



**Lewisham  
Safeguarding**  
Children Board



**Annual  
Report  
2018/19**

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## Foreword from the Independent Chair, Nicky Pace

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As the Independent Chair of the Lewisham Safeguarding Children Board (LSCB) I am pleased to present the Annual Report for the period April 2018 to March 2019. This will be my last Annual report as I intend to step down from the role in September 2019 and a new role of Independent Scrutineer will be recruited.

Local Safeguarding Children Boards (LSCBs) were established with the purpose of ensuring that agencies keep local children and young people safe and that where they have intervened they have made a positive difference in children's lives. The LSCB has a really important role in coordinating and ensuring the effectiveness of what is done by each and every person involved in protecting children and it carries statutory responsibilities for safeguarding children in Lewisham. It is made up of senior managers within organisations in Lewisham who hold responsibility for safeguarding children in their agencies, such as children's social care, police, health, schools and other services including voluntary bodies. The LSCB monitors how they all work together to provide services for children and ensure children are protected.

The last year has seen the development of the new Multi-agency Safeguarding Arrangements which will replace LSCBs. The Partnership Plan for Lewisham will be published by the end of June 2019 and the new arrangements will be in place by September 2019. There has been careful planning and consultation over the last year to develop this plan. Where possible the plan focusses on reducing duplication, joining up with other partnership groups and across boundaries as much as possible, with a real focus on making a difference to front line practice to safeguard children and builds on what we know works well. The challenge over the next year will be to ensure that replacing the LSCB with the new arrangements is done carefully and the transition is carefully monitored and reviewed. It is

recognised that the next year will be challenging for all agencies, with considerable change within their own organisations and we will need to ensure the focus and delivery of services to vulnerable children, young people and families is not adversely affected.

Lastly, I would like to thank the Board staff, for their continued support in the functioning and promotion of the LSCB. I would also like to thank members of the Board, from across the partnership of our voluntary, community and statutory services and all the frontline practitioners and managers for their commitment, hard work and effort in keeping children and young people safer in Lewisham.



**Nicky Pace**

**LSCB Independent Chair**

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## Overview of the Board

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### What is a Local Safeguarding Children Board?

Local Safeguarding Children Boards (LSCBs) were established by the Children Act 2004.

The LSCB is a statutory body and was established in 2006 in accordance with the statutory duties set out in the '*Children Act 2004*'. The activities undertaken by the LSCB reflect the requirements of the Act, and are based upon the objectives set out in Chapter 3 of '*Working Together to Safeguard Children 2015*:

- (a) 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
- (b) To ensure the effectiveness of what is done by each such person or body for those purposes.

### About the Lewisham Safeguarding Children Board

The LSCB is the statutory mechanism for agreeing how the relevant agencies in each local area will co-operate to safeguard and promote the welfare of children in that locality, and for ensuring the effectiveness of what they do. Governed by the statutory guidance in Working Together to Safeguard Children 2015 and the Local Safeguarding Children Board (LSCB) Regulations 2016, Members of the Lewisham Safeguarding Children board (LSCB) are senior managers from a range of different organisations who hold strategic roles in relation to safeguarding / child protection. They are expected to be able to speak for their organisations with authority,

commit their organisations on policy and practice issues, and hold their organisations to account on their safeguarding/child protection practice.

The LSCB has a responsibility to ensure that organisations are fully meeting their safeguarding obligations effectively, and can hold them to account if they are not.

The LSCB works to achieve this by:

- Leading collaboration across all agencies in the community
- Developing and setting policies and procedures
- Monitoring and auditing the implementation of these policies and procedures
- Conducting audits to ensure the effectiveness of what is done by agencies individually and collectively to safeguard and promote the welfare of children
- Conducting Serious Case Reviews when a child dies or is seriously harmed and abuse or neglect is suspected to improve practice across agencies
- Conducting Child Death Reviews to better understand how and why children in the locality die and use these findings to take action to prevent other deaths
- Ensuring appropriate multi-agency training is available and effective
- Promoting awareness and action in the wider community

## The LSCB Main Board

This is made up of representatives of the member's agencies. Board members must be sufficiently senior so as to ensure they are able to speak confidently and sign up to agreements on behalf of their agency, and make sure that their agency abides by the policies, procedures and recommendations of the LSCB. Please see the Appendices to see our attendance in 2018/2019.

## The Executive Board

The Executive Board manages the business and operations of the LSCB, ensuring there are clear governance arrangements in place and drives forward the strategic priorities as outlined in the Business Plan.

## Independent Chair

The LSCB has an Independent Chair who is subject to an annual appraisal to ensure the role is undertaken competently and that the post holder retains the confidence of the LSCB members. The Chief Executive of Lewisham Borough Council and Executive Director for Children & Young People appoints the Chair.

## Lewisham Borough Council

Whilst the Chair and the LSCB Board itself is independent, Lewisham Council is responsible for establishing and maintaining the Local Safeguarding Children Board (LSCB) on behalf of all agencies.

The Executive Director of Children & Young People and the Director of Children's Social Care are required to sit on the Main Board of the LSCB, as this is a pivotal role in the provision of children's social care within the local authority.

## Lead Member for Children's Services

The Lead Elected Member holds responsibility for making sure that the local authority fulfils its legal responsibilities to safeguard children and young people. The Lead Member contributes to the LSCB as a participating observer and is not part of the decision-making process.

## Partner Agencies

All partner agencies responsible for safeguarding children in Lewisham are committed to ensuring the effective operation of the LSCB as a multi-agency safeguarding group. This is supported by the LSCB governance document and partnership protocol, which sets out the governance and accountability arrangements.

## Designated Professionals

Health commissioners should have a Designated Doctor and Designated Nurse to take a strategic, professional lead on all aspects of the health service contribution to safeguarding children across the local area. Designated professionals are a vital source of professional advice on safeguarding children matters to partner agencies and the LSCB. There is a Designated Doctor and a Designated Nurse in post in Lewisham, who play an active role in the LSCB and its task groups.

## Lay Members

Lewisham LSCB has two local residents acting as Lay Members who support stronger public engagement in local child protection and safeguarding issues and contribute to an improved understanding of the LSCB's work in the community. Both Lay Members play an active role in the work of the LSCB and its task groups.

## Effectiveness of the Board

The Board is required to report on progress against the priorities set for the previous year and plan any changes to local safeguarding priorities for the next year, taking into account national priorities and local needs, and any issues arising from SCRs and multi-agency audits. When deciding our priorities, we acknowledge that our core business of safeguarding children is on-going, including identifying, assessing and providing services and help to those children who need protection. In deciding the Board's improvement priorities, we consider how well we have delivered our priorities from the previous year and if further work is needed. S

Summary of our Key Priorities for 2018-2019	Summary of our Key Achievements for 2018-2019
<p><b>Priority 1: Neglect</b> Improve the effectiveness of agencies and the community in identifying and addressing neglect.</p>	<ul style="list-style-type: none"> <li>• The LSCB continued to provide a comprehensive rolling programme of safeguarding training to inform practitioner's knowledge and skills in order to appropriately identify and address matters of neglect.</li> <li>• The Neglect Task &amp; Finish Group concluded its work in January 2018 reviewing the Neglect Toolkit and Strategy. The strategy and toolkit will be reviewed in in January 2021, with the review process to commence in the summer of 2020. . Neglect remains a LSCB Priority and further initiatives to improve practice and outcomes for children at risk of or suffering neglect will be explored in the 2019-20 year going forward.</li> </ul>
<p><b>Priority 2: Governance and Performance</b> Increasing the effectiveness of the LSCB as a truly effective agent in securing positive outcomes for children, in protecting them from abuse and exploitation.</p>	<ul style="list-style-type: none"> <li>• LSCB Performance Framework reviewed in 2018 was implemented via the MESI Sub-Group. Key indicators from across the partnership were captured and scrutinised within the MESI Task Group.</li> <li>• Consistent audit schedule ensured the monitoring of single and multi-agency audits. A MESI Audit Subgroup was created and multi-agency audits were completed to understand the scope of Contextual Safeguarding issues and the multi-agency response to this issue in Lewisham. A multi-agency audit was also completed to understand the scope of Child Mental Health concerns within Lewisham, including a direct survey of a cohort of children and questionnaire responses from parents alongside agency data and case audits.</li> <li>• Regular scrutiny and challenge of partnership agency data.</li> <li>• Regular meeting of Chairs of Partnership Boards, ensuring consistent safeguarding messages. Further developing these relationships is a priority for 2019-20. Audit outcomes were shared with some partnership boards.</li> </ul>
<p><b>Priority 3: Self-harm and suicide prevention</b> To ensure that parents and professionals are aware of the risks associated with self-harm behaviour and suicide ideation so children and young people can be better supported from harming themselves</p>	<ul style="list-style-type: none"> <li>• The LSCB continues to offer training packages on self-harm, on the LSCB training programme.</li> <li>• The LSCB also provided a Safeguarding Briefing in September 2018 regarding 'Self-harm &amp; Suicidal Ideation &amp; Young People'. This was sent to a wide network of safeguarding professionals across Lewisham and was made publicly available on the LSCB website.</li> <li>• LSCB Development Officer also provided information and resources to raise awareness amongst safeguarding professionals regarding children's mental health and supported an awareness-raising event in conjunction with Children's Social Care.</li> </ul>

**Summary of our Key Priorities  
for 2018 -2019**

**Summary of our Key Achievements for 2018-2019**

<p><b>Priority 4:</b> <b>Voice of the child and community</b> Ensuring that the voices of children and young people influence learning, best practice and the work of the LSCB.</p>	<ul style="list-style-type: none"> <li>• Continuing, regular interface with Young Mayor’s Forum.</li> <li>• LSCB facilitated two events to bring together a number of young person-led school advisory councils and youth advisory groups alongside the Young Mayor’s group and the Children in Care Council to share the safeguarding priorities they had been developing in their respective groups. The purpose of these events was to share ideas across a range of children within the borough and understand the work that these advisory groups were under-taking to inform safeguarding priorities going forward.</li> <li>• Development of the LSCB website to use as an interactive tool with children and young people continues. LSCB Development Officer is planning to update all ‘Children &amp; Young People’ pages on the website with the direct input of young people.</li> <li>• LSCB Introductory Presentations for professionals, young people and community have continued.</li> <li>• LSCB website has continued to improve communication with professionals, parents and carers and the community – web data suggests that the website is frequently viewed for information, signposting and resources. The website has also raised the profile of various safeguarding issues and the work of the LSCB via publication of Serious Case Reviews and provision of guidance for children, parents and professionals around safeguarding in Lewisham.</li> <li>• Monthly themed Safeguarding Briefings have continued, ensuring that key safeguarding messages reach professionals across the partnership and providing links onward to specialist or more detailed safeguarding information. These are also available on the LSCB website.</li> </ul>
<p><b>Priority 5:</b> <b>Missing, Exploited &amp; Trafficked</b> Increasing the effectiveness of agencies and the community in identifying and addressing Child Sexual Exploitation, children going missing and trafficked.</p>	<ul style="list-style-type: none"> <li>• Weekly MET operational meetings have continued to discuss individual cases, whilst monthly MET tactical meetings have continued to look at trends/hotspots of concern and borough-wide intelligence from operational work around MET issues. A quarterly LSCB Strategic MET Task group has continued to guide the wider strategic response to MET concerns within Lewisham.</li> <li>• LSCB MET Strategy reviewed in January 2019 to re-define and the purpose of MET groups within Lewisham and their role in combating Missing, Exploitation &amp; trafficking concerns in the borough. From the refreshing of the MET Strategy and further development of a model of working with MET concerns rooted in Contextual Safeguarding principles, the outline documentation for the LSCB ‘Concern Hub’ was developed, with implementation of the Concern Hub to replace the MET Strategic Task group in the 2019-20 year.</li> <li>• Contextual Safeguarding Multi-agency Audit addendum conducted in December 2018, following on from a previous MET audit in May 2018, developing an understanding of partnership thresholds for working with young people where there were contextual safeguarding concerns.</li> <li>• The LSCB continues to offer multi-agency CSE, Missing &amp; Trafficking training and will look to develop its training offer alongside the developing Concern Hub.</li> </ul>

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## LSCB Task Groups

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### Monitoring, Evaluation and Service Improvement Task Group (MESI)

Chaired by Agency Representative: Nicky Pace, LSCB Independent Chair

#### What did we do?

Last year we developed a new meeting structure to provide greater capacity for challenge and scrutiny of safeguarding issues across the partnership by refocusing the Monitoring, Evaluation & Service Improvement (MESI) group. An operational Audit group was set up, separate from and reporting to MESI to provide greater focus on multi-agency audit function.

The aim of this work group is to support multi-agency engagement and monitor partners' contribution to safeguarding children and young people. It will do this by effectively monitoring, scrutinising and evaluating safeguarding practice undertaken by agencies within Lewisham. It will focus on the quality assurance of multi-agency arrangements, practice and service delivery and identify areas of development and barriers to learning, improvement and change. It will also monitor the LSCB Business Plan and dataset.

#### What was the impact?

It was anticipated that the MESI group would be able to focus on wider safeguarding issues whilst providing scrutiny of multi-agency operational practice issues, particularly where there may not be the opportunity to do so in LSCB Main Board meetings.

Development of a multiagency dataset – considerable work has been undertaken this year to finalise the multiagency data set, those proxy indicators required to monitor performance of safeguarding across the partnership. However, there has been some difficulties this year in the Children's Social Care data, which has slowly evolved so that some safeguarding areas can now be reported upon, but there is more still to be done. The Lewisham and Greenwich Trust has identified and provided a robust performance dashboard. It has continued to prove difficult to receive data from other agencies, which has meant that the analysis of the data and understanding the impact of this upon multi-agency safeguarding arrangements for children continues to be a challenge.

#### Multi-Agency Audits Sub Group - Audits for 2018-19

Chaired by Amanda Harris, Quality Assurance Manager, Children's Social Care

During 2018-2019, we planned and completed a Child Mental Health (CMH) multi-agency audit in conjunction with Greenwich Local Safeguarding Children Board. We also completed a 'live audit' in December 2018 regarding cases where there were contextual safeguarding concerns for young people living in the community (as an addendum audit from a previous MET audit, which was submitted to main MESI subgroup in May 2018). We planned a 'Thresholds' audit, which will be finalised by August 2019. These audits all supported the named LSCB priorities and had been set by the LSCB Main Board.

## Child Mental Health (CMH) Audit

The CMH Audit will be taken to the LSCB Main Board on 26.06.2019, having already been agreed by main MESI; this audit took place over a number of months and highlighted several types of audit activity which shone a light on partner processes and practice locally in responding to concerns about young people's mental health. The analysis of the main themes from the audit activity (multi-agency file audit, practice events, questionnaires, feedback from parents and young people) evidenced the need to consider:

- improvement work across the partnership,
- the further development of joint CMH protocol across agencies (previously recommended from SCR work),
- a review of the CAMHS waiting list,
- development of a way of responding to families and young people which is more immediate and remains in touch with them where they are referred to CAMHS,
- consideration of longer interventions than are currently commissioned locally,
- the development of clear multi-agency 'step down' processes and services for young people to access for post CAMHS work.

When considering any changes needing to be recommended as a result of previous learning or priorities, the CMH Audit identified a need for improved care planning across agencies when considering work with child mental health issues. This is a theme that has been identified in previous audit and serious case reviews and will benefit from MESI scrutiny going forward to share learning and support improved multi-agency care planning for children with mental health issues.

## Missing, Exploited, Trafficking Contextual Safeguarding Audit & Addendum

A previous MET audit (missing, exploited and trafficked children) which was completed in May 2018 was presented and agreed by main MESI subgroup, but was not then finalised by the LSCB Main Board. It was agreed that more work was to be undertaken. This report with the subsequent addendum work, the 'Live' contextual safeguarding audit, from December 2018, will be put to the LSCB Main Board on 26.06.2019. This report will provide a fuller picture of work across the partnership with children at risk of going missing, being exploited or trafficked. The first MET report was shared with the MET Task group and Youth Offending Service (YOS) in September 2018 to assist consideration of future strategic development of work with such young people, as was also reported on last year in the LSCB 2017-18 Annual Report.

The latest addendum audit report will also consider partnership thresholds for working with contextual safeguarding risks for older young people on the cusp of adulthood will recommend that a piece of outstanding practice be shared more widely across the partnership.

Changes made as a result of this previous learning and in working toward LSCB priorities are hard to measure at this stage whilst resultant actions are being completed to complement wider strategy across the partnership. In CSC, there is considerable work being undertaken in relation to intervening in contextual safeguarding issues, including a service re-design, refresh of the hub arrangements for sharing information, assessing risk and immediate responses and the establishment of a dedicated service for this cohort of children in the Early Help offer. This has included strengthening partnership arrangements. All of the above work fits with the current priorities of the LSCB.

The third audit regarding thresholds in MASH is being collated and will be reported on in August 2019.

### Impact of audit

The impact of the CMH audit and the MET and 'Live audit' will be clearer in time as actions are implemented as noted above. The participation events were well attended by partners regarding CMH, a subject most professionals are aware of and interested in. Education and Health partners report that the impact of undertaking multi-agency audit activity alongside other demands for audit in their agencies is at times very challenging. GPs historically and currently are not able to complete case file audits or attend audit events easily, and the GP Designated Lead has had to find ways to support other health professionals to complete case file audits.

