total
Fatal		2				1	3
Serious	22	21	9	14	10	10	86
Total	22	23	9	14	10	11	89

The report highlighted a few recommendations which will ensure the work which has been done so far is maintained for the years to come and to continue to allow road safety initiatives, both engineering and education based, to develop and grow further over the next decade with the aim of reducing the number of child KSI casualties in Lewisham even further.

3.4.7. Looked after children annual report

Generally children in care continue to have poorer outcomes than the wider population, particularly in relation to educational achievement, homelessness and mental health. It is difficult to determine the extend to which these outcomes were caused by the child's experiences prior to coming into care, rather than their experiences once in care. However, the LSCB acknowledge the importance of ongoing support and stability to help these children and young people overcome the effects of the abuse and neglect they have suffered. The LSCB therefore requests regular performance information data to be presented to the Board, including placement stability, substance misuse issues, LAC going missing from care, health assessments and personal educational plans. The LSCB review this data on an ongoing basis and will challenge any data causing concern.

The LAC annual report provides the LSCB with a picture of how these children are doing in care, including location of placements, general and mental health, placement stability, missing from care, education and participation of children and young people in care. The LSCB will continue to hold the quality of services for LAC to account through the LAC annual report and other related reports presented to the Board.

- **Health**

All Looked After Children and young people are required to have an Initial health assessment within 28 days of entering the care system. This is extremely important in terms of understanding their history and planning to mitigate the impact of earlier neglect.

The table below shows Lewisham's performance for Initial Health assessments. Whilst on a monthly basis this can be a small number of children they are not always placed locally. Historically it has been a difficult target to meet. However with a huge commitment from all agencies involved performance has increased recently and in August 2013 reached 100% for the first time.

2012 – 2013	Apr	May	Jun	Jul	Aug
	14%	50%	33%	53%	38%
2013-2014	Apr	May	Jun	Jul	Aug
% CLA, who have had an initial health assessment within 28 days of BLA	64%	89%	94%	90%	100%
No.CLA who have had an initial health assessment within 28 days of BLA	14	8	16	9	12
No of IHA due in the month	22	9	17	10	12

- **Location of placements**

42% of Lewisham's Looked After Children are placed in Lewisham but 52% are cared for out of Borough. In London, this does not always equate with being placed a great distance from the family home or school. In some cases children just outside the local authority boundary have shorter journeys to school than they would have had whilst cared for at home. A better measure is 20-mile radius. An audit was conducted in 2013 to look at the reasons for children being placed more than 20-miles from their home address. The audit concluded that all these placements were in the children's best interest and according to their individual needs and to ensure their ongoing safety and wellbeing.

- **Children and Adolescent Mental Health Service (CAMHS)**

The CAMHS Symbol team is responsible for undertaking CAMHS assessments & delivering treatment for Lewisham Looked After Children. This team works with LAC placed within a 20-mile radius, assuming that the young person is able and willing to travel in borough for CAMHS support. If travel is not clinically possible, Lewisham CAMHS will travel to the child depending upon clinical urgency. Those young people over a twenty mile radius requiring a CAMHS service are referred to their local resource. If there are difficulties in obtaining a service LAC staff seek support from the commissioning team and this is proving effective.

- **Placement Stability**

Children and Young people looked after by Lewisham have individual care plans which reflect their unique needs. For those children and young people with a plan for long term fostering, placement stability is key to achieving positive outcomes in all areas. Many of Lewisham's young people have both complex needs and challenging behaviour which can impact on achieving this. However, the Local Authority recognises stability has a pivotal role in improving children's life chances and therefore places a lot of focus and resources in trying to achieve this.

All placements are reviewed on a regular basis by an independent chair. The stability of the placement and support required are discussed at every meeting. Fragile placements are given additional monitoring and concerns are escalated to team and service managers as appropriate. Any change of placement is presented to a Care Planning Panel which is chaired by the service manager of the Quality Assurance Service, a placement change will not be agreed unless the chair is satisfied everything possible has been done to resolve the difficulties.

Placement stability remains one of the LSCB's priority areas and therefore more information was requested on this subject to look at reasons for change of placement and what measures the Local Authority has put in place to try to prevent placements from breaking down. Please see section 4.2.5 of this report for more information.

- **Missing from Care**

Most Looked After Children are very vulnerable as a result of earlier trauma and abuse. There are concerns they will become involved in offending/gang activity, substance misuse and sexual exploitation and these concerns increase when they go missing from their placement.

When children are missing the allocated Independent Reviewing Officer chairs a meeting to ensure all possible actions are being taken by all agencies including the police. Children who remain missing are tracked by the

service manager who will chair subsequent meetings and make additional recommendations i.e. press coverage if required. All children (including those looked after) considered at risk of sexual exploitation are subject to meetings chaired by a Child protection chair who analyses the risk assessment and agrees actions. This cohort of young people are often difficult to reach and robust multi agency work is required with partner agencies. The LSCB is therefore assured that robust systems are in place to ensure missing LAC are found to prevent them from coming to harm.

- **Education**

The LAC education team ensures that as many young people as possible sit qualifications appropriate to their ability. During 2013/14, 30% of Lewisham's LAC gained 5 A-C's including English and maths. This is an improvement on 12-13 when 22% gained 5 A-C's. The LSCB will continue to monitor this and challenge any future concerns that might arise regarding LAC education.

3.4.8. Local Authority Designated Officer (LADO) annual report

In compliance with Working Together to Safeguard Children 2013, Lewisham Children's Social Care has a Local Authority Designated Officer (LADO) who has management and oversight of individual cases where allegations are made against people who work with children.

The London Child Protection procedures are in the last stage of being updated. Chapter 7 of the draft deals with allegations against staff, and set out helpful guidelines for managing allegations against professionals. Chapter 2 of Working Together 2013 makes reference to having clear policies in line with those from the LSCB for dealing with allegations against people who work with children, and states that an allegation may relate to a person who works with children who has:

- Behaved in a way that has harmed a child, or may have harmed a child;
- Possibly committed a criminal offence against or related to a child; or
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children

Where the above criteria are met, the LADO is responsible for chairing (or usually delegating a Child Protection Chair to chair) a Strategy or Evaluation Meeting to consider whether there should be:

- A police investigation of a possible criminal offence;
- Enquiries and assessment by Children's Social Care about whether a child is in need of protection or in need of services; and
- Consideration by an employer of disciplinary action in respect of an individual.

As part of the Ofsted Inspection which took place in Lewisham in February 2012, the management of allegations against people who work with children was intensely scrutinised. The Ofsted report states that *"The identification and management of allegations against people who work with children are robust, and especially good in schools. The service provides high-quality support to a range of agencies in ensuring that children and young people are properly safeguarded. Good work is being undertaken to promote the function of the Local Authority Designated Officer and to ensure that agencies understand safe practices. Decision making is rigorous, robust and effectively tracked. Robust LADO arrangements are extended to foster carers. Allegations are rigorously investigated and foster carers' continuing suitability is appropriately considered."*

In Lewisham, it was the case that all allegations relating to Education staff and volunteers were dealt with by the Education Child Protection Coordinator / Designated Officer for Schools and Education Services, but with management oversight and responsibility retained by the LADO. This post has been deleted and from April 2013 all allegations are dealt with by the LADO, with robust arrangements made for delegation of this responsibility in her absence.

The number of referrals increased from 91 in 2012 to 158 in 2013. The reason for the increase in referrals are likely as a result of better awareness, reporting and training across the partnership. The LSCB challenged the fact that no data was available from other boroughs for the purpose of benchmarking. The LSCB recommended the LADO to address this matter via the network meetings. This is work in progress.

The LSCB further challenged the fact that no referrals are being received from the police, as well as very low referrals from health organisations and faith groups. It was established that the police have their own robust internal procedures in place for dealing with allegations against police officers. The LSCB has requested the police information to be provided to the LADO on a regular basis.

Health organisations explained that health professionals very rarely see children on their own. Consultations usually take place in the presence of a parent or carer, hence the reason for hardly any allegations being made against health staff. Voluntary Action Lewisham will distribute the recently updated multi-agency guidance to all faith groups as well as community and voluntary organisations to ensure they are aware of the procedures to follow.

3.4.9. Multi-Agency Safeguarding Hub annual report (MASH)

The Lewisham Multi Agency Safeguarding Hub (MASH) has been in place since 13 December 2012. MASH brings together a variety of agencies into an integrated co – located multi agency team where information is shared appropriately in order to make timely and appropriate decisions. The team include staff from Children Social Care, the Early Intervention Service, Health and the Police Public Protection Desk. Information is also obtained from Probation, and the Youth Offending Service.

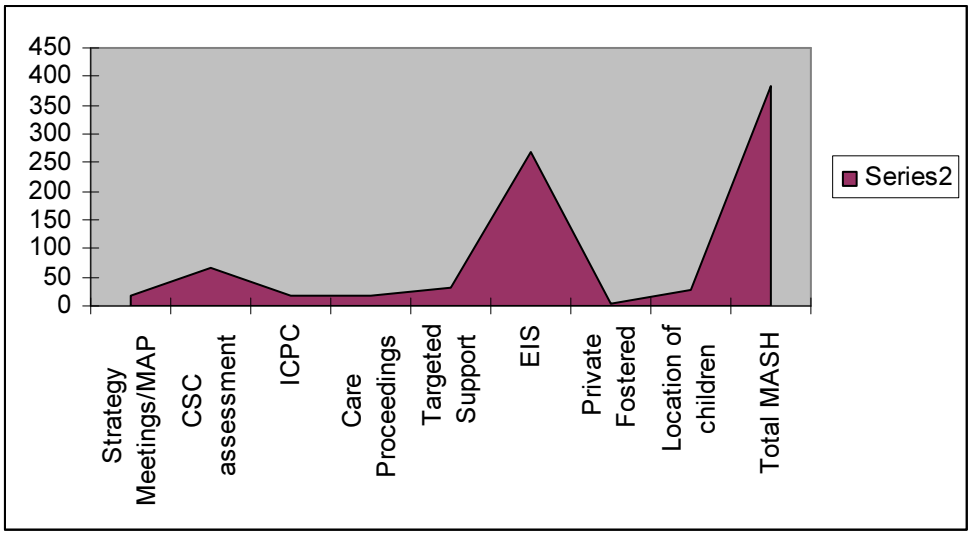
Lewisham took the approach of implementing the MASH process by a frontline practitioner taking the lead, named a Team Manager based in the Referral and Assessment Service. MASH is not a separate / specialist arm of the service; but integrated as part of existing working practices. The MASH process does not replace the assessment process in the Children's Social Care assessment teams. The Team Manager applies the following criteria to select a case for MASH enquiries:

- The case is not known and a contact is received from the NSPCC (National Society for Prevention of Cruelty to Children)
- Anonymous contacts
- Borderline cases where there appears to be a risk to the child but the extent of the risk is not clear.
- Repeat missing children episodes

Each agency identifies what information they hold on a child/ young person and the adults around them. Each agency then assesses whether it is appropriate for the information they hold to be shared (in line with the information sharing arrangement) and a summary is provided to Children Social Care within 6 hours. The Team

Manager reviews the information and decides whether to take no further action, or signpost the case for Early Intervention or Children's Social Care assessment. Once the MASH enquiry is completed the case is rag rated Red, Amber or Green. Red cases require an immediate response to safeguard the child. Amber cases are progressed to a planned assessment. Green are directed towards Early Intervention.