Where there were tasks to follow up from audit activity this has happened, particularly on contextual safeguarding cases; respective CSC Service Managers have ensured they have tracked actions. Learning from multi-agency audits needs to become more widely disseminated into partner agencies and routes and opportunities for this to happen developed; this could be linked to learning from Serious Case Reviews (SCRs), given the new proposed LSCB/LSCP partnership arrangements.

Views of parents/carers/children/young people were included in the CMH audit work. Surveys of young people during other LCSB events were helpful and highlighted the need to think more creatively across the range of LCSB activities. In audit work, we need to develop the understanding of consent and information sharing across the partnership especially when older children's consents are needed, to improve audit planning and improve best practice. Some designated leads and partners required some support when considering safeguarding issues

within the principles of audit under safeguarding board activity, consent dispensation and when to seek consent from parents and young people to support practice and support audit. Audit tools regarding consent need to be further developed; a subgroup of partners could lead on this work.

### **What we plan to do next?**

Audit themes need to be set and discussed by partners in relation to the new partnership priorities. The voices of children and feedback from service users should be planned for in audit work as this was previously under-developed. Improvements in the CMH Audit along with practice events and the use of SCIE methodology should be further supported.

Consistent partner participation in audit work would improve audit activity across the partnership and further exploration is needed to understand how best to engage partners in multi-agency audit activity alongside their daily safeguarding roles. Use of a strengths-based and appreciative style in audit work has been well-received and should continue.

Thresholds regarding MASH and partnership working from the early analysis of the current Threshold Audit require ongoing audit. Information sharing between partners and how confident partners are about this needs to be considered further. Contextual safeguarding, neglect and domestic abuse remain local key areas of enquiry, along with the involvement of fathers and family networks in multi-agency work to safeguard children.

Audit tools need further development aligning these to the Signs of Safety practice model. Tasks arising from audit need to be tracked, actioned and reported on by partners, with this being less developed in the work to date and the MESI group needs to consider how to most effectively support audit work via contextual

information analysis and liaison with the audit chair to increase audit capacity and timeliness.

#### Example of effective practice

There were examples of good practice throughout the audit work, but one case in particular, the live audit demonstrated good multi-agency partnership working; the questionnaires for young people used at an education summit represented a good use of forums to gain feedback and should be further developed (see above); practice events were well received and were a useful way of engaging safeguarding partners.

#### **What do we plan to do next?**

The MESI will continue in a different form under the new arrangements and the next year. The partnership aims to have a clear and shared understanding of the data so that we have a shared language to articulate the challenges and the impact we want to make. It also aims to have performance measures that are based on a shared understanding of what success should look like from the perspective of children, young people and their families.

The purpose of this group will focus on monitoring and evaluating the effectiveness of what is being achieved the partners, individually and collectively. Multi-agency audits help to measure the quality, effectiveness and outcomes of safeguarding work across the partnership. Members of this group participate in audit activities including case audits, interviews with children, young people and parents, surveys, consultations and discussions with practitioners and triangulate this information to establish the quality of safeguarding delivery, identify areas that require further improvement and influence system change.

It will ensure plans are delivered including the actions arising from the SCRs currently being undertaken. It will hold partners to account for their safeguarding practice during the transition to the new safeguarding arrangements and any changes to partnerships structures. It will also hold the LSCB Board partners to account for the delivery against the identified safeguarding priorities for 2019-20.

### **Policies Procedures & Training Task Group (PPT)**

Chaired by Belinda Chideme, Trust Lead Named Nurse – Lewisham and Greenwich NHS Trust and Dr Sian Morgan Named Doctor University Hospital Lewisham

#### **What did we do since the last year? (in relation to safeguarding children or to support the LSCB priorities 2018/19)**

- Policies and guidelines which have a multiagency interface have been reviewed and updated in line with changes in national legislation :
  - Protocol for the Management of actual or suspected bruising in immobile infants
  - Information & Referral to LADO Process
  - Domestic Abuse Policy
- Learning from Serious Case Reviews is reflected in the Training programme – 4 sessions specifically about the recently published SCR's have been advertised.
- £800 saving by moving Safeguarding Level 2 to online, and offering more Safeguarding Level 3 classes.
- New courses added to the training programme as a result of learning from serious case reviews.
- For the first time LSCB afternoon briefings being delivered at Lewisham Hospital to ensure clinical staff have the opportunity to attend.

- The first Early Help Champions ‘train-the-trainer’ training session was held. The objective is for all partner agencies to identify professionals who can attend the session – so they can train more professionals within their respective agency.

## What do we hope to achieve in the next year?

- Training course on Male Victims of Domestic Violence to be added to the MARAC training programme.
- Specific action to increase enrolment to LSCB courses by practitioners working in voluntary and faith organisations.
- Discussions to be held with Greenwich in light of the anticipated changes from LSCBs to Safeguarding Partnerships.
- To have Early Help Champions from all LSCB partner agencies trained and delivering training in their respective agency.
- To have the LSCB website act as a first point of contact or directory in regard to available safeguarding training and resource from various organisations, voluntary and statutory.
- Partner agencies to continue to offer relevant training courses, their service can deliver via the LSCB Training Programme.
- There will be an increased focus on including sessions that will enable practitioners to formulate strategies to listen to the voice of the child – including those with complex health and social needs.
- The LSCB currently has Female Genital Mutilation (FGM) sessions delivered by the African Advocacy Foundation this is a West African organisation which focuses on West African practices. In the next year the LSCB will include ECRO – they focus on the Kurdish Pakistani community. Changes are being

made in recognition to the different challenges and client groups the respective organisations work with.

- Policies and guidelines which have a multiagency interface will continue to be reviewed and updated to ensure they are in line with national legislation, including:
  - Children not brought an appointment
  - Parental Mental Health & Child Welfare Protocol
  - Forced Marriages
  - Working with Parents who Misuse Substances

## Challenges/risks?

- A relatively high number of PPT members have not attended meetings, which has an impact on the completion or closure of actions.
- A number of training courses are under-subscribed, which can result in the sessions being re-arranged or if necessary, cancelled. A wider issue across the training program is non-attendance by professionals who have booked a training course, thus reserving training places that are not always utilised.
- The matter regarding whether private nursery staff are expected to pay to attend sessions needs to be resolved – as private nurseries do not contribute to the LSCB – yet they are one of the agencies with a high number of subscribers.

## Example of effective practice?

- The lunchtime briefings covering serious case reviews will be facilitated jointly between Health and Children’s Social Care professionals.

## How has the voice of the child been considered?

- A good number of the training sessions provide an opportunity for practitioners to formulate strategies to listen to the voice of the child – including those deemed to have mental capacity but are vulnerable and those with complex health and social needs i.e. diminished mental capacity.

## Case Review Panel (CRP)

Chaired by: Nathan Glew Service Manager, Quality Assurance, Lewisham Council Children Social Care

## Case Review Panel (CRP)

Chaired by: Karen Neill, Interim Service Manager, Quality Assurance, Lewisham Council Children's Social Care, until May 2018 and then by Nathan Glew, Head of Quality Improvement, Lewisham Council Children's Social Care, from June 2018.

## What did we do?

In 2018/2019 the group met on five occasions and undertook the functions of:

- Determining whether cases met the Working Together 2015 criteria for a Serious Case Review (SCR) or a Learning Review.
- Managing the transitional arrangements towards Child Safeguarding Practice Reviews following the introduction of Working Together 2018, including convening Rapid Reviews within timescales set by the new National Child Safeguarding Practice Review Panel from 29.06.2018.
- Making a recommendation to the Chair of the LSCB in relation to the type of reviews to undertake.
- Commissioning Learning Reviews and/or SCRs.

- Managing the process of completing Review reports.
- Overseeing that actions and recommendations were implemented and learning was embedded within agencies.

This work enabled the LSCB to undertake its statutory functions in relation to SCRs. The process has been to review what is known about a case, gather initial information from agencies (such as chronologies) and then make a

recommendation about whether the criteria for a SCR is met. If a SCR was commissioned, the group managed the production of the SCR report and considered any potential media interest.

When the criteria for a SCR was not met but there were possible learning/key issues arising from the case, the Panel might then recommend a multi-agency case Learning Review to ensure actions were taken and learning implemented to improve safeguarding practice.

## What was the impact?

In 2018/2019 the group met five times to consider ten serious incidents and make recommendations to the LSCB Independent Chair. Through the transitional arrangements between Working Together 2015 and 2018, the National Panel began to introduce a requirement for Rapid Reviews following notification, four of which have now been undertaken.

One case met the criteria for a SCR and was commissioned to have an independent reviewer with considerable relevant experience. This SCR is currently in the final stages of report writing.

Four other cases were identified as requiring multi-agency Learning Reviews and in three of these cases, independent reviewers were commissioned. All three are currently near completion. For the most recent Learning Review, a decision was

taken to pilot the use of an Appreciative Inquiry model of reviewing, led by an interim Head of Service in Children’s Social Care, using a single multi-agency practitioner event which has yet to take place. The aim of this is to increase opportunities for multi-agency collaborative learning and strengthening partner working relationships, as well as reducing bureaucracy.

One other case, whilst not meeting the criteria for either a SCR or Learning Review, was identified for a Serious Incident Review undertaken by Health Services and an Internal Management Review undertaken by Children’s Social Care. The learning from both reviews will be collated and shared across the new Lewisham Safeguarding Children Partnership (LSCP) which replaces the LSCB in response to the Children and Social Work Act 2017.

LSCB partners are also currently contributing to a SCR being undertaken by Wandsworth Safeguarding Children Board under Working Together 2015.

A decision was also taken to undertake a Domestic Homicide Review (DHR) rather than a SCR or Learning Review, in relation to a young person, particularly as she had not long been resident in Lewisham at the time of her death and was therefore not known to LSCB partner agencies.

At the beginning of 2018/19, three SCRs were current which have all now been concluded and are awaiting publication in August 2019. In addition to the LSCB website, all SCRs are published on the NSPCC website. The repository provides a single place for published case reviews to make it easier to access and share learning at a local, regional and national level.

An issue of national significance has been the rise in serious incidents relating primarily to contextual safeguarding issues, such as “county lines,” gang related activities and criminal and sexual exploitation. The above Domestic Homicide Review has been included in the National Panel’s first thematic review, which has a focus on criminal exploitation. In this context, the CRP has been involved in an

ongoing discussion involving Ofsted, the National Child Safeguarding Practice Review Panel, and the Department for Education in relation to the criteria for notification and local or national Child Safeguarding Practice Reviews. Where the CRP has recommended such incidents have not met the criteria for SCRs/Learning Reviews/Practice Reviews, the National Panel has accepted its recommendations for their inclusion in a local thematic review of homicides and attempted homicides in Lewisham from January 2017 to December 2018, overseen by the Safer Lewisham Partnership and supported equally by the Lewisham Safeguarding Children Partnership and the Lewisham Safeguarding Adults Board.

The CRP has overseen the learning from SCRs, Learning Reviews, and Child Safeguarding Practice Reviews, to support partner agencies to implement recommendation and learning.

### What we plan to do next?

The CRP will be developed into the “Learning from Practice Group” in the LSCP and will work closely with MESI and the other sub groups of the partnership to develop a broad culture as a learning organisation and a dynamic self-improving system. This will include giving consideration to: the development of a Learning Hub approach; more appreciative and collaborative learning models of undertaking reviews; and how we better learn and improve from good practice, for example via Serious Success Reviews.

We will be working to create combined key messages from practice reviews, delivering consolidated learning and promoting improvement across the partnership.

We will work with the coming Concern Hub and national partners to further clarify the most effective criteria and processes for notification and review in relation to serious incidents concerning contextual safeguarding issues.

We will further develop and embed our processes for ensuring effective Rapid Reviews, (including their relationship with Child Death Overview Panel “Rapid Response” meetings) following notification to the National Child Safeguarding Practice Review Panel.

## Child Death Overview Panel (CDOP)

Chaired: Pauline Cross, Consultant Midwife in Public Health and Senior Public Health Strategist, Public Health team, London Borough of Lewisham.

### What did we do? (In relation to safeguarding children or to support the LSCB priorities 2018/2019)

Chapter 5 of Working Together to Safeguard Children 2015 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 new statutory guidance published in July 2018 will see changes to this process in the coming year. Currently, Child Death Overview Panels (CDOPs) are the means by which local LSCBs discharge this responsibility. Babies who are stillborn and planned terminations carried out within the law are excluded from the review.

Panel members decide what, if any, actions could be taken to prevent such future deaths and make recommendations to the LSCB or other relevant bodies so that action can be taken. CDOP referred 3 deaths to the SCR panel during 2018-19, 1 of which was taken forward by the SCR panel, 1 was taken forward for a domestic homicide review and 1 was not taken forward.

Lewisham CDOP received 27 child death notifications from 1st April 2018 to 31st March 2019 of which 13 were unexpected deaths. This was the same figure as the previous year. The complexity of the deaths reviewed has continued to be of

concern this year and included deaths in which there were significant concerns about the wider family and in particular the siblings of the child that died.

More detailed analysis on all deaths of Lewisham children will be contained within the CDOP annual report which will be completed later this year.

A total of 25 deaths were reviewed by Lewisham CDOP over the course of 2018/19 though some of these deaths occurred before 1st April 2018. 17 of the deaths reviewed (68%) had modifiable factors. 7 (28%) of the 25 deaths were related to perinatal/neonatal events, extreme prematurity being the leading cause of death in Lewisham and nationally. 5 (20%) of deaths were due to sudden unexpected death in infancy and 4 (16%) to chromosomal, genetic or congenital abnormality.

### Example of effective practice

In line with one of the main purposes of CDOP, i.e. to learn from the tragic deaths of children in order to prevent future deaths, Lewisham CDOP has initiated a number of work programmes to ensure learning is disseminated among partner agencies.

These include:

- Continuation of a Safer Sleep/Prevention of SIDS training programme to health professionals, foster carers and children’s centre staff in Lewisham
- Prevention of Prematurity research trial (POPPIE trial) at LGT supported by academic partners, which commenced in May 2017 has now completed and is due to report in July 2019
- CDOP Newsletter sent out 3 times a year to Lewisham and Greenwich Hospital (LGT) staff, GPs and other partners to share learning from our reviews

- Audit of support given to children, young people and parents when children present to A&E with self-harm or a suicide attempt. This identified gaps in information giving. The audit lead, under the supervision of CDOP has produced information packs which will be given to young people and parents aiming to promote good mental health and enable young people and their parents to be informed about support available when they are discharged
- CDOP has continued to facilitate the discussions between LGT and the Mayor's Office for Policing and Crime (MOPAC) and these discussions have secured agreement that MOPAC funding will enable the siting of a youth service in the A&E departments in Lewisham and Greenwich in order to reduce youth violence and better support young people attending A&E.

## Missing, Exploited and Trafficked (MET) Subgroup (to be re-named as 'Concern Hub')

Chaired by Geeta Subramaniam-Mooney Director Public Protection and Safety, Andy Furphy Detective Superintendent Police, Lucie Heyes Director Children Social Care.

### What did we do?

The Borough developed a forward-thinking model in 2016 which did not focus on 'labels' of types of risks such as youth offender/ CSE; but took an approach which recognised the drivers and multiple complex issues that affect children and young people as well as focussing on preventative aspects and earlier support. The Missing, Exploited and Trafficked strategy was developed alongside a Serious Youth Violence Prevention Panel.

Following on from this, the LSCB is planning to move to a 'Concern Hub' model. This model came from current structures being reviewed, taking into account a number of changes in our understanding and focus on a public health/whole systems approach to violence as well as rationalising multi agency actions for exploited children.

The Concern Hub model will work with children and young people up to the age of 25 primarily, includes missing, Child sexual exploitation, child exploitation, harmful sexual behaviour, county lines, serious youth violence and gangs.

The focus of the change is to:

- Provide a preventative offer of support for the client and family with earlier identification of risk
- Provide a multi-agency forum to jointly risk assess/ safety plan and agreed joint actions and lead agency
- Use a contextual safeguarding approach to make short/ medium and longer term change
- Join up resources across a cohort of children and young people to avoid duplication

The focus will remain on:

- Under 25 year old young people
- Using the Violence Reduction Hub Model as a basis
- Including Missing, Exploited and Trafficked cases
- Including the current Serious Youth Violence cohort of Red, Amber
- Including Habitual Knife Crime subjects
- Including the green cases from the Met Police Gangs Matrix

## Outcomes from the Concern Hub:

These will be reviewed quarterly, but initially the performance framework will include:

Borough wide:

- Reduction In Violence with Injury
- Reduction In Knife crime
- Reduction in violence with injury knife crime
- Improved response to CSE and Child exploitation

For those on the cohort of the Concern Hub:

- Reduction in Concern
- Positive change in involvement in education, training or employment
- Stable accommodation
- Progress regarding wellbeing

Safeguarding outcomes:

- Understand and better co-ordinate the risks of exploitation (link to Rescue and Response)
- Mapping peers and creating plans that address safeguarding needs including siblings and parents
- Focus on perpetrators to prevent repeated victimisation and break cycle of exploitation
- Trauma-informed and strength based approaches to reduce fear, increase hub staff wellbeing and capacity to manage stress and Vicarious Trauma.

## What is the anticipated impact?

It is anticipated that the Concern Hub's multi-agency response within a contextual safeguarding approach will have a significant impact for children and young people at risk of going missing and/or at risk of exploitation or violence.

Impact will be measured through the Concern Hub dashboard, which will provide detailed information which will support analysis of:

- Trends
- Key concerns
- Interventions used and impact in reducing concern

The impact of the Concern Hub will be monitored through the quarterly SLCB Concern Hub Strategic Meeting.

## What we plan to do next?

- Review the Concern Hub's impact and explore opportunities for evaluation once this initiative goes live
- Increase partners to support the interventions and work of the Concern Hub
- Use findings from the work of the Concern Hub to inform commissioning decisions

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## LSCB Statutory Functions

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### Children's Social Care

Lewisham Children's Social Care experienced a number of changes through 2018/19, prompted by a programme of reviews during spring and summer 2018, which identified the 2016–18 programme of improvement was not having sufficient impact. The improvement plan was refreshed through the summer of 2018 following the appointment of a new permanent Director of Children's Social Care (Lucie Heyes) and the establishment of an Improvement Board, chaired by the Lead Member for Children's Services (Cllr Chris Barnham). With renewed energy and council support the improvement programme has picked up the pace of change and started to improve safeguarding and looked after services for children and families.

Compared to other London Boroughs, Lewisham has higher than average numbers of children subject to child protection plans, court proceedings and coming into care (becoming looked after). Part of the improvement programme is to bring these numbers down to be comparable with others. The way we are doing this is by working differently with families and taking a more proportionate approach to managing risk. In early 2019 Children's Social Care began implementing a new Signs of Safety social work practice framework, which is aimed developing a more collaborative style of practice putting the child, young person and their naturally occurring network of support at the very centre of creating safety. The key areas of improvement are:

- To strengthen the Multi-Agency Safeguarding Hub (MASH), which is the referral route for all children for whom people may have safety or welfare concerns. In July 2018 a focused visit from Ofsted recommended a number of improvements to the MASH. These recommendations are being followed up, to improve the service provided at the front door.
- To increase management oversight has been to support newly qualified social workers and help ensure children and families are receiving the right services at the right time.
- In January 2019 Children's Social Care introduced a new performance and quality assurance framework to help improve standards of practice, they are also in the process of re-designing their ICT systems, reduce bureaucracy to enable social workers to spend more time with families.
- A new workforce development programme is in development to reduce the number of changes that children and families experience and to ensure social workers have the skills and knowledge to work with some of the most challenging situations.
- Young people at risk of exploitation and violence in the community is a growing area of concern and plans are underway to develop a specialist team to work closely with partners in youth offending services and police to find effective ways to keep young people safe in the community
- For children with disabilities a number of improvements have been made, such as training for social workers on different communication methods, a new care package team has been developed to better support families with complex care packages. A new transition team is being established to better

help young people transitioning to adults care services when they reach adulthood.

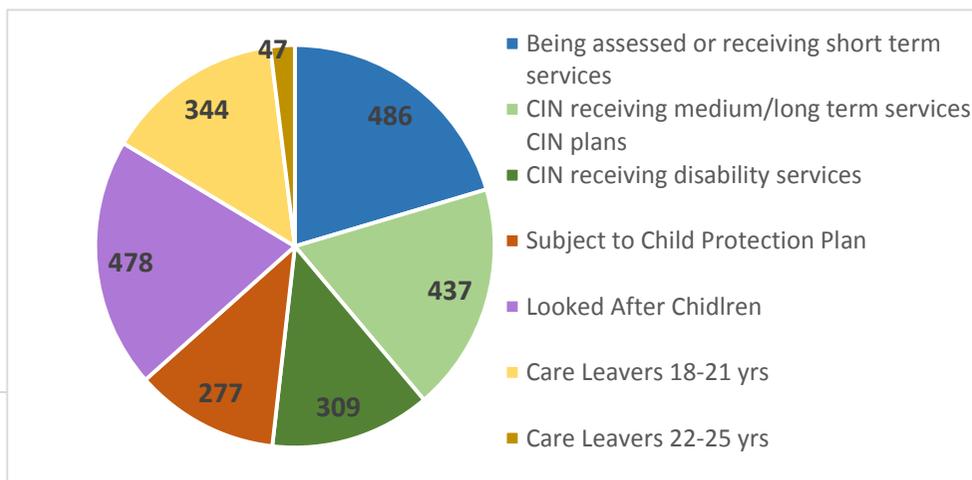
- A new foster carer recruitment strategy to attract more local residents to become foster carers for our looked after children. This is to help our most vulnerable children in care to remain local and connected to their families, schools and communities.
- To develop a new Early Help Strategy to ensure that families below the children’s social care threshold receive support to avoid escalation.

The improvement plan sets out a three year programme, with further changes to be made through 2019 – 2021. Lewisham is expecting a full Ofsted inspection in 2019, where services and the improvement plan will be comprehensively reviewed by the regulator.

Details of Lewisham Children’s Social Care Children in Need and performance benchmarked against other Local Authorities can be found at:

<https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2018-to-2019>

As at 31/12/18 Lewisham Children’s Social Care was working with 2,378 children.



## Lewisham Early Help, Multi-Agency Safeguarding Hub (MASH) & Children at risk of Missing, Exploitation & Trafficking

Lewisham’s Multi-Agency Safeguarding Hub (MASH) continues to build upon the strong multi-agency membership developed since its inception. After a refresh in January, the MASH has been refining its multi-agency response to notifications from professionals and members of the public, on the welfare of children. The MASH is a ‘single front door’ triage system, which makes a swift initial assessment of the child’s needs against the LSCB Continuum of Need (CON).

The MASH aims to identify which children can be supported either by universal services in the community or via the local Early Help offer (CON Level 1 and 2) and which require a statutory social work assessment (CON Level 3 or 4) in a 24 hour period. Through 2018-19 the MASH received 18,706 contacts, on average 1,559 per month. Of these 22.2% (4170) met the threshold for a Children’s Social Care statutory social work assessment of need and in some cases, for a s.47 Child Protection Enquiry, which may also involve the police.

At the time of writing, a review of services for children at risk of going Missing or being Exploited or Trafficked (MET) is underway in conjunction with the LSCB. A new operational and LSCB strategic group (the ‘Concern Hub’) is in the process of being developed to provide support to safeguarding professionals working with children who may be at risk of going missing from home or care, being exploited or trafficked. It is anticipated that the Concern Hub will meet quarterly to look at strategic safeguarding issues and initiatives in these safeguarding areas, including developing an enhanced dataset that will support auditing going forward. The review of Children’s Services work around missing, children at risk of exploitation and trafficking is also considering re-organisation of some service areas to provide a dedicated staffing resource to enhance practice and support the introduction of a contextual safeguarding approach with these children and young people.

## Looked After Children (LAC)

There were 491 Looked After Children in Lewisham at the end of March 2019. Looked After Children and 18–25 year old young people who have formerly been in care combined comprise over 35% of all children and young people that Children’s Social Care are working to safeguard, support and care for at any given time. Services for Looked After Children receive separate council scrutiny via the Corporate Parenting Board. The LSCB and its successor safeguarding body in Lewisham will maintain a close relationship with the Corporate Parenting Board. The LSCB will also work with Children’s Services as the review of services to oversee and scrutinise multi-agency arrangements to safeguarding Looked After Children who go missing and are at risk of exploitation, trafficking and abuse.

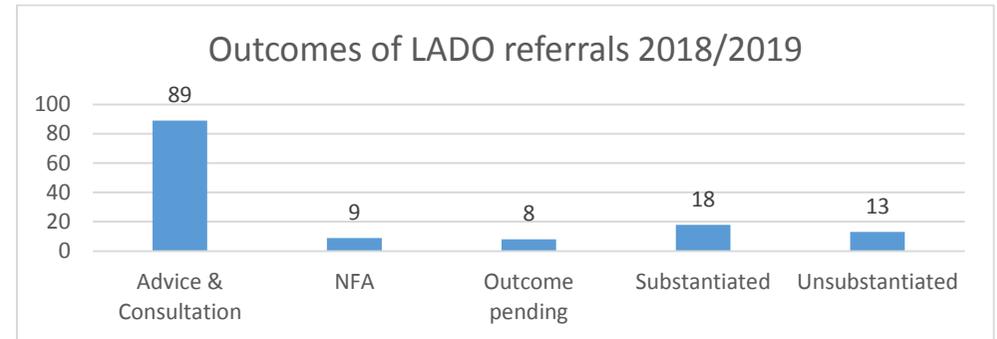
Children’s Services continues to work towards improving the physical, emotional health and education outcomes for Looked After Children and retains a focus on ensuring placement stability for children in care to provide a solid, supportive base for Looked After Children to thrive and achieve.

## Designated Officer (LADO)

The Local Authority Designated Officer (LADO) in Lewisham fulfils the local authority duty outlined in Working Together 2018 *“to be involved in the management and oversight of allegations against people who work with children.”* The LADO receives contacts relating to allegations of this type for oversight and for direct investigation where required.

In 2018-19, the LADO received 342 contacts, an increase of 10 since the previous year. Many of these contacts were initially resolved by providing advice, whilst 40% were taken forward for further investigation. Of the 137 LADO contacts that became investigations, 129 were concluded at the end of 2018-19, of these the

allegations were found to be substantiated in 18 cases (14%). In the majority of situations the circumstances can be managed through advice and consultation; 68% of cases are resolved within 7 days, 90% in 31 days.



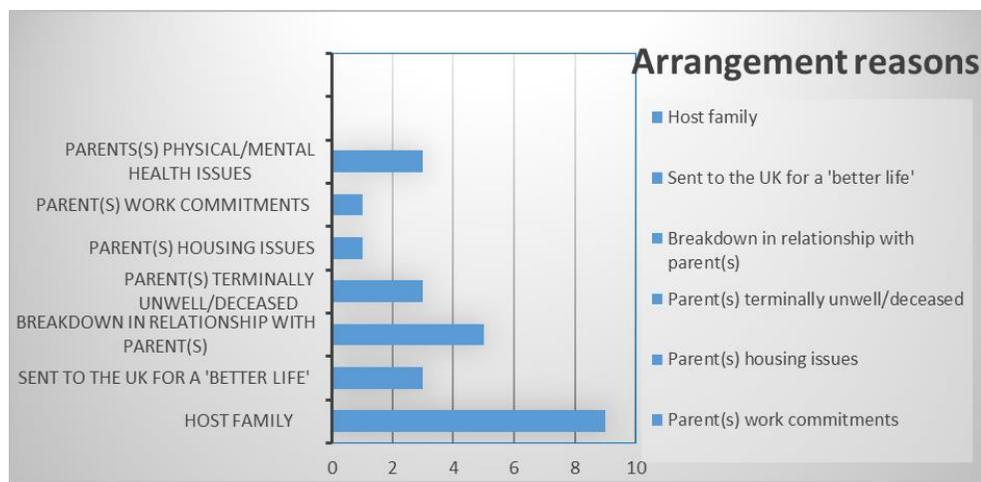
## Private Fostering

Private fostering is defined as ‘a child who is under the age of 16 (18 if disabled) and who is cared for, and provided with accommodation, by someone other than the parent a person who is not the parent but who has parental responsibility, or a close relative defined in this context as a brother, sister, aunt, uncle, grandparent or step-parent.

Children in private fostering arrangements are potentially vulnerable and the Local Authority must be notified. During 2018/19 Children’s Social Care received 25 notifications of new possible arrangements in Lewisham, a decrease from 2017/18 (No.43). The decrease is due to one of the main agencies for a private language school ceasing to host international students. Lewisham continues to have a number of international students staying with host families. There has also been an increase in the number of young people whose relationship with their parents has broken down and they are staying in Private Fostering arrangements. We also

have a number of children who have been sent to the UK to stay with family members for a 'better life'.

Notifications are received from the Home Office, Schools, Host agencies, CAFCASS and with the Council or from other Councils. 14 of the 25 notifications received were assessed as new Private Fostering arrangements, this combined with 10 known existing arrangements means there are 24 Private Fostering arrangements being monitored by Children's Social Care. The vast majority of arrangements are assessed as providing safe care for the children.



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## Partnership Activity to Safeguard Children

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### Lewisham and Greenwich NHS Trust (LGT)

Chaired by/Agency Representative: Belinda Chideme, trust lead named nurse for safeguarding children, Lewisham and Greenwich NHS Trust

### What did we do? (In relation to safeguarding children or to support the LSCB priorities 2018/2019)

Evidence for and evaluation of effectiveness

Key performance indicators are monitored and reported on a quarterly basis to the Lewisham Safeguarding Children Board and monthly to the Lewisham Clinical Commissioning Group.

Due to active involvement with three safeguarding children boards, the Safeguarding Children Team undertook a range of audits this past year including audits into the effectiveness of supervision and training, the quality of record keeping across community and acute sites and the appropriate management and risk assessment (RAG rating) of paediatric ED attendances.

The Safeguarding Children Team contributed to a Lewisham Safeguarding Children Board (LSCB) Multi Agency Deep Dive Audit: Child Mental Health and Well-being. This was also a joint audit with the Greenwich Safeguarding Children Board (GSCB). The results and recommendations were shared with all partners.

As of 01.04.2018, the data collected for Emergency Department (ED) attendances has been extended to include themes around child sexual exploitation, gang/youth violence activity, missing and trafficking.

#### Changes made as a result of previous learning/priorities and new developments

The LGT's safeguarding children training has been updated in line with changes made to the Intercollegiate Document: Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019).

The LGT's safeguarding supervision policy has been updated to reflect national and local changes and incorporates feedback and findings from previous audits. Safeguarding supervision has been extensively re-mapped to widen the breadth of professionals receiving this within LGT.

Other policies that are currently being updated include the 'Was Not Bought' policy and the overarching 'Safeguarding Children and Young People' policy.

Learning events have been delivered following findings from recent serious case reviews.

#### Fit with and contribution to LSCB current priorities

Themes around neglect, self-harm, child sexual exploitation and children and young people missing, trafficked or involved in serious youth violence are addressed within current training.

Any attendance to ED in which the above concerns are analysed at the weekly ED safeguarding meeting, to ensure robust actions have been taken to safeguard the children / young people involved.

The Trust has contributed towards three learning reviews and two SCR's which are currently awaiting publication.

## What was the impact?

### Views of parents/carers/children/young people

The Trust uses the Friends and Family Test and encourages participation from parents and children.

Parents and children (if age appropriate) are invited to meetings where their care is discussed and where hearing the voice and wishes of the child is actively encouraged.

Improvements this year-what are we doing better as a result of the activity?

All three local Safeguarding Children Boards have shared their plans. Bexley had already shared plans to be a standalone partnership. Lewisham and Greenwich have one Business Manager, but they have kept the respective subgroups separate. The Child Death Overview Panel will be joint between Lewisham, Greenwich and Bexley.

Level 3 training now includes a session delivered by the Named Nurses; the session is dedicated to disseminating learning from local serious case reviews. The plan is for the Named Nurses to deliver a session based on 2 reviews which involve

children who were known to Lewisham and the Greenwich hospital/services. The training now includes specialist topics presented by an external speaker.

Enhanced supervision has been introduced. This is a forum in which senior service leads can discuss complex cases and / or those cases which involve a large number of professional input. This was devised following learning from a recent serious case review.

## What we plan to do next?

### Challenges and priorities for this year (2019/2020)

A key challenge this year has been in reaching compliance with Level 3 Safeguarding children training. Key staff groups have been identified where low compliance is an issue and support has been put in place to overcome any barriers to accessing training.

To continue to build frontline staff knowledge and competence in the early identification of vulnerabilities and thereby enable a quick response (early intervention).

To review and strengthen safeguarding processes, safeguarding supervision and practice within maternity services.

To strengthen safeguarding supervision provision and embed a new enhanced (multi-agency) supervision model.

To continue to roll out safeguarding supervision across site for community midwives and specialist midwives.

To raise the profile of contextual safeguarding and an understanding of early help services, across all sites.

To review and strengthen frontline staff knowledge on FGM and Harmful Practices.

To participate in partnership initiatives aimed at supporting children and young people at risk of child sexual exploitation, gang/youth violence activity, missing and trafficking.

## Safer Lewisham Partnership

### For 2019-2020 the Partnership seeks to focus on:

- In taking a public health approach to tackling violence there will be a collective and whole system approach to reducing exploitation, harm and violence.
- The partnership will build on the foundations in place towards making Lewisham a trauma informed borough;
- The strength of our response places equal focus on victims and perpetrators to help support and bring about positive change

**In taking a public health approach to tackling violence there will be a collective and whole system approach to reducing exploitation, harm and violence.**

(See Lewisham's Public Health approach to Violence Reduction - <https://lewisham.gov.uk/inmyarea/publicsafety/our-public-health-approach-to-reducing-violence> )

**Violence is not normal nor acceptable.** Many of the factors that may lead to violence include exposure to violence, experiences to adverse childhood experiences and the environments in which we live from birth to older age. Greater understanding of these aspects will seek to promote preventative approaches, promote protective factors and build resilience for individuals and the community as a whole. Violence prevention needs to be seen as a key part of tackling inequalities.