At December 2013, a total number of 384 cases have been processed by MASH. The chart below shows what actions were taken following a MASH enquiry.



MASH has been very valuable in reducing the turnaround time in dealing with cases. In some cases MASH has unearthed risk which has led to convening child protection conferences and care proceedings which otherwise would not have taken place because the information on the CAF referral form was such that the case may not have met Children's Social Care threshold. These cases would have been closed. It is therefore evident that the MASH process is contributing to the safety and wellbeing of Lewisham's children and young people.

Further developments for the MASH includes locating the health representative within the MASH team at Laurence House. Arrangements have also been started for a Probation representative to be located within the MASH team for one day per week.

3.4.10. Lewisham Healthcare NHS Trust Annual report (LHT)

LHT shares its Annual Safeguarding Children Report with the LSCB to provide assurance that the statutory and local requirements regarding safeguarding and protection of children are being met, and to provide detail with regard to the means by which this is achieved.

The formation of LHT, following integration of Acute and Community services, has offered a valuable opportunity to enable closer working relationships between the sectors. Organisational boundaries, that often compromise safeguarding practice, have been minimized. Integration has also enabled a sharing of expertise to ensure an enhanced service delivery. Areas such as safeguarding training and reflective practice fora are now undertaken jointly with colleagues from Acute and Community sectors. This promotes a richer understanding of roles and responsibilities and allows for more effective use of resources.
All child protection policies and procedures are robust and were updated in 2013.

The overarching Safeguarding Action Plan and the safeguarding risk register are reported to the Integrated Operational Group who is responsible for reviewing and updating it and exceptions are reported to the integrated Adult and Children and Young People Safeguarding Committee. This committee feeds upwards to the Integrated Governance Committee, LHT Board and the Lewisham Safeguarding Children Board (LSCB). The clear governance structure was commended by Ofsted / CQC in providing good quality and effective assurance of safeguarding practice.

There is a Safeguarding Team, consisting of safeguarding advisors, based in the hospital who has well established working relationships with hospital staff. They are an integral component of the Safeguarding Team ensuring that the needs of vulnerable children are not overlooked when they present to hospital. They are well placed to work with colleagues in the hospital to ensure speedy, safe and effective discharge of children and young people. The Safeguarding Advisors assist hospital based staff to conduct team around the child meetings and discharge planning meetings in order to plan care and reduce risk to vulnerable children. The role of the Safeguarding Advisor incorporates providing safeguarding supervision to all relevant staff.

The relationship between Health and Children's Social Care (CSC) is pivotal in providing an effective safeguarding function. Monthly electronic transfer of data from CSC is received, ensuring that an up to date awareness of children who are the subject of a child protection plan is maintained. This is important to ensure that supervision databases are up to date and that alerts and flagging systems are accurate. Access to the LA database by the LAC team has proved beneficial in providing more timely access to movements of children.

The Named Nurse and Doctor hold tri-monthly meetings with the Lead and Team Managers within Children's Social Care for Referral and Assessment and Family Social Work Teams.
This relationship ensures that there is an opportunity to discuss cases that present difficulties as well as maintaining a forum where operational issues can be addressed. Between these meetings, cases of concern are raised as required. These regular meetings are also an opportunity to communicate changes that may have taken place in either service and to enable this information to be shared with frontline practitioners through team briefings.

Health attendance at case conference is a key performance indicator and there is a robust system in place to follow up conferences that are not attended. The increasing number of conferences held during 2013/14 represents a significant impact on services required to contribute to the process. Feedback from Children's Social Care is that the quality of case conference reports from health staff is of a high calibre and attendance is very good.

Some key performance indicators for LHT are being reported and monitored by the LSCB. However, the LSCB will be developing its performance framework further in 2014/15 to include specific safeguarding data from LHT.

3.4.11. Lewisham Clinical Commissioning Group annual report (CCG)

The statutory safeguarding duties of CCGs were clarified through the publication of two key documents:

- Safeguarding Vulnerable People in the Reformed NHS – Accountability and Assurance Framework (NHS Commissioning Board, March 2013)

- Working Together to Safeguard Children, A guide to inter-agency working to safeguard and promote the welfare of children. (Department for Education, March 2013).

Lewisham Clinical Commissioning Group (LCCG) commissioned services from a wide range of providers including Lewisham Healthcare NHS Trust, South London and Maudsley NHS Foundation Trust and over 100 Independent Contractors. In terms of acute providers, LCCG holds contracts with many Trusts across the country but in terms of safeguarding, LCCG undertakes the primary role in assuring that robust systems are in place in Lewisham Hospital, Lewisham Healthcare NHS Trust.

LCCG, Lewisham Healthcare NHS Trust & South London and Maudsley NHS Foundation Trust strengthened and maintained the operation of robust safeguarding arrangements, assurance systems and processes. These include effective supervision arrangements, proactively disseminating & embedding learning from serious case reviews into practice, innovative safeguarding training and strong interagency partnership working. This was recognised by Care Quality Commission & Office for Standards in Education, Children's Services and Skills (Ofsted) inspection of Lewisham Borough in February 2012.

The LCCG board have embraced the framework and have built on and strengthened the safeguarding work that already exists in Lewisham. Safeguarding has remained high on local agenda. The LSCB has been satisfied that improved and effective robust safeguarding arrangements, assurance systems and processes continue to be place across Lewisham's health economy.

3.5. Section 11 audits considered and key issues identified

Section 11 of the Children Act 2004 places a duty on key people and bodies to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children. The application of this duty will vary according to the nature of each agency and its functions. Section 11 places a duty on:

- Local authorities and district councils that provide children's and other types of services, including children's and adult social care services, public health, housing, sport, culture and leisure services, licensing authorities and youth services,
- NHS organisations, including the NHS Commissioning Board and Clinical Commissioning groups, NHS Trusts and NHS Foundation Trusts
- The police, including police and crime commissioners and the chief officer of each police force in England and the Mayor's Office for Policing and Crime in London
- The British Transport Police,
- The Probation Service
- Governors/Directors of Prisons and Youth Offender Institutions,
- Directors of Secure Training Centres, and
- Youth Offending Teams/Services

Section 11 submissions for Lewisham organisations have been divided into two cohorts and has been presented to the LSCB on a rota basis for scrutiny and comments. The following agencies' section 11 reports were considered during 2013/14:

- Community Services (including Crime Reduction and Supporting People, Sport and Leisure Services, Community and Neighbourhood development, Adult Social Care, Joint Commissioning)
- Youth Offending Service
- CYP Commissioning
- Youth Service
- Early Intervention Service
- Strategic Housing
- Probation
- CAFCASS
- Licensing Service
- South London and Maudsley (SLAM)
- Lewisham and Greenwich Healthcare NHS Trust
- General Practitioners
- Lewisham Clinical Commissioning Group

Section 11 audits are submitted to the MESI task group (please see section 4.6.3 of this report for an explanation of the roles/responsibilities of this task group) for scrutiny and challenge where needed. The MESI task group will make recommendations to the agency where it is felt that their audit lacks clarity of their safeguarding arrangements under each of the safeguarding standards and highlight where further developments might be needed to ensure children's safety and wellbeing is taken into consideration during all aspects of work. All recommendations will be tracked by means of SMART action plans until complete. The MESI task group will escalate any identified concerns to the LSCB.

3.6. Task groups

3.6.1. Child Sexual Exploitation task group (CSE)

The CSE task group was established to conduct an initial scoping exercise and to build on a protocol with the Metropolitan Police and other key agencies to tackle child sexual exploitation in the borough and to ensure Lewisham LSCB fulfil its statutory duties outlined in Safeguarding Children and Young People from Sexual Exploitation: Supplementary Guidance to Working Together to Safeguard Children, and to advise the Board on key CSE issues.

The CSE task group is drawing up a guidance and procedure document for dealing with CSE appropriately, based on the work done nationally by the office of the children's commissioner. In addition, the police PAN London Child Sexual Abuse Operating Protocol has been disseminated to the CSE task group for their consideration and consultation. The final document has been launched by the police in February 2014 and was distributed across the partnership in Lewisham, along with the CSE warning signs. The CSE task group further developed an information sheet on CSE which can be found on the LSCB website.

3.6.2. Neglect Task group

The Neglect task group is tasked to look into the effectiveness of early help/intervention in cases where neglect is a feature to establish if more needs to be done to prevent these cases from escalating to meeting the threshold for Children's Social Care involvement.

The group conducted an audit of 10 cases where neglect is suspected or identified through the Common Assessment Framework (CAF) The cases were selected from the CAFs received from Children's Social Care which did not meet the threshold for social work involvement. The Children's Social Care no further action CAFs are processed by the Family Support Team to ensure the relevant services are identified and support provided thorough early intervention. The purpose of the audit was to examine how well neglect cases are supported by early intervention.

The outcome and overall conclusion of the audit included the following:

- The Early Intervention and Assessment Service (EIAS) is continuing to provide practical support, advice and consultation to CAF practitioners ensuring complex cases are managed within the Team Around the Child (TAC) arrangements.
- Universal services have developed good assessment skills in using the CAF and TAC processes to identify and support children earlier in neglect cases.
- There is strong evidence that schools, child health and housing professionals are working collaboratively to provide early support to children and families before seeking Children's Social Care involvement.
- Primary schools and child health practitioners are more likely to share information with other agencies, contact the EIAS helpdesk or the designated area Early Intervention Coordinator when they have concerns about children and their families before starting the CAF assessment.

The audit revealed a lack of documented outcomes for children. The TAC meetings did record specific actions and expected outcomes for the family and TAC agencies with clear timescales. It was noted that communication between agencies was effective and transparent. The audit demonstrated that early intervention can be a robust mechanism for children's services to manage complex cases that do not meet the threshold for social work support. Practitioners need ongoing support to increase their confidence to manage cases when neglect is apparent and goes beyond the capacity of their routine frontline work. Less experienced staff will need additional support to develop their skills of engagement with challenging parents and self-confidence to work with cases when safeguarding issues are present. A number of recommendations were made as a result of the outcome of this audit, which will be addressed by means of a SMART action plan, which will be tracked by the Neglect task group.