**Lewisham is taking a public health approach to reducing violence** which means:

- Understanding the extent of all violence, where and how it happens and who is affected to better inform including youth violence, domestic abuse, and sexual violence.
- Understanding that violence damages physical and emotional health and can have long-lasting negative impacts. It increases individuals' risks of a broad range of health damaging behaviours – including further violence – and reduces their life prospects in terms of education, employment and social and emotional wellbeing.
- A wide range of factors relating to individuals, their relationships, and the communities and societies in which they live can interact to increase or reduce vulnerability to violence. Issues such as Adverse Childhood Experiences (ACEs) can have significant impacts on families.
- There are a wide range of strategies that can be used to address risk factors for violence and promote protective factors across all ages. Some can be implemented universally and others are targeted specifically. Using evidence based models will shape impact.
- Working with the strengths that exist in communities to listen and collaborate on designing solutions together.

- Dialogue that challenges social norms aim to prevent violence by making it less socially acceptable.
- The safer Lewisham partnership will play a significant coordinating role through the newly formed violence reduction board.

**The Aim is to:**

- Reduce the impacts and actual violence across Lewisham
- Identify the causes of violence in Lewisham, and act to deliver short and longer term reductions
- Listen and work with communities to build on their strengths and deliver solutions together.
- Create a learning environment for continuous improvement.
- Impact positively on wider social, economic and health outcomes for our residents.

**The partnership will build on the foundations in place towards making Lewisham a trauma informed borough;**

“**Safety**—Throughout the organisation, staff and the people they serve feel physically and psychologically safe.” **Guiding Principles of Trauma-Informed Care, 2014.**

“A **trauma-informed** service system and/or **organisation** is one in which all components of the system have been reconsidered and evaluated in the light of a basic understanding of the role that violence and **trauma** play in the lives of people seeking or referred to services.

**ACES** provide a measure of traumatic experiences in childhood are used to influence prevention and predict future harm. According to Scottish research people with 4 or more Adverse Child Experiences ( abuse,neglect, household dysfunction) are:

- **14** times more likely to have been a victim of violence over the last 12 months
- **15** times more likely to have committed violence against another person in the last 12 months
- **16** times more likely to have used class A drugs
- **20** times more likely to have been incarcerated at any point in their lifetime.

**Lewisham will aim to adopt the following principles and apply to organisations throughout the borough:**

- **Safety** – creating spaces where people feel culturally, emotionally and physically safe
- **Transparency and Trustworthiness** – full and accurate information about what’s happening and what's likely to happen next
- **Choice** – an approach that honours an individual’s dignity
- **Voice** – creating the opportunity where the individuals views, opinions and feeling are heard and acknowledged
- **Collaboration and mutuality** – healing happens in relationship and partnerships with shared decision making
- **Empowerment** – Recognition of an individual’s strengths. These strengths are built on and validated.

To achieve these outcomes the following is needed:

- **Realising the prevalence** of trauma through a consistently applied training program

- **Recognising and supporting** how stress and fear affects all individuals involved with the program, organization or system, including its own workforce
- **Resisting re-traumatisation**, labelling and re-victimisation
- **Responding** by putting this knowledge into practice. The Trauma Recovery Model responds to readiness of intervention to underlying need.
- **Restorative**: Using conflict or an incident as an opportunity to repair harm and heal relationships

## The strength of our response places equal focus on victims and perpetrators to support and bring about positive change

### Studies of trauma among groups of young people found that:

- 91% of violent young offenders have experienced abuse or loss
- 40% of female and 25% of male youth in custody have suffered violence at home
- 33% of female offenders have suffered sexual abuse

Research also indicates that offenders are more likely than non-offenders to have suffered adverse effects from traumatic experiences, which appear to be linked to offending behaviour. Trauma can result in inappropriate aggression and is strongly associated with a range of problematic behaviour including violence, antisocial/criminal conduct, sex offending and substance misuse. We understand that many child and adult offenders will have been subject to a range of adverse experiences, from substance misuse problems, difficult family backgrounds including experience of childhood abuse or time spent in care, unemployment and financial problems, to homelessness and mental health problems and this knowledge underpins our trauma informed, restorative approach to tackling offending. However we also acknowledge that there are victims of the crimes

perpetrated by these exploiters and our focus on supporting these victims must remain resolute.

### Services for all victims will:

- Support through a recognition of trauma to assist with recovery
- Provide safety advice and planning
- Support participation in the criminal justice processes as appropriate improving compliance to the victims code of practice
- Crime prevention advice for all
- Restorative approaches to help heal the harm caused.

### Lewisham approach to breaking the victim/offender cycle will:

- Focus on both the individuals and their families, understanding the dynamics of these relationships and interactions.
- Aim to stop re-victimisation within interpersonal relationships.
- Explore appropriate perpetrator desistance programs.
- Create approaches to tackle specific victim/perpetrator relationships
- Focus on how perpetrators are supported to change and understand the impact of their harmful behaviour.
- Be developed as a multi-agency **Concern Hub**, which will work with children under 25; those who are missing or who are victims of child sexual exploitation, child exploitation, harmful sexual behaviour, county lines, serious youth violence and gangs.
- Challenge social norms to making interpersonal violence of all kinds less socially acceptable.

- Coordinate this work through the Violence Reduction Board, the Concern Hub and the Violence Against Women and Girls Steering Group.

### Action at all levels

- **Lewisham is committed to tackling and reducing the impacts of violence and crime on our communities**, linking into strategies and plans that are in place such as the Violence against Women and Girls (VAWG) Plan 18-21, knife crime action plan 18/19, the Public health approach to violence framework 2019, the children and young person’s plan 2019 and building stronger communities programme.
- Working with colleagues in **other London boroughs** on this agenda to share practice and findings will help to build the evidence base and opportunities for collaborative working. Doing more together helps to bring about greater change and impact.
- Working with the **London Mayor’s office for policing and crime (MOPAC)** is essential to ensure that Lewisham are learning from and feeding into the work of the Violence Reduction Unit for London. This focus for London is essential as our communities are affected by what occurs across London. Accessing resources for Lewisham community and voluntary sector groups, partners and the Council will be a priority where available.
- Working at a **National level** to influence policy and bring about whole scale change is something we will continue to do working with colleagues in the Ministry of Justice, Home Office, National Crime Agency, and Department of Education. Lewisham is constantly learning from its approach to date and are keen to ensure that this is fed into National learning to help greater understanding about violence.

## Children and Adolescent Mental Health Service (CAMHS)

### Safeguarding Children Supervision arrangements

In CAMHS there is a Safeguarding doctor and a Safeguarding lead who are available to discuss concerns for children with mental health problems and safeguarding needs. All CAMHS staff receive inter-disciplinary and disciplinary supervision.

#### Our Priorities:

- For all staff to access appropriate level 3 Child Safeguarding Training.
- To ensure all children who access CAMHS with safeguarding needs are identified.
- To ensure that where safeguarding needs are identified they are appropriately discussed on a daily basis with senior staff and a care plan is in place.
- To ensure that we jointly work with multi-agency staff to support children with mental health and safe guarding needs

### What did we do?

Neglect	<ol style="list-style-type: none"> <li>1. CAMHS staff have training and knowledge to identify both gross and subtle neglect.</li> <li>2. CAMHS staff have access to discuss concerns and formulate plans to safeguard children with neglect in the context of complex mental health concerns with senior staff, on-call Consultant, Safe Guarding Doctor, trust Lead Safeguarding Nurse and doctor.</li> </ol>
Governance and performance	<ol style="list-style-type: none"> <li>1. The SLAM trust safeguarding board works closely with the local Lewisham safeguarding lead and doctor to ensure trust wide policies and procedures in line with the local performance targets are met.</li> </ol>

	<ol style="list-style-type: none"> <li>The monthly CAMHS senior strategy meeting monitors performance related to safeguarding and addresses any concerns both at trust level and locally for Lewisham CAMHS.</li> <li>All CAMHS staff have access to joint Level 3 safeguarding training which includes case study and discussions of children presenting with complex mental health needs and safeguarding needs</li> </ol>
Self-harm and suicide prevention	<ol style="list-style-type: none"> <li>All CAMHS staff have training in eliciting concerns around self-harm and discussing safety plans with children and young people presenting in crisis.</li> <li>Lewisham CAMHS strives for 100% compliance with 7 day follow-up of all children presenting with suicidal and self-harm concerns to ED at UHL to reduce risks.</li> <li>Lewisham CAMHS is a partner in I-Thrive Self-harm and Suicide Prevention strategy in Lewisham.</li> </ol>
Voice of the child and community	<ol style="list-style-type: none"> <li>Lewisham CAMHS has a thriving YAG (Youth Advisory Group) group which is an active young people's forum which helps shape the way Lewisham CAMHS delivers services for children with mental health problems.</li> <li>The award winning Alchemy project organises on-going inclusive groups for children, which are co-produced by young people.</li> <li>The parents group for children presenting with complex mental health needs is a space for parents to share experiences.</li> </ol>
Missing, exploited and Trafficked	<ol style="list-style-type: none"> <li>The safeguarding lead monitors and liaised closely with the MASH team on vulnerable children. Safeguarding leads will liaise with the Concern Hub when implemented.</li> <li>The safeguarding lead continually escalates and work closely with relevant agencies to ensure safety of vulnerable young people.</li> </ol>

## London Ambulance Service (LAS)

### Our priorities in 2018-19

- Secure sufficient resources to develop safeguarding in the Trust
- Monitor trust's safeguarding processes and compliance
- Support Trust with safeguarding practice & requirements
- Assure Trust processes by driving consistency & improvement in safeguarding practice
- Forge effective relationships internally and externally

### What did we do?

- Secured funding to increase safeguarding team by 100% to enable a dedicated safeguarding specialist in each area of Trust.
- 7% increase in safeguarding concerns and referrals to 23,471.
- Introduced 24/7 safeguarding telephone line for staff
- >90% safeguarding training Compliance
- Introduced Quarterly Safeguarding Newsletter
- Produced new safeguarding pocketbook for staff
- Introduced Chaperone and Supervision policies
- Held Safeguarding Conference for over 170 staff and partners
- Introduced Learning Disability and Mental Capacity Act Strategies.

### Our priorities for 2019-20

To be outstanding in quality standards and drive continual improvements

- Excellent Governance and Assurance of Trusts safeguarding processes and compliance
- Development of the Safeguarding Team
- Successful delivery of safeguarding training plan, local education and supervision
- Safeguarding innovation and review current practices to identify cost savings.
- Ensure integration of 111 & IUC
- Forge effective relationships internally and externally to safeguarding children and adults

In conclusion the LAS is committed to safeguarding and has invested in the safeguarding team to ensure trust is compliant with standards and provides the highest level of care for its most vulnerable patients.

The Full LAS annual report can be found on the Trust website.

## London Community Rehabilitation Company (CRC)

AJ Brooks, Contracts and Partnerships Manager, London Community Rehabilitation Company

### What did we do?

In 2018/2019 LCRC have sought to further embed the utilisation of our internal safeguarding assessment to inform our practice. These safeguarding assessments, which were a large part of our previous year's work program, act to obtain the necessary information in relation to a Service User's contact with children and young people under the age of 18 so that the risk that they may pose to them can be managed from the outset. In embedding this LCRC have invested heavily in a new case recording and assessment tool, Omnia, which helps to support the individual practitioner's assessment process by highlighting the evident risks and intuitively seeking the necessary risk management plans to reduce the perceived risks.

Further to this, LCRC have implemented local geographical area Public Protection Boards, where safeguarding risk management processes and procedures are discussed both independently, but also in relation to the other public protection themes including Domestic Abuse, Serious Group Offending and Extremism. These local Boards are attended by senior management and operational leads to help understand the local picture and drive forward the actions that stem from these meetings. Oversight to these Boards is through LCRC's strategic Public Protection Board which is chaired by our Director.

In order to improve partnership work and operational responses to the actions stemming from the Public Protection Boards, we have also established 'Subject Matter Expert' (SME) roles in each of our teams. These SMEs are tasked with ensuring the implementation of any improvement actions, leading peer learning on

specific safeguarding themes picked up out of our monthly and quarterly audits and providing a single point of contact for our safeguarding partners.

### What was the impact?

The addition of the Public Protection Boards allows an extra level of operational and strategic oversight to our case management and risk assessment. This additional oversight has shown to have a positive impact on the safeguarding practices in Lewisham as evidenced through our monthly audit data. At the start of 2018, when our safeguarding training program was drawing to a conclusion from the previous year, the sufficiency of our safeguarding practices were assessed by our central Quality & Performance team to be around the 33% mark. However, at the end of 2018/19 the monthly audit showed a marked improvement in the sufficiency with a score of 100%.

### What we plan to do next?

With the recent announcement that offender management function of Probation services managed by the CRC's across the country will be re-nationalised by Spring 2021, in 2019/20 we are heading into a period of substantial change. In order to ensure the smooth transition of cases in the lead up to the re-nationalisation and therefore the on-going effective management of risk, we will be looking to continue to strengthen the partnership work we do with the National Probation Service.

## Phoenix Community Housing

Leon Yohai, Head of Housing Management

### What did we do in 2018-19?

In 2018-19 to support the LSCB in safeguarding children and deliver its priorities we:

LSCB Priority	Our Support
<b>Neglect</b>	<ul style="list-style-type: none"> <li>Implemented guidance for staff on what they should do if they come across children who are home alone when visiting properties.</li> </ul>
<b>Governance, performance, analysis and outcomes</b>	<ul style="list-style-type: none"> <li>Implemented the restructure of our Safeguarding Panel, updated our Terms of Reference and reporting procedures.</li> <li>Reviewed our Safeguarding training programme.</li> <li>Ensured the Designated Officer and Deputy attended Designated Officer training.</li> </ul>
<b>Missing, exploitation and trafficking</b>	<ul style="list-style-type: none"> <li>Delivered a workshop for staff on Modern Day Slavery and continued to promote our Anti-Slavery and Human Trafficking Statement as part of our development of new services.</li> </ul>
<b>Voice of the child and community</b>	<ul style="list-style-type: none"> <li>Reviewed our Young Makers Agency activities and our approach to working with children and young people.</li> <li>Reviewed our Community Engagement and Empowerment Strategy, this includes specific</li> </ul>

	objectives to support and empower children and young people.
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## Evidence for and evaluation of effectiveness

Evidence is monitored through an action plan by our Safeguarding Panel alongside a suite of key performance indicators (KPIs). The Safeguarding Panel is chaired by the Designated Officer and reports to the Executive Team quarterly. The Safeguarding Panel reports to the Board quarterly through KPIs and an annual performance report.

Our Phoenix Gateway Committee selected the suite of KPIs whilst our Resident Scrutiny Panel monitor them on quarterly.

We also reviewed our activities with children and young people against the NSPCC Safeguarding Standards and Guidance for the Voluntary and Community Sector.

## Changes made as a result of previous learning/priorities and new developments

Fit with and contribution to LSCB current priorities

Our plans and priorities support the LSCBs priorities but as a landlord, we deliver limited activities and services directly to children and young people which means our impact is less direct.

## What was the impact?

Key learning included:

- The need for clear specific guidance to support staff with facilitating or running children and young people activities.

- The benefits of separating our adult and children safeguarding procedures.
- The benefits of supporting staff dealing with safeguarding cases in different ways, for example: learning circles and Mental Health First Aiders.

## Views of parents/carers/children/young people

We have a specific complaints and feedback form for children and young people at our events and activities.

Improvements this year-what are we doing better as a result of the activity?

Following the restructure of our panel we are now able to monitor our cases more frequently and with structured reviews.

## What we plan to do next?

What have you identified-This will inform priorities for next year  
Challenges and priorities for this year (2019/2020)

Our Plans for 2019-20:

- Review our Safeguarding Policy as part of good practice and to ensure that there is clear definition and separation of Adult and Children needs.
- Develop guidance for our teams when they offer work experience or volunteering for people under 18
- Implement procedures and a commissioning checklist to support staff specifically working with children, young people and young adults.
- Improve compliance with Safeguarding Training (87.65% at year-end) and implement a new training programme.

- Start implementation of our reviewed Community Empowerment Strategy 2019-22. A key theme of the strategy is to improve life chances of children, young people and their families. Outcomes will be assessed against community based interventions as part of the delivery.
- Improve our approach to procurement with a focus on contract management audits. This will ensure that our contractor’s policies and procedures related to safeguarding are robust.

### Example of effective practice

Our Community Engagement and Empowerment Strategy included reviewing current practice. We took a risk-based approach to activities we will deliver directly and those where we will commission others who have more specialist skills to work on our behalf; particularly when this involves working with younger children.

### Metropolitan Police Service – South East Basic Command Unit

Jim Foley, Detective Superintendent, Metropolitan Police Service

### What did we do? (In relation to safeguarding children or to support the LSCB priorities 2018/2019)

Evidence for and evaluation of effectiveness

Changes made as a result of previous learning/priorities and new developments

Fit with and contribution to LSCB current priorities

South East Basic Command Unit are committed to safeguarding children and young people. Our ambition is to provide better outcomes for the most vulnerable people in our communities by keeping them safe from harm. The delivery of Safeguarding

is considered a core component of policing but inevitably it crosses over into other areas of activity in the Police Service, as well as having a direct focus in the new established South East BCU Safeguarding Hub.

### What did we do? Why?

The South East Basic Command Unit has a CID Proactive Unit, whose remit includes safeguarding young people being recruited into gangs who go on to be missing from home or care and safeguarding young people becoming victims of gang-related violence or intimidation. By conducting home visits with children and their parents, the team gather relevant information which would be shared via Police Systems for long-term support and awareness with partnership engagement. Officers will listen and provide the relevant safety advice/support referrals if the subject has expressed the wish to exit a gang.

These home visits also provide reassurance as well as reality to the child, detailing the consequences of criminality in an effort to deter them from criminality. It is anticipated that in future, information where required will be shared through the Concern Hub meeting, so all partner agencies are actively involved in the overall support to the child who may have become involved in gangs as well as the mechanism to identify potential gang risks to any siblings. This forum will also provide overall support options to parents and carers, providing them with information in relation to County Lines (CL) and Child Sexual Exploitation (CSE), detailing what they should look for and how they could best safeguard their child.

A dedicated PC attends schools (particularly those identified as having CSE/CL recruiters) to present on these dangers and how to negate them. The CID Proactive team proved critical in developing effective, sustainable working relationships to minimise harm to young people who were reported missing and will take proactive accountability if county line/human trafficking investigation is involved.

## Multi-Agency Safeguarding Hub (MASH) and Youth Offending Service

Police officers within the MASH team work in partnership with Children's Social Care, Health, Housing and the MPS Child Abuse Investigation Team, delivering proven early intervention.

Since the BCU Transformation, CAIT referral officers - supported by Police Community Liaison Officers (PCLOs) – will also be in the MASH to allow fast time information-sharing between agencies to enhance the safety of children and where absolutely necessary, support children being removed from unsafe environments.

As areas of learning are identified, including through Serious Case Reviews, these are shared throughout the MASH, to frontline officers and within the community. The team now delivers on Operation Encompass, which was incorporated and went live in January 2019. This provides Lewisham schools that have opted in to receive information from police of a domestic incident that has occurred, where a child was present when police attended. This allows a cohesive awareness to partners for safeguarding children.

The MASH has been enhanced with the CASO Referral Desk forming part of the Lewisham MASH. Case conferences are progressed more quickly and Social Worker interaction is face-to-face, which leads to closer inter-departmental working between MASH police and CAIT, smoother information-sharing and timely, swifter safeguarding outcomes. The drive for 2019/2020 will be to examine more cases to try and identify and support a greater number of vulnerable children within Lewisham; this is currently on target to proceed. The Youth Offending Service (YOS) also works closely with the MASH, forming strong partnership-working between YOS police and Children's Social Care, ensuring that safeguarding concerns are shared through the MASH and protective/support plans created quickly.

The work volumes through the police MASH team are substantial, and this translates into a constant stream of referrals through to CSC partners. Although challenging, CSC continue to effectively review and manage this demand, reviewing each of the referrals to provide timely interventions to vulnerable families where appropriate. Between April 2018 and May 2019, a total of 7594 PAC and Pre-Birth PACs relating to children were processed through the police MASH team, with the vast majority of these reports shared with CSC partners. The MASH team also dealt with 242 complex multi-agency reports to target concerns relating to vulnerable children and families. Complex matters relating to CSE, Child Criminal Exploitation, Female Genital Mutilation and many other serious concerns are identified, reviewed and progressed on a weekly basis.

In April 2019, 492 police Merlin reports were processed, of which 472 were shared with CSC partners. In May 2019, 497 merlin reports were processed of which 428 were shared with CSC partners.

The police MASH team also deals with all child death notifications through partner agencies; this is through a new process known as ECDOP. Police also cover Rapid Response strategy meetings when required. MASH also deal with all Sarah's Law (Child Sexual Offences Disclosure or CSOD); liaising with CSC partners for complex or high risk cases. MASH deal with all external enquiries from other police services relating to child safeguarding, where the local authority needs to be made aware. The impact of the co-location and ongoing development of MASH is clear to see, and the police MASH team have an excellent working relationship with CSC at all levels. Over the past year, this has meant that when difficult and complex cases are identified through Merlin/MASH, we have addressed them effectively and expeditiously to achieve the best outcome for the vulnerable child or young person. We look to build on this great work over the coming year.

## Safeguarding in Schools

Safeguarding is the schools police officers' main role. Lewisham have dedicated Safer Schools Officers, who regularly interact with pupils through work with the pastoral staff of all secondary schools and at safeguarding meetings, assemblies with teachers, pupils and parents. By interacting through school youth council meetings and surgeries, the Schools Officers listens to student concerns, identify and address children who come to notice re: missing, drugs, CSE, gangs, knife crime and domestic abuse concerns. Going forward, the most high risk cases will be referred through to Concern Hub meetings. These cases will then be discussed with leading professionals including Early Help, Children's Social Care, YOS, CSE leads, Police Missing teams, St. Christopher's, Youth First, Refuge, NHS, Probation, Compass and Trilogy plus. It is anticipated that care strategies will be developed by this group within these meetings to ensure there is that safeguarding grip around risk for these children and young people.

## Dedicated CSE and Missing Teams

The South East Basic Command Unit now has a dedicated CSE and Missing Unit with a direct focus on Contextual Safeguarding. Significant work has taken place regarding Child Sexual Exploitation (CSE) and Human Trafficking within the Borough; dedicated teams have established clear reporting pathways and a structure for referrals has been developed to assist safeguarding partners. A new Missing policy identifies robust supervision and proactivity of prevention for missing people and this will be a key principle in the upcoming Concern Hub, which will focus on all contextual safeguarding concerns in Lewisham, with the right professional membership present to prevent, protect and avoid. Police and Lewisham partners continue to have a good relationship with the Metropolitan Police's centrally based Sexual Exploitation Team, who have delivered training to every Schools Officer on the Borough to assist in identifying young people who may be subjected to CSE. The CSE team have developed a training package for Borough

Officers. Reporting pathways for officers to make referrals are developed with the MASH team.

## What was the impact?

The impact and effectiveness can be clearly seen through the ongoing implementation of focused delivery of contextual safeguarding (including the planned implementation of the Concern Hub), which provides better outcomes for the most vulnerable people in our communities by keeping them safe from harm. The promotion of greater partnership working, early intervention and support for vulnerable children with particular emphasis placed on securing suitable accommodation and support for at risk children in preference of enacting Sect 46 powers by police. This greater knowledge and understanding ensures officers and staff feel more confident in knowing when and how they can share data/information; with or without consent. MPS places emphasis to all that consent / concern should not be a barrier to sharing vital, accurate, relevant and proportionate information relating to the safeguarding concerns of a child who has come to notice of police or a partner agency. The direction from the Pan London MASH protocol document, and recent reports lean towards a stronger and more relevant information sharing stance. This allows quicker identification and investigation into those children identified as being most at risk.

As areas of learning are identified, including through Serious Case Reviews, these are shared throughout the MASH, to frontline officers and within the community. MPS also have Dedicated Inspection teams who conduct inspections of work undertaken by individual teams. Learning is disseminated across the Basic Command Unit to ensure an improvement in performance focussing on prevention, protection, prosecution, support and learning development and early intervention in all areas of safeguarding. SE Safeguarding Hub have created an

internal audit team to dip sample cases to identify and disseminate further learning opportunities.

Ongoing training to front line officers and support staff to ensure they are fully aware of the resources available to them in Children's Services, including the MASH team, professional's consultation line, in hours, and out of hours social worker advice and support. In addition, training/advice to MASH team partners and managers within children's services to explain police procedures/actions.

Further examples of effective practices include new searchable BRAG features on Merlin to assist with accurate record keeping and the establishment of consistent daily meetings with partners and missing children co-ordinators to discuss MASH cases and other safeguarding cases.

### **What we plan to do next?**

#### **Protect and support: Focus on what matters most to Londoners**

Quality assurance processes by the safeguarding boards and partners provide reassurance that basic practice across all agencies is effectively safeguarding young people.

Ensuring support to vulnerable adults, children and young people who have been exploited is delivered, ensuring that what is offered is appropriate for each individual, child or young person based on their gender, age, ethnicity, disability, and the nature of the exploitation that they have experienced.

The Safeguarding Boards to develop their individual and collective expertise through joint learning exercises and strong collaboration across the South East. Partnerships to be open to joint commissioning opportunities. Set strategic

direction for safeguarding across the BCU, understanding the strategic partnerships to deliver a best framework.

### **Knowing our problem and knowing our response: Mobilise partners and the public**

Continually developing and understanding our problem profile in the context of vulnerability, perpetrators and the spaces and places they frequent online and offline.

Professionals who come into contact with adults, children and young people have relevant and proportionate knowledge of the broader profile of vulnerability. This includes the factors that exacerbate risk and the consequential vulnerabilities arising from exploitation.

Engaging, educating and empowering the broader community forums a critical element and this work will be directly supported and informed by the Adult and Child Safeguarding Boards of Lewisham (and by the subsequent body that will replace the LSCB in 2019-20).

Analytical support – to be coordinated across a range of agencies to identify themes, patterns and trends relating to vulnerability. Stronger intelligence gathering and sharing across the partnerships on individuals, peer groups and geographic hotspots engages a tactical response from the partnership to make young people and vulnerable adults safer. This intelligence should include information gathered from young people, their families and the wider community.

Contextual safeguarding – We will ensure that our safeguarding response is contextual in relation to the people and places we, as a partnership, are protecting from harm. This approach will address all safeguarding matters across all age

ranges from young children through to elderly adults that officers come across on a daily basis.

### **Disruption and Prosecution: Achieve the best outcomes in the pursuit of justice and in support of victims**

Working with Professionals to identify, assess and mitigate any vulnerabilities that might reduce the chances of young people exiting gang culture or involvement in youth crime and violence.

Ensure robust policing responses to perpetrators are in place: agreeing and monitoring investigation plans to run alongside support plans developed in response to a child sexual exploitation referral.

Engage with agencies to effectively share information and routinely utilise intelligence-led disruption in relation to any local businesses, individuals or groups associated with exploitation.

Through intelligence and partnership meetings ensure all agencies flexibly apply the full range of disruption tactics available through both criminal and civil routes to protect children and young people, including powers available in relation to licensing, health and safety, fraud, housing provision and other related legislation. Mechanisms put in place to ensure young people demonstrating harmful sexual behaviours are identified and support put in place to address their behaviours, with their own vulnerabilities and developmental stage being considered within any response.

Robust offender management strategies post-conviction and/or effective intervention strategies that reduce the risk presented by identified abusers.

### **Learning, Developing & Support**

Ensure that mechanisms are in place to capture learning from a number of sources; Local, Partnership, OFSTED, JTAI, HMIC, SCR, SAR, DHR. We will be able to demonstrate how that learning informs practise. Internal and multi-agency audits used to support learning and development of practise.

As part of Tri-Borough considerations, completing the implementation of the Bexley local learning hub (which brings frontline practice challenges to the board) to assist evaluation of Lewisham & Greenwich's learning models and to work towards a hub model and priorities as part of Tri-Borough multi-agency safeguarding arrangements supported by the early adopters bid to Department of Education.

Establishing an annual programme of safeguarding partnership improvement and delivery priorities that are shared across the new BCU.

Establishing shared mechanisms and processes for initiating local serious case reviews, which incorporate a shared Tri-Borough, multi-agency serious incident and learning sub-group. Each review to be led by one of the three participating local authorities and published across the local areas. This strand will also consider the provisions of a bi-annual learning and improvement report (with conference) for the local tri-borough area.

Establishing Tri-Borough arrangements following the death of a child. Ensure that we learn from these as part of business as usual.

Explore Omni-competence and continual professional development in the safeguarding arena. Look for local, regional and national best practise to support the development of Police Safeguarding Professionals.

Deliver training around Mental Health training to all SE BCU frontline officers.

## Prevention and early intervention

The performance of Early Help systems to reduce the need for statutory interventions – effectively dealing with need and vulnerability. Early Help is subject to ongoing scrutiny by the safeguarding boards testing the difference it is making to children and young people’s lives.

Young people who are particularly vulnerable to exploitation (i.e. looked after children, missing children) are identified early and supported by their families/carers, professionals, and their community to prevent and build resilience against exploitation.

Schools deliver high quality Sex and Relationships Education (SRE) and take a whole-school approach to gender equality, safeguarding, and preventing exploitation.

Professionals engaged in providing universal and targeted services to adults young people, empowering them to identify harmful behaviours and supporting them to build positive and healthy attitudes towards relationships and friendships, gender identity, and sexuality.

Public trust is built through proven and visible positive attitudes towards all cases involving vulnerable persons. It is essential that Police and the local authorities of Lewisham, Greenwich and Bexley have current and effective information sharing agreements.

Attending all initial case conferences – achieving 100% performance - following onto 100% attendance at review case conferences.

## NHS Lewisham Clinical Commissioning Group (CCG)

Agency Representative on Safeguarding Board:

- Martin Wilkinson Managing, Director (Attends LSCB Executive)
- Dr Abimbola Adeyemi, Designated Doctor Safeguarding Children & Consultant Community Paediatrician (LSCB Board and subgroups)
- Maureen Gabriel, Designated Nurse Safeguarding Children & LAC (LSCB Board & Subgroups)
- Dr Agelika Razzaque, Executive Lead Safeguarding Adults & Children/ A CCG Clinical Director (GP) (Attends LSCB Board)

As a health commissioning organisation, Lewisham CCG has a statutory duty to ensure that all health providers, from whom the CCG commissions services, promote the welfare of children and protect children from abuse or the risk of abuse. This includes specific responsibilities for Looked After Children and for supporting the Child Death Review process.

The CCG also supports NHS England with the quality assurance of Primary Care Services (GP, Independent Practitioners and private hospital services in the Borough). This role includes safeguarding assurance as well as strategic leadership and influencing.

## What did we do?

- CCG fulfilled statutory functions. There were no gaps in safeguarding roles within the CCG.
- CCG contributed to the LSCB (Executive and Main Board) and its subgroups.
- CCG gained assurance of provider health services safeguarding arrangements by embedding safeguarding into contract monitoring arrangements,

monitoring at the Clinical Quality Review meetings (CQRG) for the local hospital and the Mental Health Trust and by Designated professionals attendance at assurance meetings at these meetings.

- All CCG staff received safeguarding training and are compliant.
- CCG provided Safeguarding Children Level 3 training for General Practitioners, Practice Nurses and other primary care clinicians. Training incorporated learning from serious case reviews and learning reviews, raised awareness of the particular safeguarding needs of disabled children with complex needs and involved applying a range of knowledge and understanding to solve practical child abuse situations such as Child Sexual Exploitation, Domestic Violence.
- 150 clinical staff in primary care were trained during the year.
- CCG facilitated bi-monthly GP Safeguarding Leads meetings. A wide range of safeguarding cases including findings of serious case reviews was discussed. Guest speakers imparted additional safeguarding information on variety of topics such as, Information Governance & GDPR, Neglect Toolkit, Domestic Violence, Lewisham Threshold Document & MASH, Fabricated & Induced Illness CCG ensured primary care contribution to serious case reviews and learning reviews.
- CCG actively contributed to implementation of the New Safeguarding Partnership arrangements and Child Death Review process.

### Changes made as a result of previous learning/priorities and new developments

- Lewisham CCG appointed Primary Care Safeguarding Children Practitioner to work alongside the Named GP & Designated Professionals for Safeguarding to ensure Primary Care contributes effectively to the safeguarding agenda in the borough.

- Work has commenced to complete safeguarding children audits in primary care (Recommended from serious cases reviews and learning reviews).

### What was the impact?

- CCGs are membership organisations that bring together General Practices (GPs) to commission local health services for the population in the area. An advantage of the CCG being a clinically-led organisation is that the CCG is in the position of being able to take account of the experience of patients who are best placed as service users, to know the right services for the area and can comment objectively when new services are commissioned. The CCG ensures that safeguarding is included in all contracts of the services from which it commissions. For example, access to health services locally for children with complex needs was reviewed as part of the NHS Transformation plans. Children with complex needs have increased vulnerability and may be at more risk of abuse and neglect. Safeguarding was considered in the development of the service. This has resulted in a revised service offer for the community nursing of children with complex needs and the implementation of a Hospital at Home scheme.
- The CCG Designated professionals have supported local health providers and the Local Authority with assistance from NHS England to implement the CP-IS (Child Protection Information Sharing Project). This process has taken a number of years to embed. This has improved identification of vulnerable young people and unborn children on CP plans and also for Looked After Children who attend Emergency Departments (ED) or other unscheduled health care settings anywhere in the Country where CP-IS is also implemented. An example of how this is enabled is if a child from Lewisham attends a Dorset hospital, the emergency department in Dorset checks the NHS Spine for information that Lewisham Local Authority has uploaded to

the NHS Electronic Spine. An electronic message is sent to Lewisham Local Authority to indicate the child or young person had attended the ED. CP-IS does not contain the contents of the medical record of attendance. Agencies must still communicate for further clarity.

- iii. The CCG has improved engagement with the safeguarding children agenda in primary care.