The Neglect task group has been exploring training options in conjunction with the Policies Procedures and Training (PPT) task group to ensure the workforce is equipped with the appropriate skills and knowledge to identify signs of neglect at an early stage to ensure the best outcomes for the children they work with. The Neglect task group is developing a guidance document / tool to assist practitioners in their task to identify the signs of neglect at an early stage.

3.6.3. Monitoring, Evaluation and Service Improvement task group (MESI)

This task group is responsible for monitoring and evaluating the effectiveness of what is done by agencies both individually and collectively to safeguard and promote the welfare of children. This task group is responsible for quality assuring practice by conducting multi-agency audits to identify lessons to be learnt across the partnership. This task group is also tasked with scrutinising and challenging agencies section 11 audits to ensure safeguarding arrangements are robust and effective in keeping children safe.

Children in residential care are extremely vulnerable to exploitation and abuse and the LSCB needs to be assure that children are safe in these settings. This followed a concern by Children's Social Care to identify and ensure that these particular children were safe. The MESI task group therefore conducted an audit in September 2013 on the safety of children in residential care to test how the local authority assures residential providers have robust safeguarding systems in place.

Findings and recommendations:

- The audit found that every effort is made to ensure children know how to complain and raise concerns about their care. Children know about the independent advocacy service. All children have access to an adult family member or an independent visitor who can support them. However measures need to be in place to ensure statutory visits to Look After Children take place so that children can convey any worries they may have.
- The audit further found that the local authority takes incidents of bullying seriously and action is taken to address bullying and safeguard children.
- The audit found evidence of restraints being proportionate to the threat posed by the child. Reports on restraints were sent promptly to the local authority. The social worker had spoken to the young people after the incident to ascertain what happened directly from them. Because of this discussion, action was taken in one case where two male members of staff restrained a female resident which is not appropriate.
- Appropriate action is taken when a child goes missing from care, which includes alerts to the police and social worker. The audit found that Missing from Care Meetings were held for children and young people who went missing for over 5 days. However there was no such meeting for children who repeatedly go missing for less than 5 days at a time. Procedures therefore will now be strengthened in relation to developing a multiagency strategy to reduce missing episodes for this group of children. Missing from Care Meetings are held as soon as possible for children deemed to be at high risk.
- The local authority must continue to encourage early disclosure of alleged abuses by professionals. All Looked After Children are given a child friendly booklet which sets out the various ways they can tell someone, other than the social worker or the Independent Reviewing Officer, such as Child Line and the NSPCC etc. More account needs to be taken of children's views when they refuse to engage with a social worker.
- This audit found that in the vast majority of cases children have a good relationship with social workers and are able to share their worries with them and ask for help
- The audit found that in the vast majority of cases Independent Reviewing Officers see children on their own, which is important for safeguarding.
- The audit found that procedures to safeguard children from Child Sexual Exploitation are being implemented.
- The Director of Children's Social Care as well as Service Managers have completed quality assurance visits on all children's homes where Lewisham have children placed. Issues about the homes and care planning were identified as part of this work and it is also an important component of Lewisham's quality assurance framework to ensure that these young people, some of who are placed a long way from Lewisham, are not "out of sight and out of mind".

Conclusion of the audit:

Although systems are in place to promote their safety and manage challenging risks, further actions have been

identified to strengthen safeguarding practice, which will be tracked by the MESI task group.

3.6.4. Policies, Procedures and Training Task group (PPT)

In Lewisham to meet the requirement to draw up local procedures we have always used the Pan London Child Protection Procedures to inform our practice and meet this requirement. The Pan London Procedures have been updated during 2013/14 after a rigorous consultation process.

Lewisham LSCB has its own interagency threshold document in line with the Working Together 2013 document, which can be found on the LSCB website.

The LSCB undertakes a comprehensive programme of workforce development and training via the Policy, Procedure and Training (PPT) task group. This group is responsible for developing policies and procedures, monitoring and evaluating the effectiveness of single and multi-agency training in order to safeguard and promote the welfare of children.

This year the PPT conducted a training survey across the partnership to establish the main training needs and training gaps across the workforce. The survey also provided valuable feedback regarding previous training events facilitated by the LSCB.

Partner agencies made a financial commitment to the LSCB which allows for the training programme to be provided to everyone who works with children and families in Lewisham at no cost. The training programme for 2013/14 included the following courses:

- Female Genital Mutilation
- Safer Recruitment
- Understanding Gangs and Gang activity
- Child obesity
- Child trafficking
- Safeguarding children affected by parental substance misuse
- Working with evasive families
- Advance course on domestic violence
- Safeguarding level 2
- Race, culture and faith belief systems in safeguarding children
- Understanding and assessing neglect

In addition to the above, a number of lunchtime briefing sessions were offered as part of the training programme. This has proven to be an effective method of learning and information sharing, which makes use of local professionals' knowledge and experience and is delivered as a 'favour in kind':

- No recourse to public funds
- Young carers and hidden harm
- Child sexual exploitation awareness in Lewisham
- Family justice review and changes in law
- Fabricated and induced illness
- Forced marriages

- MARAC: Lewisham domestic violence process
- Learning from serious case reviews (local and national)
- CRB/ DBS

A breakdown of training attended by agency can be found in Appendix F.

The PPT group drawn up a new training strategy which provides a framework for the delivery of learning and development by the LSCB. The Lewisham LSCB Training Strategy is designed to support safeguarding and promoting the welfare of children, including multi-agency working and information sharing. It is also designed to keep under review the effectiveness and impact of training on practice. This is a three year strategy which will be reviewed annually by the PPT group.

The strategy further sets out the new '3 level' evaluation process, which will be implemented from April 2014. This evaluation process is based on the London Safeguarding Board's framework and ensures to effectively evaluate the impact and change the training has made to the practitioners day-to-day work to ensure better outcomes for children they work with. The 3 level evaluation is set out as:

- Pre-evaluation – to be completed before the training event
- End of course evaluation – to be completed after the training event
- Post course evaluation – to be completed 3 months from the training event to evaluate impact on practice. This includes feedback from supervisors on the impact of training on casework practice.

The PPT group will be responsible for driving the strategy and reporting progress regularly to the LSCB.

3.6.5. Communications and Publications Task group (C&P)

The C&P task group is responsible for communicating and raising awareness of the need to safeguard and promote the welfare of children and how this can best be done by agencies, children and young people, families and the community.

The C&P group's core business is to promote the key messages of the LSCB, which are:

- Children and young people in Lewisham must be safeguarded
- It is everyone's responsibility to safeguard children and young people: everyone has a part to play
- Organisations in Lewisham are committed to working together to safeguard and promote the welfare of children and young people
- The LSCB coordinates and ensures the effectiveness of organisations working with children, young people and families in Lewisham

During 2013/14, the C&P group revised the communications strategy of the LSCB to ensure the focus is on capturing the voice of the child. The group are driving this work forward by ensuring children's voices are heard by utilising existing Children and Young People's Forums in Lewisham.

The C&P group has been updating the LSCB website on a regular basis during 2013/14 and ensured important safeguarding documents being disseminated across the partnership, such as the revised Working Together document, PAN London Safeguarding procedures and reports by the Office of the Children's Commissioner. This group is committed to raising awareness and promoting National events across partner agencies which

keeps the subject of Safeguarding high on local agenda and increases effective inter-agency working.

This group produces a quarterly newsletter which is disseminated across the partnership and published on the LSCB website. The newsletter is an effective tool for informing the partnership of new initiatives and services available and to promote ongoing safeguarding work across the Lewisham partnership.

3.6.6. Serious Case Review Panel

The Serious Case Review (SCR) Panel is responsible for conducting Serious Case Reviews, as well as individual management reviews. Lessons and learning from these reviews are disseminated and shared across the partnership by means of briefing sessions and learning events.
During 2013/14 Lewisham LSCB commissioned three serious case reviews.

The LSCB has agreed that there are a range of methodologies available for undertaking case reviews, and our principle is that we will use the methodology which best fits the circumstances of each case. In general this has meant using some aspects of the "traditional" approach (the development of a chronology and the use of Individual Management Reviews and an Overview report) as well as some aspects of systems approach (the use of deeper analysis to determine not just what happened but to engage practitioners in a discussion about why this happened if it seems appropriate to question this, using learning events and interviews to secure this understanding). The Independent Chair and Overview Report Writer for each review are briefed on the principles of this approach and given the task of designing the process which best fits them, working in conjunction with our SCR standing Panel. The following serious case reviews initiated in 2013/14 used this general approach whilst tailoring the detail to the context:

- **Case 1: Child M**

This case was in respect of a three-year-old boy who died under suspicious circumstances while in the care of his uncle. The uncle was later found guilty of his murder. The SCR Panel met on 11th September 2013 to review the information from the Chronologies and Individual Management Reports (IMRs). There were no historical concerns known to any agencies in respect of Child M or his cousins. The Independent author had gained from his meeting with mother and Grandmother a clear picture of a little boy whose life was celebrated and enjoyed. This was evidenced through family mementos and corroborated by the generally positive nature of the IMRs and reports from those universal services which had contact with Child M.

The one significant learning point from the review, identified in the Lewisham Healthcare NHS Trust Individual Management Review, relates to the concern raised by several serious case reviews in recent years, that of the "invisibility" of men/fathers to agencies working with children and their families. In this instance little information was known or sought about Child M's Father and his role and impact in Child M's life, by healthcare professionals who had contact with Child M and his Mother. Child M's father lived abroad. This learning has resulted in an appropriate recommendation that Health Visitors should always record details of a child's father on the family health needs assessment.

The SCR Panel concluded that there was no information of any concern that could have caused professionals to predict and avert this death. The independent Chair of Lewisham Safeguarding Children Board wrote to the National Panel of Independent Experts on Serious Case Reviews on 20th September 2013 to seek advice. On 18th November 2013 the National Panel replied with their agreement that, in the absence of any concerns

coming to light, or evidence that any agency failed in their duties in respect of the lack of concerns, it would be appropriate to stop the Serious Case Review at this stage.

- **Case 2: Child O**

This case is in respect of a child who sustained serious injuries in the care of her parents when she was twelve weeks old. Both parents have denied knowing how the injuries were sustained.

The serious case review process has started and the final overview report will be published once the criminal investigation has been concluded. However, the review team will ensure that any lessons identified from this review is addressed by means of a SMART action plan, which will be tracked by the LSCB until complete.

The following key themes have been identified as part of the review:

- Supervision management
- Domestic abuse
- Cognitive assessment of mother's parenting ability
- Invisible father
- Vulnerable pregnancy
- Information sharing

The view of the review team and independent author are that the injuries to the child were neither predictable nor preventable. However, improvements in recognising and responding to vulnerabilities in pregnancy might have influenced the outcome. The review team will consider the impact of any new information from the police investigation and the court case.

- **Case 3: Child S**

This case is in respect of a baby who was admitted to hospital one week after birth due to a significant weight loss, jaundice and positive toxicology for heroin. The baby's mother has a longstanding history of drug use and had a previous child removed from her care. No referral has been made to Children's Social Care in line with the London Child Protection Procedures.
The serious case review process has started and a number of recommendations have been identified by the Individual Agency Report writers, which will be tracked by means of SMART action plans.

- **Management Reviews**

The SCR Panel considered two further cases and concluded that the criteria for a SCR was not met. However, it was felt that there were important issues to address in respect of both cases and Management Reviews were therefore completed. Both reviews made a number of recommendations which are tracked by the LSCB by means of a SMART action plan. Some changes and improvements to partnership working has already been implemented as a result of these reviews. This includes:

- Improved maternity pathways (to include better communication between health professionals as well as with parents)
- Did not attend (DNA) policies are being audited and improved to ensure the focus remains on the child
- Multi-agency training on how to work with avoidant families will be delivered
- Better use of the Attendance Order process for children who are being home educated

- Audit on GP attendance and participation with the Child Protection Conferences process
- Robust process of escalation of cases for Children's Social Care Service Management reviews (social workers will inform Service Managers that they are formally escalating concerns regarding Team Managers advice and direction on a case where there are disagreement regarding the decision)
- Auditing programme for Elective Home Educated (EHE) children to establish if there are any safeguarding concerns as well as progressing cases to Attendance and Welfare service in a timely way
- A directory of extra-curriculum activities for Elective Home Educated children
- An agreed protocol with the EHE Safeguarding Board to identify systems and triggers for escalation of cases which causes concern
- Immunisation protocol for all GP practices
- Development of a Vulnerability Factors list and protocol for GPs

The outcomes and learning from these reviews have been shared with the partnership by means of briefing sessions. These are ongoing as part of the LSCB annual training programme.

3.6.7. Child Death Overview Panel (CDOP)

The Child Death Overview Panel (CDOP) is responsible for reviewing the deaths of all children in Lewisham. This became a statutory duty in 2008.

CDOP reviewed its terms of reference during 2013/14 and adapted these to ensure its in line with the functions set out in paragraph 8 and 9 of chapter 5 of Working Together 2013. Lewisham CDOP aim to better understand how and why children in Lewisham die and use the findings from the comprehensive, multidisciplinary reviews to take action to prevent other deaths and to improve the health and safety of children in Lewisham.

CDOP submits an annual report to the LSCB, detailing the work done around the reviews of children who died in Lewisham. Please see section 4.4.3 of this report for more information on the work of CDOP during 2013/14.

4. Executive Board

The LSCB main board feeds into the Executive Board (Appendix D) , whose main responsibilities are to direct and oversee the business of the LSCB and to ensure there is a focus on monitoring the strategic horizon and taking into account, understand and respond to the opportunities and threats posed by the national and local policy and resource changes. The Executive also controls resources for the LSCB and can direct or support staff in making contributions and provide financial support.

The Executive Board keeps a log of potential risks for the LSCB. The Risk Register is a standing item on the agenda and it is the responsibility of the Executive Board to manage these risk appropriately to ensure these from escalating.

During 2013/14, the key issues addressed by the Executive Board included the following:

- A LSCB Escalation Policy was put in place to address issues around partner agencies not cooperating with the LSCB in carrying out tasks that have been set by the Board. This policy has proven highly effective to date. Examples include: ensuring S11 submissions occur, monitor attendance of members of the LSCB, ensure reports are produced in a timely fashion and increase to the budget of the LSCB to support its work.

- A report on the DBS systems and checking arrangements is being presented to the LSCB on an annual basis. The LSCB was not satisfied that there were a number of outstanding DBS checks for school staff and the matter was escalated to the Executive Board for immediate action. The Executive Board was assured in June 2013 that all the outstanding risks have been eliminated or mitigated and an annual checking process has been put in place by Lewisham's Human Resources department. A letter was sent to all Lewisham schools, informing that the Executive Board takes a 'zero tolerance' approach on staff working without a full and up to date DBS check/clearance. The Executive Board further requested and received assurance from private schools and academies in relation to their compliance with safer recruitment processes. The Director of Children's Social Care has written to all the independent schools in Lewisham, inviting them to meet with him.
- The Executive Board received direct feedback regarding the progress of the safeguarding action plan for Lewisham Healthcare NHS Trust to ensure this is progressing in a timely manner.
- The Local Authority Designated Officer (LADO) annual report on allegations against professionals was referred to the Executive Board due to a lack of information provided by some agencies, such as the police and health services. The Executive Board was assured that the police and health services have rigorous processes in place to deal with such allegations appropriately. It was agreed that the police and health services will look into the possibility of providing the LADO with this information on a regular basis.
- The Executive Board committed to and oversees the work being undertaken by the LSCB in relation to developing the performance framework to ensure this includes key safeguarding data from across the partnership. This is work in progress and is monitored by the Executive Board on a regular basis.
- There has been a significant increase in children becoming subject to Child Protection Plans (CPP) during 2013/14. The Executive Board instructed the LSCB to look into this matter to establish possible reasons for the increase, as well as comparing Lewisham data with statistical neighbours to establish if this is a local or wider trend. Please see section 4.2.1 for further information regarding this.
- A comprehensive review of the LSCB funding arrangements and contributions were conducted during 2012/13, which resulted in Executive Leads agreeing for an increase in their financial contributions from 2013/14. The increase in contributions made allowance for the LSCB training to remain free of charge to all delegates as well as the increase in the working hours of the Business Manager.
- The Executive Board remains concerned about the low uptake of multi-agency training by police officers. The Board acknowledge that this is a London wide trend and the matter has been referred to the London Chairs by Lewisham's independent chair. The police has also been requested to provide the Executive Board with data regarding training for police officers so this matter can be looked into further to assure the Executive Board that police officers are receiving appropriate training to deal with safeguarding matters for children.
- The important matter of sharing police Merlin reports of incidents of domestic violence with health professionals was discussed by the Executive Board in February 2014. Both executive leads for Lewisham's Child Abuse Investigation Team (CAIT) and Lewisham Borough Police agreed that it is important to share these reports, unless there are clear evidence as to why it should not be shared.

5. Analysis of early help offer and CAF / safeguarding referral information

Working Together 2013 emphasises the role of the LSCB, under regulation 5 of the Local Safeguarding Children Board Regulations 2006, to assess the effectiveness of the help being provided to children and families, including 'early help'.

In Lewisham, Children's centres and Targeted Family Support are commissioned by the Early Intervention and Access Service (EIAS) as part of their broader early intervention work. The aim of the Service is to deliver and embed the early intervention vision across the borough and work to ensure that the needs of children, young people and families are being identified and addressed by all services. This is underpinned through the following key principles:

- Delivering **outcomes** for children, young people and families
- **Be proactive** at first signs of trouble
- Using **predictive patterns** – supporting siblings
- **Tailored and creative** approaches which help
- **Partnerships and relationships which work for families** rather than for providers
- **Building resilience** – children, young people and families are able to make the difference themselves
- **No wrong door**
- Using an **evidence-based approach**

These key principles are all achieved through universal, targeted and specialist services working together with children, young people and their families to support them in reducing needs and preventing the future escalation to targeted and specialist services.

The Early Intervention and Access Service (EIAS) seek to support these principles through the delivery of commissioned children's centre and Targeted Family Support, which work across the borough to identify and address family needs and implement tailored and creative solutions with partners to improve outcomes. An example of this identification includes the outreach work of one children's centre that led to a family being identified in need of children's centre support by staff at a local supermarket .

The EIAS also provide multi-agency training and individual support to encourage the effective use of the Common Assessment Framework (CAF) and Team Around the Family/Child (TAF/C) meetings. The commitment to 'no wrong door' is also embodied through the Service working with practitioners who have made referrals that have not met the social care threshold and advising on appropriate support for that family.

The Government's Troubled Families programme is also supported through the EIAS by working with practitioners and families to ensure they have the appropriate borough wide services around them.

The EIAS undertake regular quality assurance exercises to ensure that the service are identifying key issues that Children's Centres and Targeted Family Support face and ensuring they are delivering value for money. An example of a key issue arising that have been addressed through this process includes the nature of the outcomes set with families. It was identified through submissions that providers were setting outputs rather than outcomes with families (e.g. 'parent X to attend parenting group' rather than measuring what the outcome of this attendance will be for the child). The EIAS has followed this up with site visits with Centre Managers reviewing the outcomes set with families. In addition the Service hosted an interactive workshop session with one of its provider's outreach team and managers on setting outcomes with families. Further Training on Outcome setting with a focus on the impact on the child is ongoing.

Please see section 3.2.4 of this report for more information regarding the Ofsted thematic inspection of Early Help that took place in February 2014.

6. Key performance data

The primary focus of the LSCB is on the 'staying safe' outcomes of the Children and Young People's Plan 2012-2015, and to ensure that agencies are meeting their statutory requirements in safeguarding and promoting the welfare of children and young people. The LSCB is responsible for ensuring that the appropriate action is taken by the partnership to address any areas of concern in relation to the key indicators and holding agencies to account.

The LSCB is in the process of developing the current performance management framework further to assist in understanding the manner in which agencies work both individually and together to safeguard children and young people and to identify any areas for development. The intention is for the information to incorporate quantitative data, information about the quality of services and information about outcomes for children. This work will form part of the key priorities for the LSCB during 2014/15.

6.1. Contacts, referrals and assessments

The number of contacts in Lewisham remained significantly higher than the target. However, for the percentage and number of new referrals from contacts, monthly performance has been good. The number of contacts received increased from December 2013 to January 2014. This shows that referrals continue to be well targeted.

Section 47 enquiries has increased significantly during 2013/14, as previously discussed in this report. Section 47 enquiries which went on to Initial Child Protection Conferences dropped slightly in August 2013. Although the number of s47 enquiries increased by 25% at November 2013, the number of those progressing to Initial Child Protection Conferences remained relatively stable. Thus the position hasn't changed in Lewisham but there is still a slightly lower conversion rate than for Lewisham's statistical neighbours.