### Challenges and priorities for this year (2019/2020)

The CCG will need to fulfil its statutory key role in the revised Safeguarding Partnerships under Working Together 2018. This includes:-

- Fulfilling the strong leadership responsibilities placed on it working alongside the local authority chief executive and chief officer of police as the lead representatives with accountability under the legislation.
- Setting the vision, strategy and policy direction for Lewisham's safeguarding arrangements.
- Ensuring wider accountability across services.
- Delivering a fully accountable multi-agency system for safeguarding and protecting children in all settings.
- Holding to account all providers of health services on how effectively they participate and implement the local arrangements.

The CCG together with the Local authority will need to ensure implementation of the changes in Child Death Review Process (CDR).

## Lay Members

The attendance of our Lay Members at Board meetings and Task Groups has been instrumental in offering a unique perspective. Both Lay Members are residents of Lewisham, and this provides an insight into local issues and concerns in our borough. Although it is not a requirement of the role, both of our lay member's contribution to the LSCB are assisted by their backgrounds in children services.

### What did we do?

In 2018/2019, in addition to attending our Main Board meeting, both Lay Members were actively involved in 3 of our Task Groups, including being a Panel Member on all of our SCRs. Sonia Chambers is a member of our Communications and Publications Task Group, including being a panel member on 2 SCRs, while Derek Churchman is a member on our MESI Task Group, and a panel member on 1 SCR.

### What was the impact?

Having our Lay Members involved in some of our Task Groups contributed to the LSCB priorities. Lay Members are asked to provide feedback on how the Board's business is done and how children and their views can be better incorporated. This is especially useful in our SCRs, so as to ensure we get it right for children.

## National Probation Service

The National Probation Service (NPS) is responsible for the following areas of work:

- Advice to the Judiciary with regard to sentencing and Parole decisions
- The management of:
  - High risk offenders
  - MAPPA offenders (all categories and levels, irrespective of risk)
  - Foreign national offenders who receive 12 months or more custody or community sentence and who are in scope for deportation
  - Offenders where there is significant public interest
- Approved Premises
- Victim Contact Service

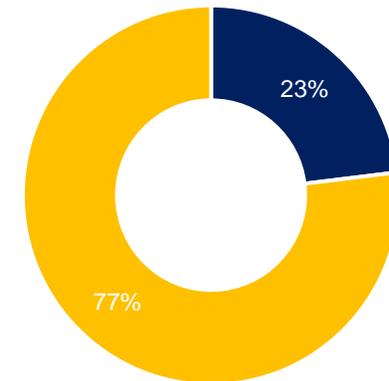
The National Probation Service is divided into six regions and Wales. NPS London is divided into 12 Local Delivery Units, each covering 2-3 London Boroughs. NPS Lewisham and Southwark is one of those clusters.

In Lewisham, the NPS currently manages approximately 570 cases (excluding those cases who are being moved to the new Offender Management in Custody system). The current caseload is a mixture of both community and custody cases, with approximately two thirds of service users being supervised in the community on either a Licence, a Community Order or a Suspended Sentence Order.

NPS is committed to Safeguarding Children and it contributes to protecting vulnerable children and young people by undertaking the following:

- Advice to Courts: In appropriate cases NPS will contact Children's Social

### Youth First Participants 2018/19



■ Regular ■ Occasional

Care pre-sentence to find out if a defendant is known and if there are any safeguarding issues that need to be taken into consideration prior to making a sentencing proposal.

- All service users have a thorough assessment after they have been sentenced, whether in custody or in the community. This assessment (OASys) provides a holistic picture of risks and needs presented by each individual, there are specific questions in relation to safeguarding Children. There are also specialist assessments in relation to Sex Offending and Domestic Abuse. Once the risk and needs are assessed, risk management and sentence plans are developed to address the issues identified in the assessments. Risk management can include restrictive measures such as preventing those who pose identifiable risks from having contact with children.

- Referrals – NPS staff will make appropriate referrals into Lewisham MASH, in order to instigate child protection investigations and to alert partnership agencies to concerns about children.
- Multi-agency partnership working. NPS contributes to a range of Multi-agency structures including MAPPA, MARAC, Care Plan Approach and other case conferences. The aim is to share information and ensure the holistic management of service users and that risk to children is minimised.
- Senior Management participation in strategic boards including the Lewisham Safeguarding Children’s Partnership.
- All NPS Staff, including administrative staff, are required to undertake basic Child Safeguarding and Domestic Abuse training in the form of an e-learning module. All practitioners are required to undertake more advanced Child Safeguarding/Domestic Abuse training in the form of face to face training. Ad hoc briefings and workshops are also delivered to staff. Staff are also encouraged to attend Local Authority training where available.
- A Lead Practitioner who participates in Lewisham MASH is provided. The lead practitioner also provides advice and support to Probation colleagues in the form of workshops and case discussions.
- Practice is audited using Her Majesty’s Inspectorate of Probation (HMIP) criteria. Learning is shared with practitioners across the borough. The case audit tool asks specific questions regarding safeguarding activity and these audits take place every 6 weeks. All staff are required to part during the year.
- Work with the Youth Offending Team to improve transition from youth to adult services – this has included the new implementation of the new ‘transition programme’. The programme consists of 4 modules and is designed to improve the transition of young adults from the YOS to Probation.

## Youth First

Youth First has been delivering youth provision under contract with LBL for three years. Our core activity is the delivery to all young people in Lewisham aged 8 to 19 (up to 25 for those with special educational needs) of ‘free at the point of access’ youth clubs and adventure playgrounds, both during school terms and holidays. These are run across six directly run youth clubs, three commissioned youth clubs and five directly run adventure playgrounds. In addition this year Youth First has increase service with a Lewisham based street based team. Sessions are sometimes broken into specific age and/or gender. Youth First also commissions additional targeted activities and provision for example sports, gender specific programs and skills based provision.

In 2018/19 we have seen real growth in attendance by young people year on year. With c.84,500 visits in 2018/19 compared to c.81,000 in 2017/18. This year’s attendance includes c.5000 individual young people of which around 1,500 attended regularly (defined as eight times in any school term or 24 times per year as opposed to the government definition of five times a year). As we reach more young people we have a better chance to safeguard them.

### Safeguarding due to our location

The location of our sites whilst inherited and often unchanged for many years is not simply accidental nor has it been without relatively regular review by LBL, including within the past five years. In 2018/19 we have increased provision in central Lewisham with our pop up Youth Club at Glassmill Leisure Centre. All our sites are by design in areas of high deprivation and as such more accessible and attended by children and young people with a higher prevalence of associated vulnerabilities including a high proportion of attendance from areas of deprivation as defined by both Indices of multiple deprivation (IMD) and the income deprivation affecting children index (IDACI). Whilst this does not of course

demonstrate that those who attend have vulnerabilities it does demonstrate that there is a higher probability that our sites safeguard those who need it the most.

### **Universal School Safety Program**

In its second & third years the Universal School's Safety Program (USSP), funded by MOPAC, LBL and Youth First directly, was delivered by Youth First and Compass to 1420 pupils in 52 Year seven forms across nine Lewisham secondary schools (Forest Hill Boys, Addey and Stanhope, Bonus Pastor, Prendergast Hillyfields, Haberdashers Hatcham College, Sedgehill School, Prendergast Vale, Haberdashers Askes Knights Academy).

The scheme uses informal education techniques/youth work to teach young people about issues relating to the borough's five key safety themes. These are: how to stay safe (including the danger of knives), the dangers of substance misuse, importance of healthy sex and relationships, online safety and bullying. Sessions are delivered to a full year seven cohort in a single day of revolving sessions.

To date the feedback from both pupils and schools has been very good with a vast majority saying they learnt valuable information and that it was preferable to receive the subject matter from youth workers rather than their teachers. Many young people also reported that they now knew where to get additional support and Youth First reports an uptake of universal youth provision (youth clubs and adventure playgrounds) off the back of sessions.

Youth First and LBL are currently looking for funding to expand the program to more schools and, at schools request, in-house youth club curriculum, colleges and PRUs.

### **Partnership working, Workforce Development and Quality Mark**

In addition Youth First run two inset weeks per year and all year round for staff to access training through LSCB training provision but also internal training programs. All senior staff which manage youth and Adventure Playgrounds are trained to level three safeguarding and have also trained as lead professionals, Trauma and restorative informed practitioners.

Youth First has 6 out of 10 directly delivered youth clubs which are Bronze London Youth Quality Mark approved with the other units working towards accreditation.

Youth First works in close partnership with LBL Targeted Services, Children's Services, Youth Offending Service (YOS), local schools and are active members of Early Help Services, Safe Spaces, Compass and Kooth. Youth First will be a member of the Concern Hub also.

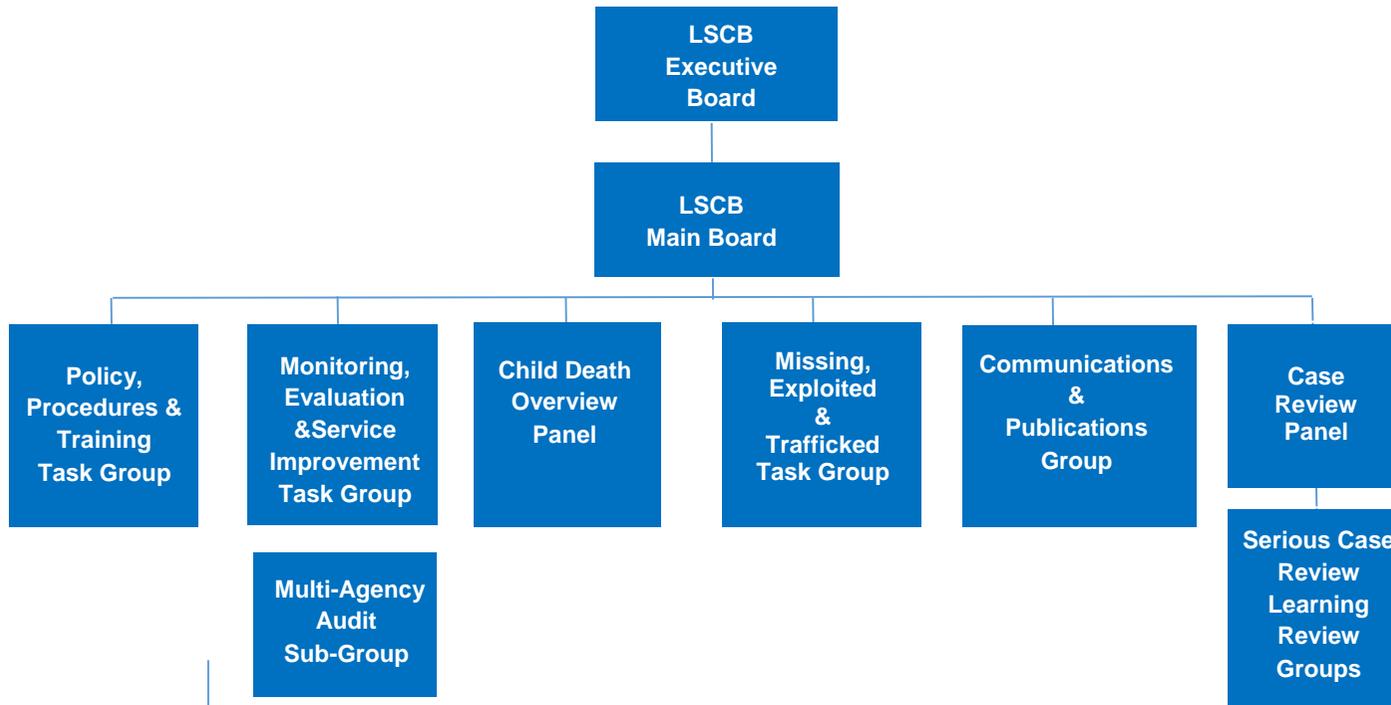
# Appendices

## Lewisham Safeguarding Children Board Business Structure Chart



**Lewisham  
Safeguarding  
Children Board**

## Lewisham Safeguarding Children Board Business Structure Chart



*There is also a quarterly Chairs of Task Groups meeting, which meets approximately 4 weeks prior to each Main Board*

## LSCB Financial Arrangements for 2018-19

### Income:

Organisation	LSCB contribution 2015/2016	LSCB contribution 2016/2017	LSCB contribution 2017/2018	LSCB contribution 2018/2019
Lewisham CCG	45,110	45,110	50,110	45,110
LBL Children's & Young People's service	83,280	83,280	88,280	83,280
Cafcass	550	550	550	550
Community Rehabilitation Company	1,000	1,000	1,000	1,000
London Fire Brigade	N/A	N/A	500	500
London Probation	2,000	2,000	1,850	1000
Metropolitan Police Service	5,000	5,000	5,000	5,000
Lewisham & Greenwich NHS Trust	22,555	22,555	27,555	22,555
South London and Maudsley NHS Foundation Trust	22,555	22,555	22,555	22,555
<b>Total:</b>	<b>182,350</b>	<b>182,350</b>	<b>197,400</b>	<b>181,550</b>

# Training Summary

## LSCB Training Delivered 2018-19

### Lunchtime Briefings

Children Missing Education  
Fabricated & Induced Illness Awareness  
Introduction to Safeguarding Children & Young People in Lewisham  
Learning from Domestic Homicide Reviews  
Learning from Serious Child Safeguarding Practice Reviews  
Multi-Agency Risk Assessment Conference (MARAC) Awareness  
Safeguarding Sexually Active Young People  
Understanding the Different Strands of Violence Against Women & Girls  
Workshop to Raise Awareness of Prevent  
Young Carers & Hidden Harm (parents who substance misuse)

### Half Day Courses

Gangs, Exploitation & Effective Practice  
Safe Recruitment  
Sexual Violence and Exploitation Amongst Young People (Peer-on-Peer Abuse)  
Workshop to Raise Awareness of Prevent – Greater Depth

### Full Day Courses

Breast Ironing & Harmful Cultural Violence  
Child Sexual Abuse in The Family  
Child Trafficking, Modern Slavery and the National Referral Mechanism  
Child Sexual Exploitation – Advanced  
Cultural Competence in Safeguarding Children & Young People  
Domestic Violence & Abuse Awareness  
Early Help Champions  
Neglect  
Safeguarding Children Affected by Parental Substance Misuse  
Safeguarding Children Level 3 – Designated Safeguarding Leads  
Safeguarding Sexually Active Young People  
Self-Harm & Suicide Ideation in Children & Young People  
Working with Challenging & Hard to Help Families  
Working with Perpetrators of Domestic Violence

100% delegates agreed to share learning with their colleagues

Working with Perpetrators of Domestic Violence  
Delegate Comment

"I am better able to explore incidents of violence with perpetrators and assess future risk"

100% delegates experienced an overall increase in knowledge, skills and understanding in each of the training courses delivered.

Child Sexual Abuse in The Family Course Delegate Comment

"I will be able to support the child / family through the process of recovery and repair and ensure correct information is shared with professionals."

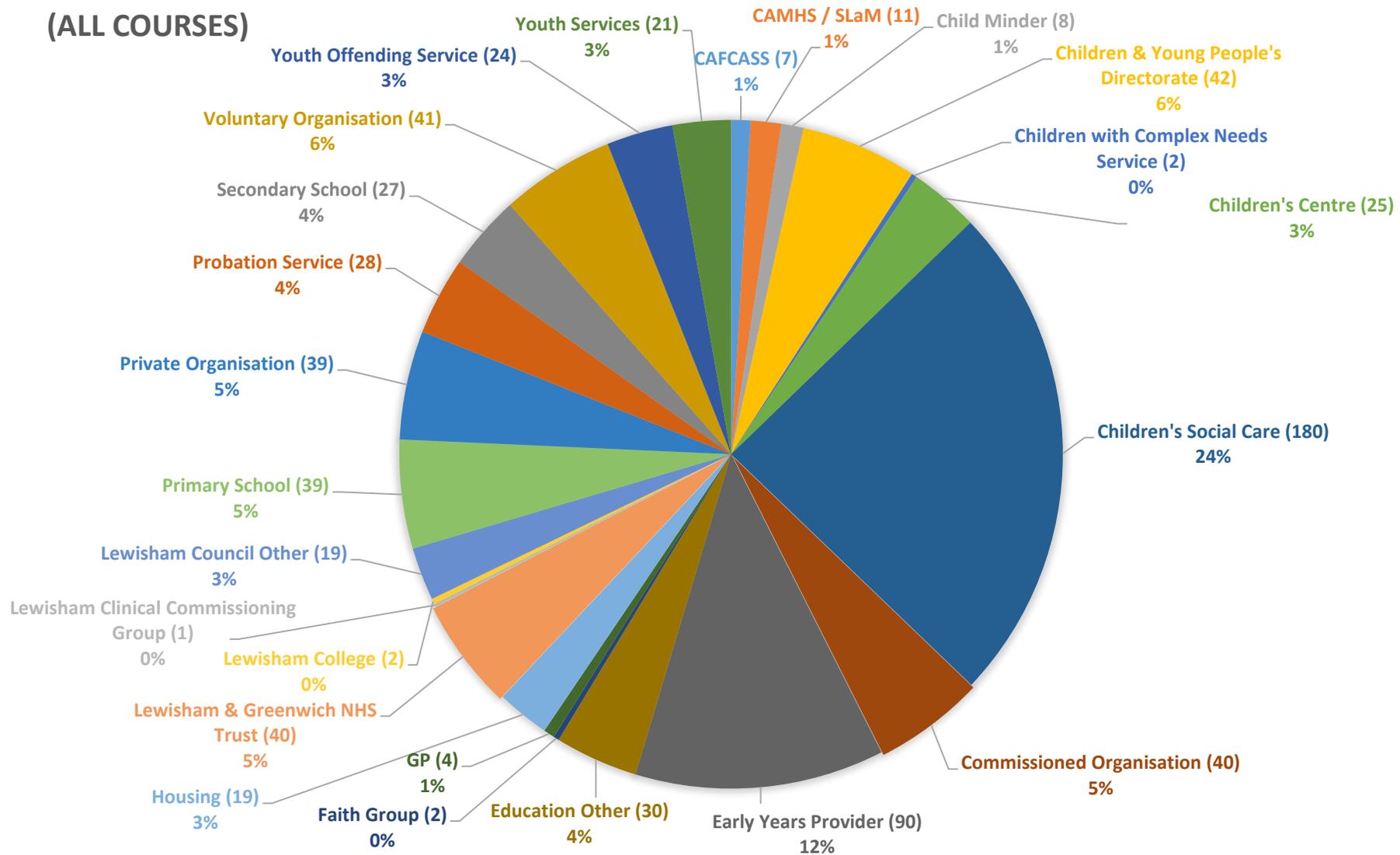
Delegates rated Trainers performance as Good or Excellent

Child Sexual Exploitation Advanced Delegate Comment

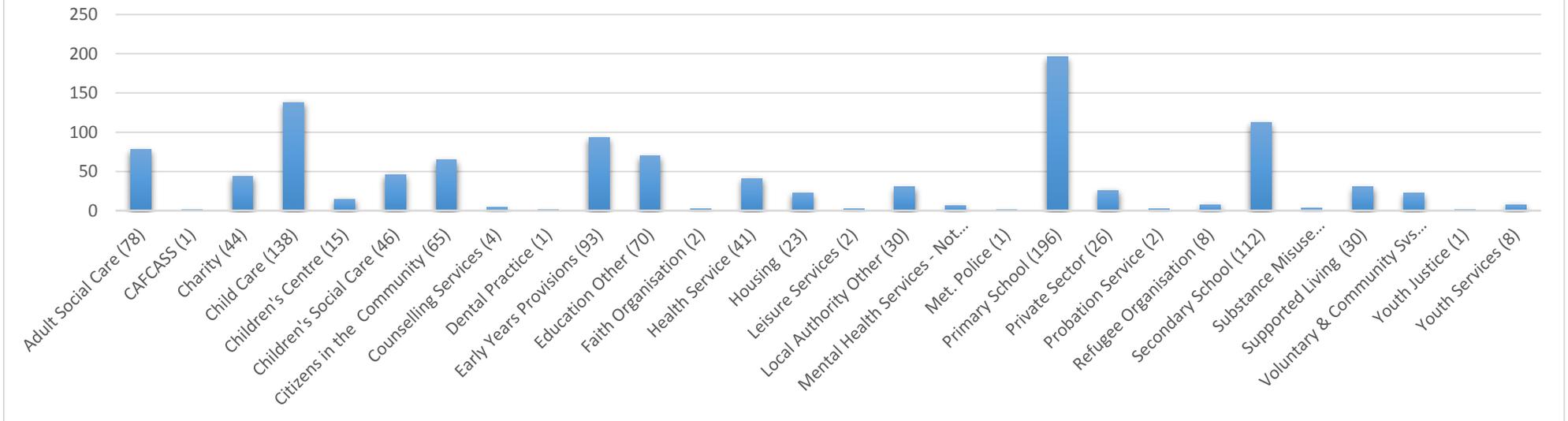
"This course will enable me to support and guide staff on resources to use to engage young people"

Delegates had a good understanding of where to seek further advice and support in each subject.

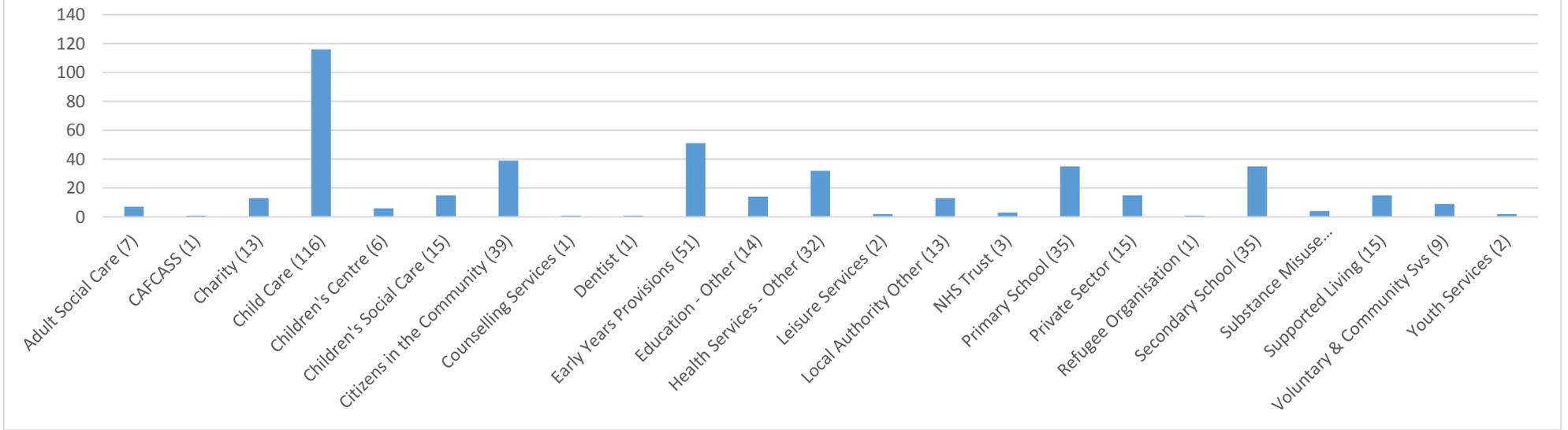
# AGENCY ATTENDANCE (ALL COURSES)



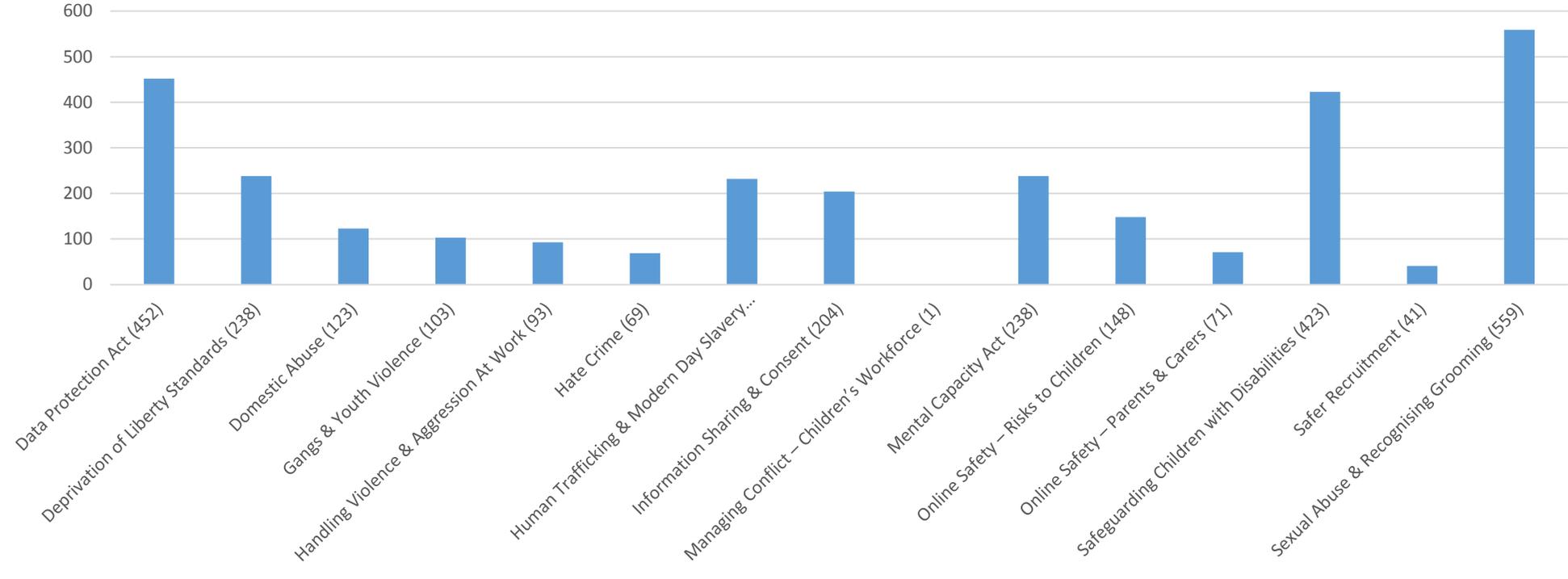
### MeLearning Safeguarding Children Level 1 (by delegate role)



### MeLearning Safeguarding Children Level 2 (by delegate role)



### All Other MeLearning (by numbers of completed courses)



## Safeguarding Children Level 3 – Designated Safeguarding Leads (Full day)

No delegates had additional requirements, such as wheelchair access.

**1512** Individuals viewed the course on the LSCB Website

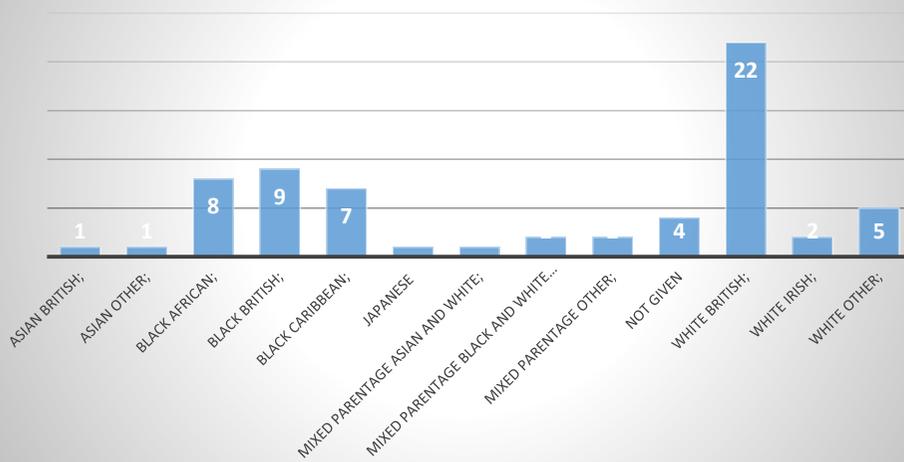
**4x** courses were completed in 2018-19

**119** Individuals booked to attend the training, out of a possible 80 spaces available

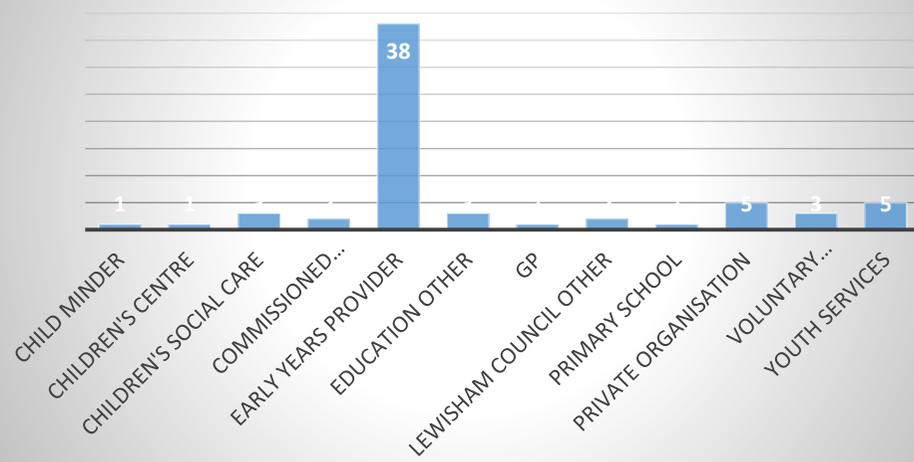
**65** individuals attended training (81.3%)

**99%** of delegates agreed to share the learning with their colleagues and line manager.

### Equal Opportunities Monitoring



### Agency Type



Delegates said they would go for additional advice and support from:-

**LSCB Website**  
x37

**MASH**  
x13

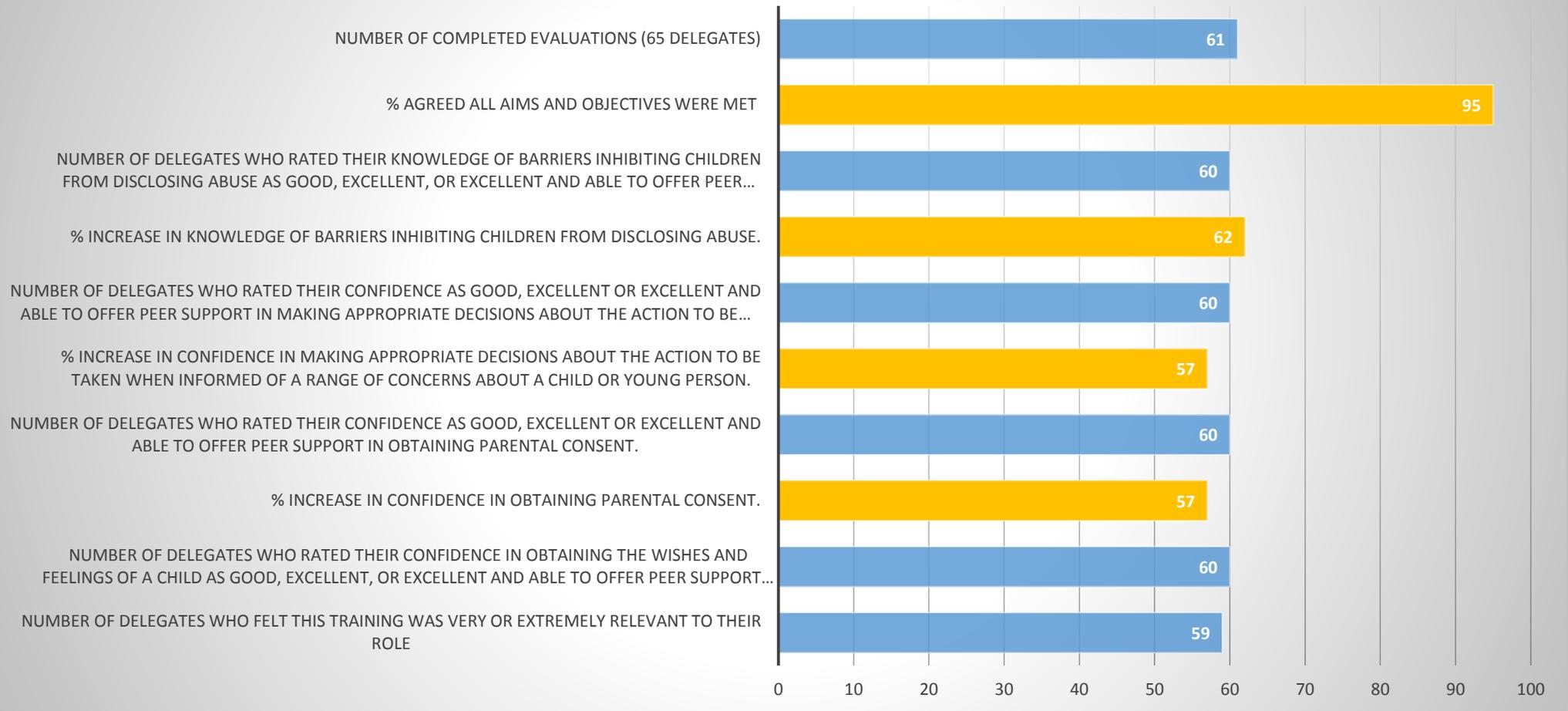
**Line Manager**  
x5

**London Child Protection Procedures**  
x10

**LADO**  
x 4

Key: Orange = % Blue = Numbers

## Learning Evaluation Statistics



"I am working with young people so I will be able to identify the triggers and safeguard even better."

"I am more confident about my role and what action and discussions to have."

"Content was very good and it is so relevant to my practice. It has provided me with more confidence."

"Much clearer about the relevant legal documents and guidance."

"Understanding of bigger picture when looking into concerns."

## Neglect – An Analytical Approach (Full Day)

No delegates had additional requirements, such as wheelchair access.