The number of parents attending Child Protection Conferences was a concern at 18% below target at November 2013. This increased to 5% below target at February 2014. The LSCB will continue to monitor this as it is of vital importance for parents to engage in this process.

Referrals going onto initial assessments continued to be lower than the 93% target. The early help inspection identified the need to understand the sources of these referrals better in order to assess whether all partners were being as pro-active as they should be in making referrals. This will be written into the business plan for 2014-2015.

Lewisham Children's Social Care began to use the Continuous Assessment in November 2013. 100% of Single Assessments were being completed within 35 working days during November and December 2013, dropping to 90% in January 2014. However, national timescales for completion is 45 days, so Lewisham has been performing well in relation to this. The LSCB will continue to monitor this on a regular basis.

Core assessments and initial assessments completed within timescales remained stable throughout the year.

6.2. CAFs

CAFs initiated has increased throughout the year. The number of No Further Action (NFA) CAFs from Children's Social Care has also increased. The Early Intervention Service (EIS) follows up all CAFs that has been NFAs by Children's Social Care. However, there has been a significant decrease by 105 CAFs on the number of NFAs by Children's Social Care at January 2014 and the number accepted by Children's Social Care increased by 7%.

CAFs going straight to the EIS has also risen throughout the year. The amount of CAFs received linked to open referrals almost doubled at January 2014.

6.3. Child Protection Plans (CPP)

Initial Child Protection Conference outcomes to start a CPP decreased in May 2013 to 82.2%. This was below SN (84%) and national (92.5%). However, this increased significantly to 97.8% at August 2013. This remained high at 100% for both September and October 2013, exceeding Lewisham's target of 96%. The number of children with a CPP continued to rise and a report was presented to the LSCB which considered the possible reasons for this. Please see section 4.2.1 of this report for more information on this.

There continues to be a relatively high number of CPP lasting 2 years or more in Lewisham, but this has started to decrease to 5.6% in May 2013 and much lower than the target of 8%.

The percentage of ICPCs held within 15 days continued to be a challenge. The LSCB will continue to monitor this to ensure children are protected in a timely manner by means of Child Protection Plans.

6.4. Looked After Children (LAC)

The number of LAC in Lewisham remained relatively stable throughout the year and the total number of LAC is usually less than 500.

The incidence of LAC per 10000 population age 0-17 was 78.4% at May 2013. Lewisham continues to have a higher incidence of LAC than the SN (76.9) and national (59.1).

Placement stability for LAC (same placement for 2+ years) remained close to 73% during the initial months of the 2013/14 financial year. It was around 69% at August 2013 and 66% at October 2013, somewhat lower than the target of 72%. The placement stability measure for the number of placements (3+ placements in 12 months) remained a concern and is one of the LSCB's priorities to take forward.

Initial Health Assessments completed within 28 days have improved drastically with 100% assessments completed on time at August 2013 and October 2013. However, there has been a 6% drop since August 2013 in LAC who have had a up to date dental check within the last 12 months. The LSCB will continue to monitor these indicators to ensure LAC receive appropriate health care in a timely manner.

Please see appendix G for more performance information for 2013/14.

7. Key partnership data and activity

The LSCB receives a regular suite of information from the Local Authority Performance team which enable both Local Authority and some partnership information to be analysed. However the LSCB is in the process of prioritising the data it requires in the shape of a few simple key performance indicators from partners, these being indicators which should go to the heart of the safeguarding task and effectiveness. These will be identified in 2014/15 for implementation during this year, providing a baseline from which to assess progress over time.

7.1. Early Intervention and Access Services (EIAS)

Key safeguarding activity during 2013/14 for the EIAS included the following:

Youth Service:

- Refresh on safeguarding training for all staff as part of the re-structure
- Established appropriate supervision mechanisms to ensure ongoing support for youth workers on safeguarding
- Ensure all commissioned providers meet basic youth work standards including safeguarding policies

Early Intervention and Access:

- Audit of early intervention commissioned providers to ensure staff are up to date on safeguarding training
- Delivery of training on the safeguarding induction course
- Audit of quality of outcomes and provision of training to improve quality of outcomes

Commissioning and Strategy:

- Ensured that all contracted and commissioned activity, including Children's health services commissioned on behalf on Lewisham Clinical Commissioning Group, complies with the Council's safeguarding standards and policies
- Responded to the increase in the number of children subject to a child protection plan - funding additional capacity in the School Aged Nursing Service and assessing how the increased demand can be best managed while retaining consistent safeguarding practice

7.2. South London and Maudsley (SLAM)

The South London and Maudsley NHS Foundation Trust is committed to safeguarding children across the organisation. This is reflected in the Trust's Safeguarding Children policies and procedures which the Trust is currently updating to ensure that we are working in line with government Working together 2013 and pan London procedures. Safeguarding children ensuring that safeguarding and promoting the welfare of children is embedded across every part of the Trust and in every aspect of its work.

Children and young people are considered in all interactions with service users and their carers. The welfare of children is the paramount consideration of all staff across the Trust and guides their work. All staff whether permanent, temporary or contracted have a duty to ensure that children are protected from harm and comply with the principles laid down in the Children Acts (1989 and 2004),

The trust continues to work to strengthen and improve safeguarding children arrangements by providing in house training levels 1, 2, 3 as a minimum for all clinical staff but also encouraging attendance at LSCB

multiagency training.

The following arrangements are in place:

- DBS Checks are in place for all relevant staff
- Policies currently being updated
- Accessibility of Information, Support and Guidance via Safeguarding leads and the Trust Safeguarding website
- Training
- Governance arrangements in place via the Trust Safeguarding committee and Trust Quality Committee
- Child Need and Risk Screen to be undertaken on all adults coming to SLaM for an assessment or intervention
- Roles and Responsibilities clearly laid out in the Safeguarding polices
- Participation in Governance Structures
- Contribution to Child Protection Conferences
- Inter-Agency Communication, Collaboration and Information-Sharing
- Young people participation in service feedback and individual feedback on own intervention

Priorities for the coming year:

- The Trust will be continually challenging all elements of our safeguarding children arrangements, striving to ensure that they are ever more embedded in day-to-day practice.
- To continue to establish methods of obtaining feedback from service users.
- To facilitate the full role out of the Domestic abuse E-Leaning which has been specifically developed for staff working in SLaM to ensure that the DV policy is embedded in practice.
- Engage in multiagency audits.
- To monitor Child Protection referrals made to Local Authority Children's Social Care Service to ensure that staff are completing CAF's appropriately and staff are making full use of Lewisham Early Intervention Services to provide early help and support.

To continue to strengthen partnership working with Children's Social Care and enhance links with Adult Mental Health Services.

7.3. Child Abuse Investigation Team (CAIT)

The Metropolitan Police have a dedicated Child Abuse Command with dedicated Child Abuse Investigative Teams (CAITs) which cover all of the 32 Boroughs across London. These are supported by central functions such as training and partnership teams. The CAIT team for Lewisham covers both the Boroughs of Lewisham and Bromley and consists of one Detective Inspector, 3 Detective Sergeants and 16 Detective Constables. Their remit covers:

- Intra-familial abuse
- Professional abuse
- Carer abuse

This list is not exhaustive and consideration is given to new forms of abuse such as those who facilitate child trafficking, exploit children sexually or use children in organised criminal activity. It also includes adult victims where the abuse occurred whilst he or she was a child, connected matters (offences against other children),

allegations such as parental abduction, intelligence led investigations in relation to Internet crimes and the investigation into the sudden and unexpected death in infancy of children under the age of 2 within the family.

Children at risk of significant harm are identified by police officers through robust risk assessments and reported to children's social care. Risks for children living within Domestic Abuse households are reduced and minimised as police have a good awareness of the impact this has on the emotional well being of children. Joint investigations undertaken by the CAIT and children's social care are underpinned by strong working relationships between both agencies. Strategy discussions are timely and actions match the risk accordingly. CAIT officers also attend Initial and Review Child Protection Case Conferences and attendance and contribution to these is extremely high and ensures risks are identified and responded to immediately.

All CAIT staff are required to complete the Specialist Child Abuse Investigators Development Programme (SCAIDP) and Achieving Best Evidence training. All non detectives are required to pass a national detective exam and complete the Nationally Accredited Initial Crime Investigator Development Programme (ICIDP) to develop their skills and confidence.

The Command has seen some recent developments during 2013/4 period, most noticeably the merging of SCO2 (Sapphire) and SCO5 (Child Abuse Investigation) to form the Sexual Offences Exploitation and Child Abuse Command (SOECA). This has not led to any changes with the way the Child Abuse Investigation command operates but has seen the introduction of a Grip and Pace Centre which monitors all matters of child abuse on a daily basis across the whole command to ensure daily grip and a prompt effective response to allegations. The Command also successfully launched CSE pan-London wide and so now manages all investigations in relation to Child Sexual Exploitation in liaison with BOCU CSE units.

7.4. Lewisham Borough Police

In support of Safeguarding Lewisham Borough Police have dedicated investigation units for Domestic Abuse, Missing Persons and Child Sexual Exploitation with a Public Protection MASH team embedded within the multi agency team. During the course of the financial year the Missing Persons Unit investigated 1619 missing person enquiries of which 66% related to young persons under 18. Sixty four level 1 (non crime investigation) CSE reports were received that led to strategy and intervention coordinated through MASE. Police made 124 referrals to MARAC and of the overall 450 cases addressed at MARAC 555 children were discussed and 16% of MARAC cases were repeat referrals. In addition Police schools officers have conducted bullying / online bullying awareness talks in schools across the Borough and worked closely with educational welfare officers to tackle incidents of bullying that fall outside of a criminal investigation.

8.5 Lewisham Clinical Commissioning Group (CCG)

The CCG has a governance structure for safeguarding with the Accountable Officer assuming ultimate responsibility for safeguarding

The NHS Lewisham CCG Health Safeguarding Assurance Committee is assigned the responsibility of ensuring assurance to the Governing Body that all commissioned services are fulfilling their responsibilities on

safeguarding and to ensure training and awareness of safeguarding is up to recommended national standards. Providers safeguarding leads attend this quarterly meeting.
The designated and named professionals are members of the NHS Lewisham CCG health safeguarding Assurance Committee which reports to the Governing Body through FLAG (For learning and Action) as per the NHS Lewisham CCG governance structure. All the designated professionals work within the local health economies to influence local safeguarding strategy and practice.

Assurance is sought on the Quality of service provision for safeguarding using a safeguarding monitoring template.

- All organisations should be able to provide assurance that their safeguarding practice meets the standards within outcome 7 of the CQC Essential Standards
- Enable commissioners to seek assurance through visits by designated professionals and by sharing action plans and lessons learnt from SCRs
- Undertake regular case audits with reference to the standard of record keeping, sharing information and multi-agency liaison.
- Be able to demonstrate that they have acted on recommendations from local SCRs and National Inquiries.

In addition The For Learning and Action Group (FLAG) reviews the CQCs Quality Risk Profiles to see if there are any safety issues related to any of the providers for which Lewisham CCG commissions services from.
The FLAG committee is chaired by the Governing body lead Director for Safeguarding (with the Nurse Director as deputy) and receives assurance and exception reports from the Safeguarding Assurance Group that the duties related to this accountability are completely discharged and to closely monitor all safeguarding arrangements, systems and process and escalate and manage safeguarding risks. The Nurse Director is a member of the Health Safeguarding Assurance Group (HSAG) and will present safeguarding assurance reports to the FLAG committee at every meeting, exception reports as required and escalate any risks with mitigating action plans.
The HSAG will meet on a quarterly basis and be chaired by the Governing body Director Lead. Minutes of the LSCB and the LSAB will be received by the FLAG committee for local health actions.
Minutes and exception reports from the HSAG are received by FLAG. Lewisham CCG Governing Body receives a bi monthly quality report in including safeguarding, with exceptions. The Governing Body also receives an annual report for both Adults and Children's safeguarding (including Looked After Children).

8.6 Lewisham & Greenwich NHS Trust

Lewisham and Greenwich (LGT) NHS Trust was formed on 1 October 2013 following the dissolution of South London Healthcare Trust. LGT provides a full range of acute hospital services at Queen Elizabeth Hospital (QEH) Woolwich, University Hospital Lewisham (UHL) and community health services within the London Borough of Lewisham. On the Queen Mary's site LGT provides midwifery services and retained the responsibility for the management of the Children and Young Person's Assessment Unit (CYPAU) until the end of March 2014.

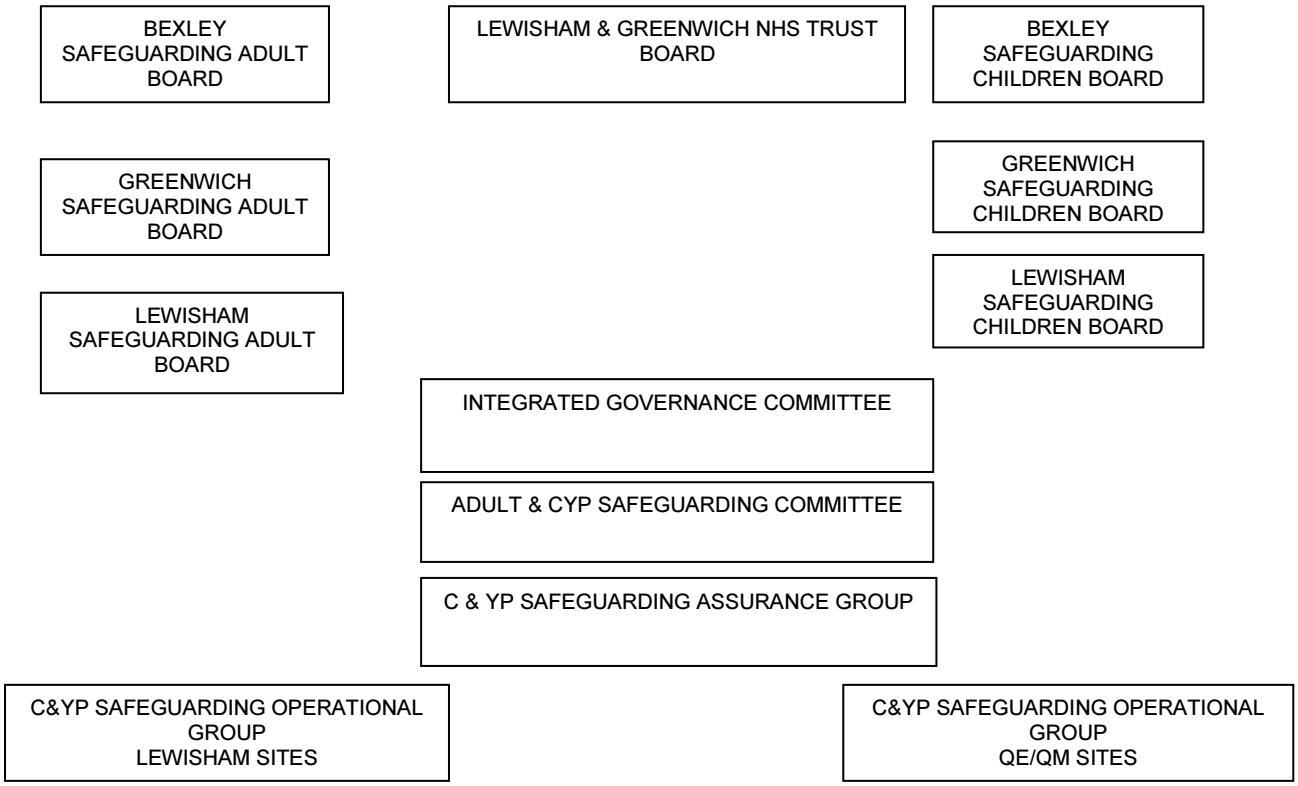
Section 11 of the Children Act (2004) places a duty upon the Trust to ensure its functions are discharged with regard to the need to safeguard and promote the welfare of children. Working Together (2013) highlights that health professionals are ideally placed to identify welfare or safeguarding needs of children and young people and, where appropriate, to provide support.

Key safeguarding themes identified by LGT/SLHT in 2013 include neglect, increasing levels of young people with mental health issues, children with disabilities and those affected by adult issues such as domestic abuse or mental health issues. There has been an increase in delay of discharge from hospital of mothers and babies where courts are involved, nil recourse to public funding and late disclosure of housing issues.

LGT Trust is promoting the 6 C's of communication, care, courage, compassion, commitment and competency and has taken as its mantra the following values and behaviours: respect and dignity, commitment to quality of care, compassion, improving lives, working together for patients and everyone counts.

The Trust maintains an Action Plan, Risk Register and an Annual Audit Programme around Safeguarding. These are reviewed bimonthly within the Trust's safeguarding forums (Trust Governance structure attached). An action plan has been formulated to harmonise safeguarding polices/procedures and guidance across the sites. This is expected to be completed by October 2014.

safeguarding Governance Arrangements for C&YP



The Trust has contributed to and implemented actions resulting from the Lewisham Safeguarding Children Board audit plan. Senior LGT representation at the LSCB Main Board, the Monitoring Evaluation and Service Improvement (MESI) task group, neglect task group, Child Sexual Exploitation task group, Policies, Procedures and Training (PPT) task group and Communications group has been agreed and implemented.

Learning and Impact of Work

LGT inherited two Serious Case Reviews arising within 2013 from the University Hospital Lewisham site and community services. Learning from these reviews resulted in the development of a maternity safeguarding pathway and maternity substance misuse pathway. These themes are now included within all Safeguarding Training and arising action plans are monitored via the governance structure mechanisms.

The weekly Safeguarding Meetings in the Emergency Department Children's and Neonatal units, along with the Maternity Safeguarding meeting, are well embedded and offer an opportunity for identification of those children in need of early help services, interagency working, professional challenge and reflective practice.

Views of Children/ Young People/Parents/Carers

To improve information sharing and engagement of children and families in safeguarding processes when accessing Trust services, posters on confidentiality, information sharing, asking whether a child has a social worker and referral pathways to substance misuse services are now clearly displayed within the Emergency Department.

This is further supported by the development of a child friendly complaints leaflet. Two further guides for children/ young people and families explaining safeguarding roles responsibilities and information sharing are in development. Gaining the views of children accessing The Trust will be extended through several schemes and will build upon the use of 'Matron Mouse' on UHL site.

Equality and diversity

All women attending for ante-natal care are routinely asked whether they have undergone Female Genital Mutilation (FGM). There are multi-language posters displayed within the units and the use of interpreting services via telephone or face to face is available. All safeguarding training incorporates issues regarding equality and diversity.

What have we learned?

The Trust continues to progress harmonisation of safeguarding policies and practices in order to enhance safeguarding practice and the sharing of knowledge.

What do we need to do better?

The identification and support to those children and adults experiencing domestic abuse who access services is a priority for 2014. The safeguarding team are part of a multi-agency working party to address this.

A Trust wide policy on referral pathways for women who have undergone FGM and consideration of risk assessment for resulting children is required. This needs to be in line with London Child Protection Procedures (2014).

- To ensure that staff are aware of the differing referral pathways into early help provision and social care services offered by the three local boroughs.
- To ensure that safeguarding training levels increase and are maintained to improve staff safeguarding children skills.

8.7 London Probation Service

Until 31st May 2014 Probation Services were delivered by the London Probation Trust (LPT). From June 2014 the service will be delivered by two separate organisations, the London Community Rehabilitation Company and the National Probation Service. Probation works with offenders over the age of 18 who have been sentenced to community orders or custodial terms by the Courts. The aim is to prevent further re-offending and

to manage risk by working with individuals to address a wide range of offending related needs including substance misuse, employment, emotional wellbeing, thinking and behaviour and relationship issues. In addition Probation carries out assessments and provides advice and information to the Courts and the Parole Board. Although Probation services work primarily with adults, Child Safeguarding is an absolute priority. Practitioners understand that offenders could be parents, carers or have younger siblings, who could be at risk. Practitioners are encouraged to 'Think Family' to ensure that the needs of the children in an offender's life are taken into account, and risk issues addressed. Activities to improve practice have included: :

- Mandatory training for all practitioners
- Case Audits
- Presentations for Children's Social care
- Access to Local Authority training
- Team case discussions
- Staff supervision

LPT has been committed to partnership working at all levels as demonstrated in its work in MAPPA, various MARACs, MASH, Lewisham Safeguarding Board and the Community Safety Partnership. Despite the changes Probation Service Providers remain committed to working in partnership to improve outcomes for children by reducing offending and helping to make our local community safer.

8. Future Priorities for the LSCB

The overall role of the LSCB is to monitor how well safeguarding of children and young people is going in Lewisham, and to ensure and assure that children and young people are being kept safe. To achieve this the Safeguarding Board needs to do two things, it needs to have the right information to determine how well safeguarding is going, and it needs to act effectively to address any weaknesses by either taking action itself, or by holding to account those responsible so that they act to address the situation.

The LSCB, like the Partnership, puts children and young peoples interests, wellbeing and safety at the centre of everything it does. The LSCB aspires to arrive at a situation whereby it has a good understanding of how well safeguarding is going. To this end, over the last year, and carried forward into 2014-2015 and onwards, it is developing and refining its performance management system in order to improve the voice of children and young people, and to ensure that it has a thorough and comprehensive understanding of the quality of practice derived from both qualitative and quantitative data sources. Much progress has already been made with this work.

The priorities for next year are drawn form a number of sources. These include national priorities as set by Government policy or legislation. They also include priorities drawn from local findings such as recent Serious Case Reviews, multi-agency audits, performance management data or other local information sources. The LSCB also draw on local and national inspection findings, reviews, research and other best practice sources to challenge and improve its scrutiny. Taking into account all of these sources, the LSCB's priorities for 2014/15 include the following:

Neglect remains a priority having been identified in the Serious Case Review bi-annual report as an area of national concern. The LSCB will continue to draw from its audit findings and to work through its neglect task group in addressing this challenging area of work.

Child Sexual Exploitation continues to be a national priority ,driven and informed by the work of the Children's Commissioner. The LSCB will continue to work on policies, procedures and partnership initiatives to drive up the numbers of CSE cases identified and responded to, and to ensure that offenders are brought to justice through effective prosecution strategies and victim support.

Looked After Children, including Care Leavers and children placed out of borough, continue to be a high priority for the LSCB due to the vulnerability of these children. Work will be ongoing in partnership with the Corporate Parent Group to ensure that all aspects of the wellbeing of Looked After Children are identified and addressed. This will include monitoring of the stability of placements for LAC which the LSCB has focussed on as an area of concern.

Female Genital Mutilation (FGM) is an area which the LSCB will focus on during 2014-2015, derived from the Violence Against Woman and Girls (VAWG) strategy. We are looking to improve identification both of FGM risks and of actual cases, ensuring better protection and prosecution of offenders as appropriate. Policies, procedures and joint agency actions will therefore be developed in this area.

Child Protection Increases in rates of referral remain a concern and the LSCB will monitor closely the ongoing situation to ensure that correct thresholds are in use and that plans are effective in the delivery of improvements and outcomes in safeguarding.

Bullying remains a priority area and the LSCB will continue to work on its action plan to support schools in their anti-bullying work, aiming to improve the quality and effectiveness of responses to bullying through best practice guidelines and through work to be commissioned on cyber bullying.

Private Fostering remains a priority for the LSCB and we look to see an increase in the number of placements identified and improvements in the quality of the environment being offered.

Early Intervention is a priority for this year, with the LSCB due to undertake a review of the current thresholds to test whether they remain appropriate, and also to ensure that outcomes are clearly embedded in early intervention plans so that improved information on the effectiveness of these services can be assured.

Safeguarding in Health is a priority area, drawn from our recent Serious Case reviews. Further analysis and audits will be undertaken this year to ensure that action plans are having an impact and outcomes are improving.

Lewisham LSCB Website During the next year we want to improve the website, making it accessible and informative to both professionals and to the local community.

Road Traffic Safety the LSCB continues to see this as a priority and will monitor the impact of work sitting with the Director of Public Health in this area.

Safeguarding in the third sector remains a priority area and the LSCB has funded Voluntary Action Lewisham (VAL) in order to improve the knowledge and awareness of third sector agencies in safeguarding. The LSCB will continue to look to strengthening this approach, including some of the faith groups who are currently less well networked in to the safeguarding system.

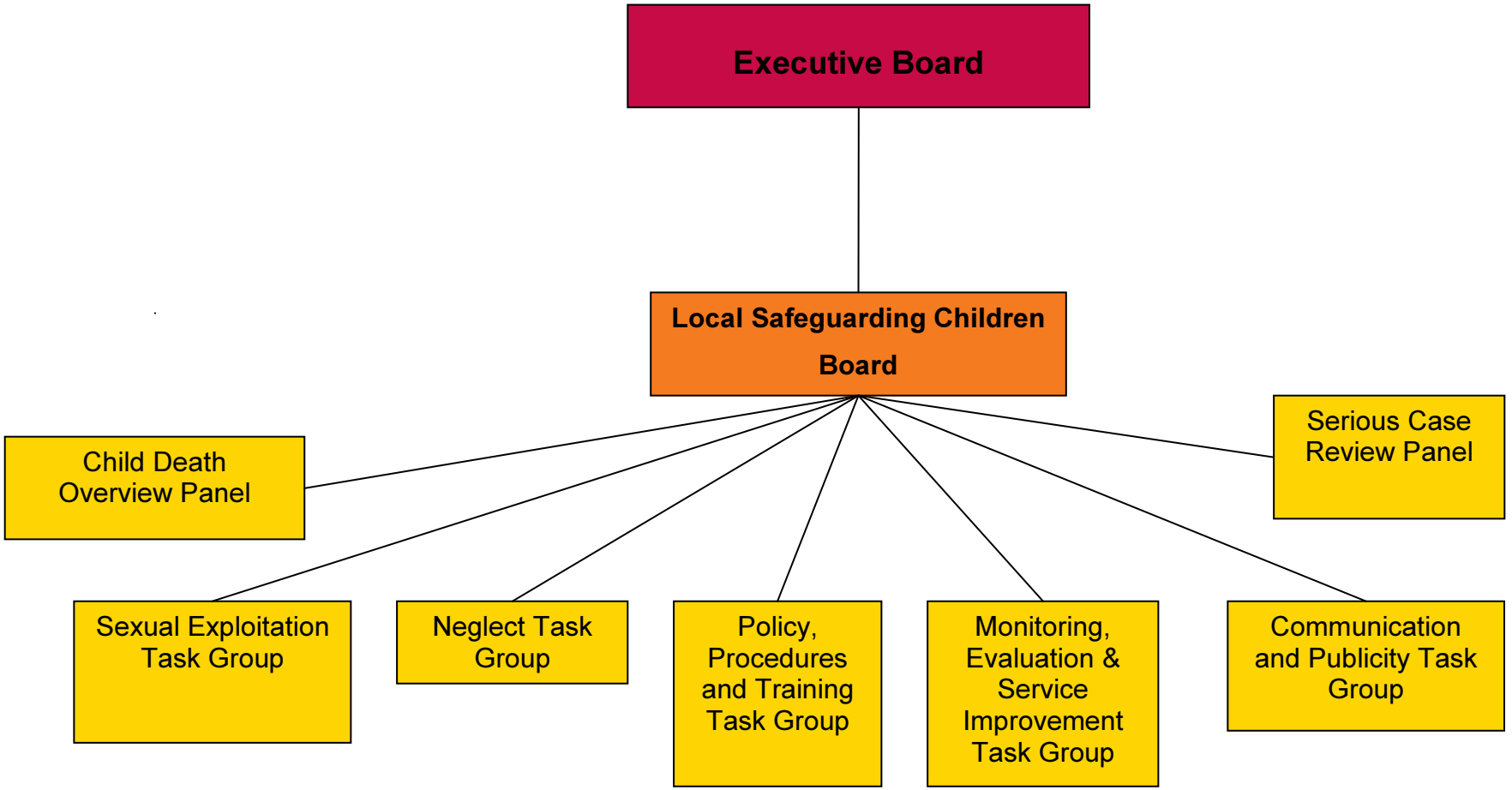
The voice of Children and Young People Whilst generally a strong feature of the Lewisham Partnership, we want to make sure that the LSCB is effectively listening to children and young people whilst not duplicating activities undertaken by the children's partnership. We will undertake an overview of how effectively the LSCB listens to young people and will look to strengthen this area during the next year.

Inspection Findings will be incorporated into the work of the LSCB as appropriate. The LSCB remains strongly sighted on all relevant partner inspections, including the recent CQC Lewisham and Greenwich NHS University Hospital Trust inspection, the OFSTED Lewisham Children's Services Early Help inspection and national overview and single agency reports as appropriate. Action plans derived from these are monitored by the LSCB until completed. We also create further action plans drawn from national sources where we believe they are relevant and monitor these for completion too. These are included in our business plan.

Serious Case Reviews, Management Reviews and Audits previously undertaken by the LSCB will continue to be monitored until all of the outcomes are achieved from the action plans.

Performance Management remains a priority for the LSCB as we want to make sure that we have enough of the right sort of information in order to know how well local safeguarding is going. We will be finalising this work during this year, having made great progress during 2013-14. Our detailed business plan will therefore continue to draw on information as it unfolds, in order to effectively challenge throughout the year those areas of practice which cause the LSCB any concern, and to assure that these are quickly addressed.

Appendix A: Structure Chart



Appendix B: LSCB Budget

Income

Agency	2013 / 14	% Contribution
CCG	£ 18,311	22.2%
CYP	£ 36,621	44.4%
Probation	£ 2,000	3.0%
CAFCASS	£ 550	0.8%
Met. Police	£ 5,000	7.4%
UHL	£ 9,115	11.1%
SLAM	£ 9,115	11.1%
Total	**£ 80,792**	**100%**

Expenditure

Expenditure	2013 / 14
Training	£ 8,547
Business Manager's Salary	£ 37,100
Administrator's Salary	£ 23,145
Independent Chair's Salary	£ 12,000
Total projected expenditure	**£ 80,792**

Appendix C: LSCB Membership

Name	Organisation / Role
Christine Doorly	Independent Chair
Marinda Beaton	LSCB Business Manager
Dr Abimbola Adeyemi	Consultant Community Paediatrician & Designated Doctor, Clinical Commissioning Group
Dr Judy Chen	Named GP, Clinical Commissioning Group
Dr Faruk Majid	Senior Clinical Director, Lewisham Clinical Commissioning Group
Joy Ellery	Director of Knowledge, Governance and Communications, Lewisham & Greenwich Healthcare NHS Trust
Chris McCree	Acting Assistant Director of Nursing & Safeguarding, SLAM
Pat Barber	LGA Governor Representative
Louise Hubbard	Assistant Chief Officer, Probation
Cheryl Spender	Safeguarding Adults Strategy Development Officer
Cllr Helen Klier	Cabinet Member for Children and Young People
David Travis	Head of Student Services, LeSoCo
Jonathan Sharpe	Brent Knoll School
Liz Jones	Executive Principal, Abbey Manor College
Jonathan Slater	Strategic Development Officer for CYP, Voluntary Action Lewisham
Genevieve Macklin	Head of Strategic Housing, Customer Services
Graham Norton	Ambulance Operations Manager, London Ambulance Service
Dr Donal O'Sullivan	Consultant in Public Health Medicine, Public Health
Bernice Walters	Service Manager for Quality Assurance, Children's Social Care
Chris Smart	South Regional DCI, CAIT, Metropolitan Police
Ian Smith	Director of Children's Social Care
Geeta Subramanian-Mooney	Head of Crime Reduction & Supporting People
Sue Tipler Deputy: Louise Comely	Head of Standards and Achievement, Directorate for CYP Principal Educational Psychologist
Nick Topliss	Borough Manager, CAMHS, South London & Maudsley NHS Foundation Trust
Neil Evans	Superintendent, Crime and Operations, Metropolitan Police Service
Maureen Gabriel	Designated/Lead Nurse, CP/Safeguarding Children & Young People and LAC, Clinical Commissioning Group
Zafer Yilkan	Service Manager, CAFCASS
Warwick Tomsett	Head of Commissioning, Strategy and Performance
Georgina Nunney	Principal Lawyer, Legal Services, (LBL papers only)
Dawn Smith	Lay Member
Filomena Brockwell	Lay Member
Derek Churchman	Lay Member

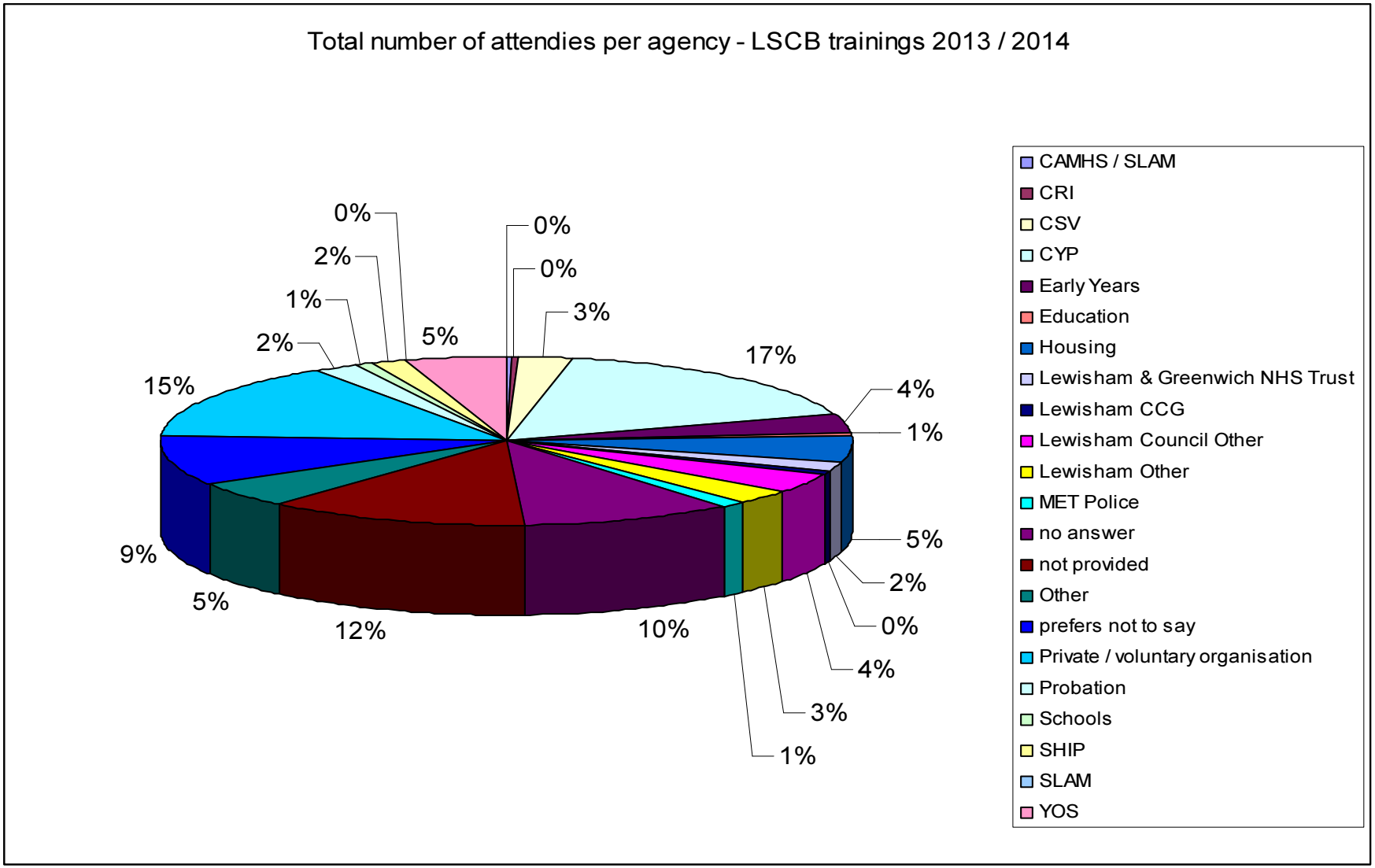
Appendix D: Executive Board Membership

Name	Organisation / Role
Christine Doorly	Independent Chair
Marinda Beaton	LSCB Business Manager
Frankie Sulke	Executive Director for Children and Young People, Directorate for Children and Young People
Dr Faruk Majid	Senior Clinical Director, Lewisham CCG
Tim Higginson	Chief Executive, Lewisham Hospital
Cllr Helen Klier	Cabinet Member for Children and Young People
Russell Nyman	Chief Superintendent, Metropolitan Police
Justin Armstrong	South Regional DCI, CAIT, Metropolitan Police
Ian Smith	Director of Children's Social Care, Directorate for Children & Young People
Martin Wilkinson	Chief Officer, NHS Lewisham Clinical Commissioning Group
Danny Ruta	Director of Public Health
Chris McCree	SLAM

Appendix E: Rota for annual reports to the LSCB

March:	
Agency:	**Person responsible:**
Early Intervention (to include threshold suitability, outcome of sample audit of safeguarding outcomes achieved)	**Warwick Tomsett**
Community Safety Partnership (including MARAC)	**Geeta Subramaniam**
Voluntary Action Lewisham	**Jonathan Slater**
Clinical Commissioning Group Annual Report	**Faruk Majid**
June:	
Agency:	**Person responsible:**
HR report on CRB systems	**Andreas Ghosh**
Private Fostering	**Richard Hodgkiss**
Child Death Overview Panel	**Donal O'Sullivan**
Children Missing from Education	**John Russell / Warwick Tomsett**
Safeguarding Children with Complex Needs	**Keith Martin**
September:	
Agency:	**Person responsible:**
CAMHS	**Nick Topliss / Chris McCree**
Road Traffic Safety in Lewisham	**Donal O'Sullivan / Liz Brooker**
LADO Annual Report	**Bernice Walters / Lin Blakelock**
LSCB Annual Report	**Marinda Beaton / Chris Doorly**
Safeguarding in Schools	**Sue Tipler / Louise Comely**
December:	
Agency:	**Person responsible:**
MASH Annual Report	**Naeema Sarkar**
Missing Children	**Richard Hodgkiss**
Looked After Children (including placement stability)	**Tina Benjamin**
Lewisham & Greenwich Healthcare Annual Report	**Joy Ellery**
Child Sexual Exploitation	**Bernice Walters**

Appendix F: Breakdown of training attendance by agency



Appendix G: Key Performance Indicators

Reduce child abuse and neglect (SS1)

Number of CAFs initiated in month		
Month	**Number**	**Target**
May 2013	393	300
August 2013	258	300
November 2013	443	300
February 2014	417	300
% of referrals going onto Initial Assessments		
Month	**Number**	**Target**
May 2013	83.20	93
August 2013	88	93
November 2013	85.50	93
February 2013	84.90	93
Initial Assessments within 10 working days		
May 2013	88	91
August 2013	89.10	91
November 2013	89.50	91
February 2014	89.10	91
Subject to CPP second or subsequent time		
May 2013	8.30	10
August 2013	9.60	10
November 2013	7.90	10
February 2014	10.30	10
CPP lasting more than 2 years		
May 2013	6.50	8
August 2013	6.10	8
November 2013	5.20	8
February 2014	4.90	8
Number of new referrals to CSC each month		
Month	**Number**	**Target**
May 2013	229	250
August 2013	165	250
November 2013	249	250
February 2014	112	250
% Referrals due to abuse/neglect		
May 2013	80	77
August 2013	67	64
November 2013	30	34
February 2014	33.30	34
Number of ICPC held within 15 days of the start of the s47 enquiry		
May 2013	78	85

August 2013	71.80	85
November 2013	71.40	85
February 2014	70.20	85
Number of section 47 enquiries each month		
Month	**Number**	**Target**
May 2013	90	80
August 2013	60	82
November 2013	128	82
February 2014	81	82
% of s47 enquiries that went onto ICPC		
May 2013	35.3	34
August 2013	33.50	36
November 2013	34.60	36
February 2014	34	36
Number of children subject to protection plan		
Month	**Number**	**Target**
May 2013	279	240
August 2013	280	240
November 2013	327	240
February 2014	307	240
% children subject to CPP receiving stat visit within 6 weeks		
May 2013	95.5	99.10
August 2013	98.80	98.80
November 2013	92	98.80
February 2014	85.90	98.80
% Core group meetings within timescale		
May 2013	91.70	94.20
August 2013	87.30	91.20
November 2013	92.60	91.20
February 2014	70.90	91.20
% of CP conferences attended by parents		
May 2013	74.80	80
August 2013	67.40	80
November 2013	62.30	80
February 2014	75.60	80

Provide secure and consistent support for Looked After Children, particularly placement stability (SS3)

Stability of placements of LAC (% 3+ placements)		
Month	**Number**	**Target**
May 2013	11.90	9
August 2013	12.60	9
November 2013	13.30	9

February 2014	12	9
Stability of placements of LAC(% placement 2 years+)		
May 2013	73.40	72
August 2013	63.10	72
November 2013	66.20	72
February 2014	70.30	72
Number of LAC		
May 2013	506	481
August 2013	506	481
November 2013	505	481
February 2014	501	481
% LAC who communicate their views at reviews		
Month	**Number**	**Target**
May 2013	98	99.30
August 2013	100	99.30
November 2013	99.50	99.30
February 2014	99.80	99.30
% LAC placed outside LBL > 20miles from home		
May 2013	17	15.40
August 2013	17.20	15.40
November 2013	18.40	15.40
February 2014	18	15.40
% LAC 28+ days age 5-16 with who've a completed PEP		
May 2014	96.70	100
August 2013	96.70	100
November 2013	97.20	100
February 2014	96.60	100

Ensure that children and young people feel safe (SS5)

Number of repeat missing LAC		
Month	**Number**	**Target**
May 2013	22	25
August 2013	25	25
November 2013	25	25
February 2014	25	25
Number of bullying incidents in primary schools		
Summer 2012/13	30	
Autumn 2013/14	30	
Number of bullying incidents in secondary schools		
Summer 2012/13	21	
Autumn 2013/14	29	