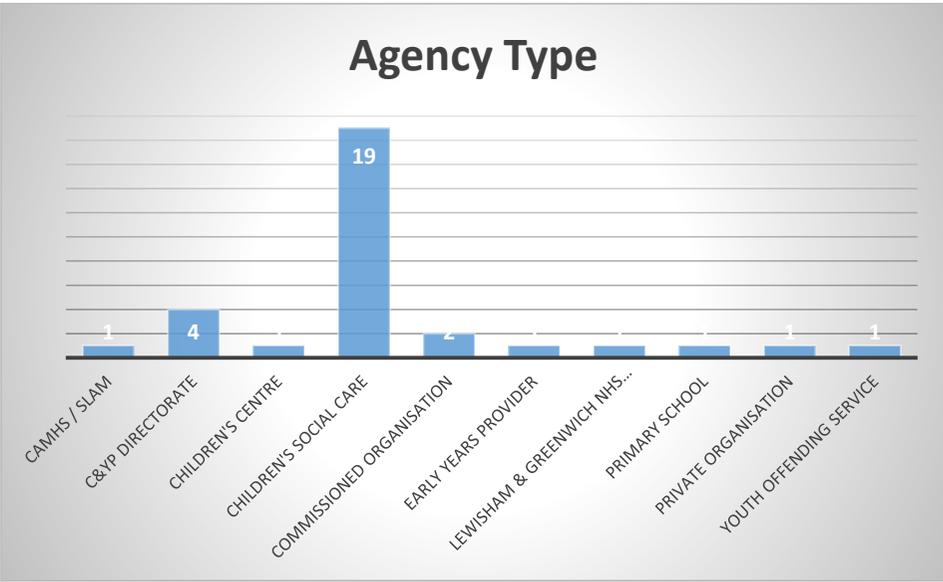
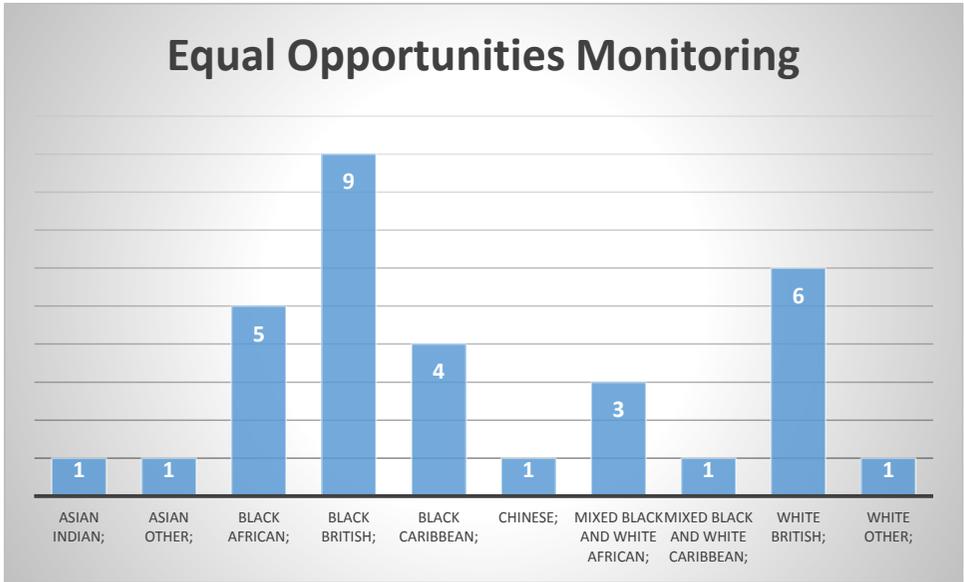
**1086** Individuals viewed the course on the LSCB Website

**2X** courses were completed in 2018-19

**41** Individuals booked to attend the training, out of a possible 40 spaces available

**32** individuals attended training (80%)

All delegates agreed to share the learning with their colleagues and line manager.



Delegates said they would go for additional advice and support from:-

**LSCB Website**  
x14

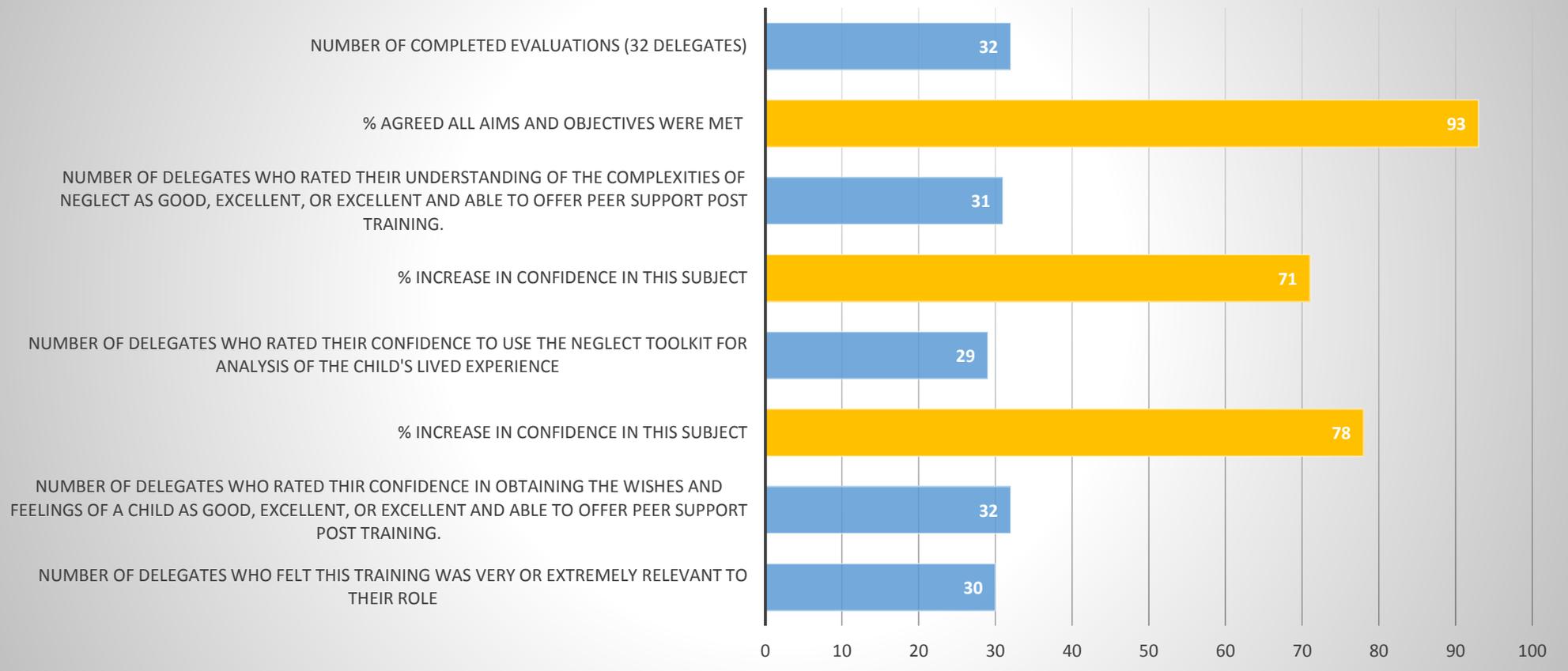
**Line Manager**  
x9

**Work in Partnership with Other services**  
x3

**Neglect Toolkit**  
x2

Key: Orange = % Blue = Numbers

## Learning Evaluation Statistics



"This helped to refresh my knowledge in this area and given me key ideas on how to improve practice and support families."

"Being able to explain and support parents to hold their child in mind."

"Looking at neglect through a different lens and language to use with parents."

"Exploring different ways in learning to deal with neglect and difficult parents."

"It has helped to challenge parents and get them to think about their child's views. Help to set baby steps."

# Self-Harm & Suicide Ideation in Young People Awareness (Full Day)

No delegates had additional requirements, such as wheelchair access.

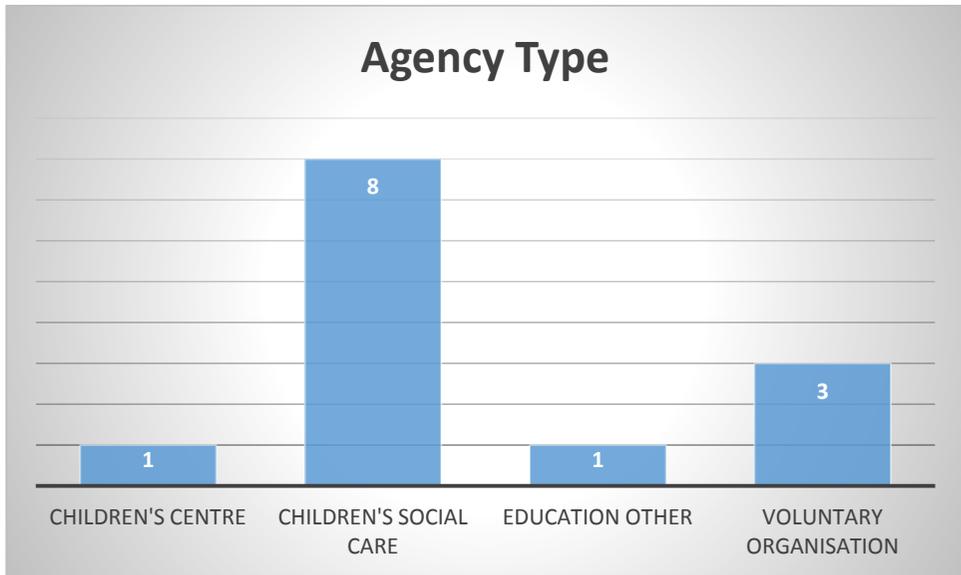
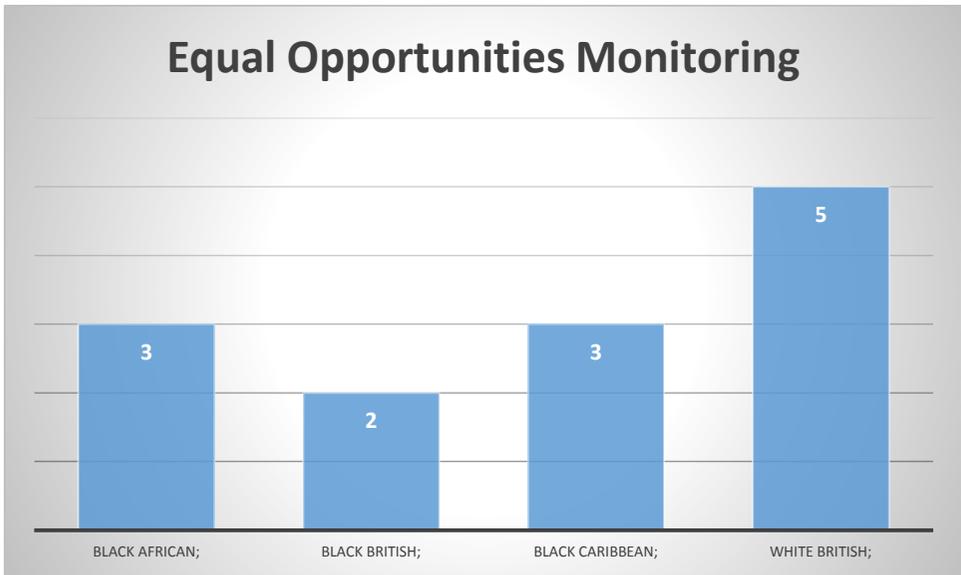
**833** Individuals viewed the course on the LSCB Website

**1x** course was completed. **1x** course was cancelled by the trainer due to service pressures. The course content has been reviewed for the 2019 training programme

**19** Individuals booked to attend the training, out of a possible 20 spaces available

**15** individuals attended training. (75%)

**99%** of delegates agreed to share the learning with their colleagues and line manager.



Delegates said they would go for additional advice and support from:-

**LSCB Website**  
x7

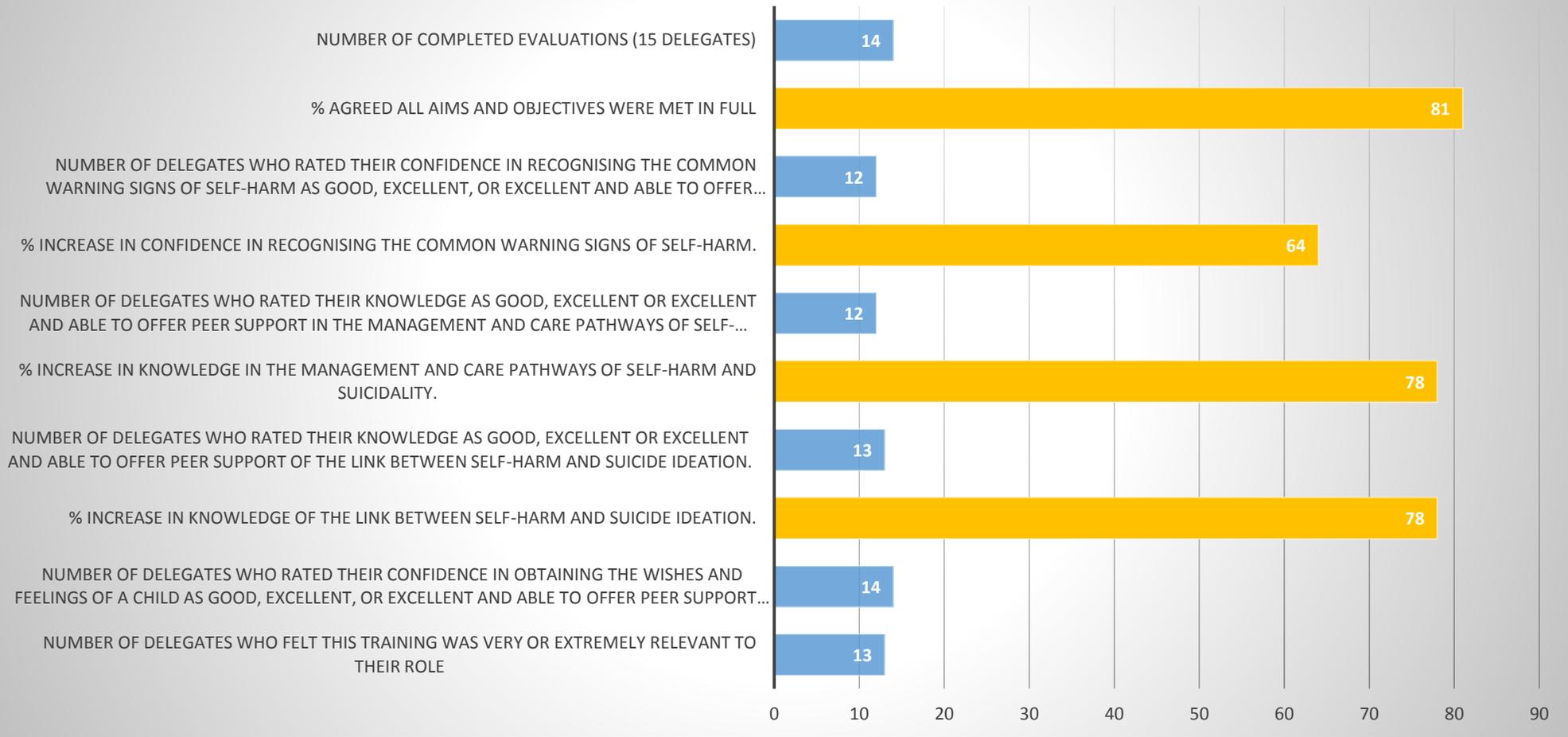
**Line Manager**  
X3

**Lewisham CAMHS**  
X5

**Other Online Resources**  
x7

Key: Orange = % Blue = Numbers

## Learning Evaluation Statistics



“Will feel less worried about discussing the topic with young people.”

“I will be able to have a more informed decision when it comes to dealing with children who self-harm.”

“Better knowledge of management pathways and self-harm increased awareness and confidence in assessing self-harm.”

“I am now confident in being able to approach and discuss with individuals their mental health issues.”

## Child Sexual Exploitation Advanced Course (Full Day)

No delegates had additional requirements, such as wheelchair access.

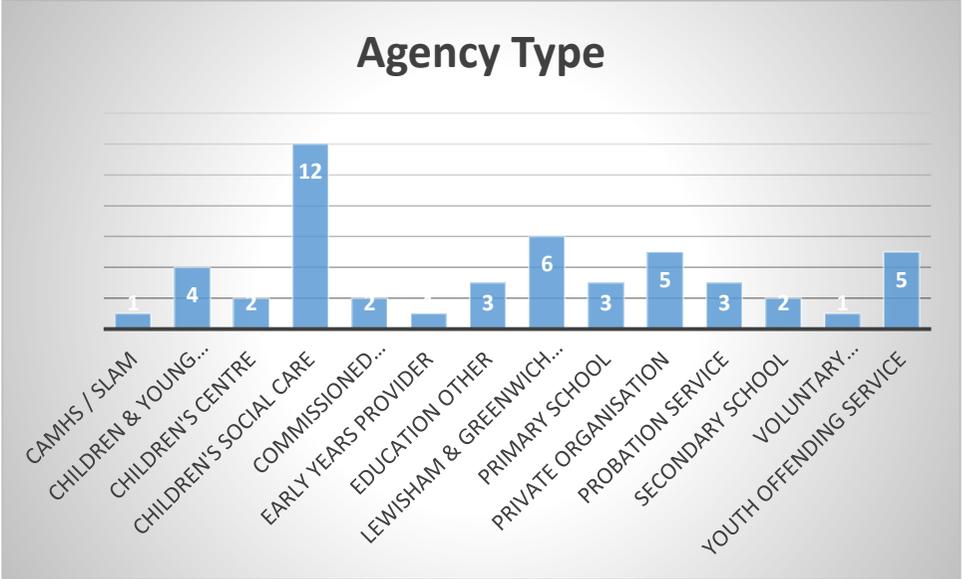
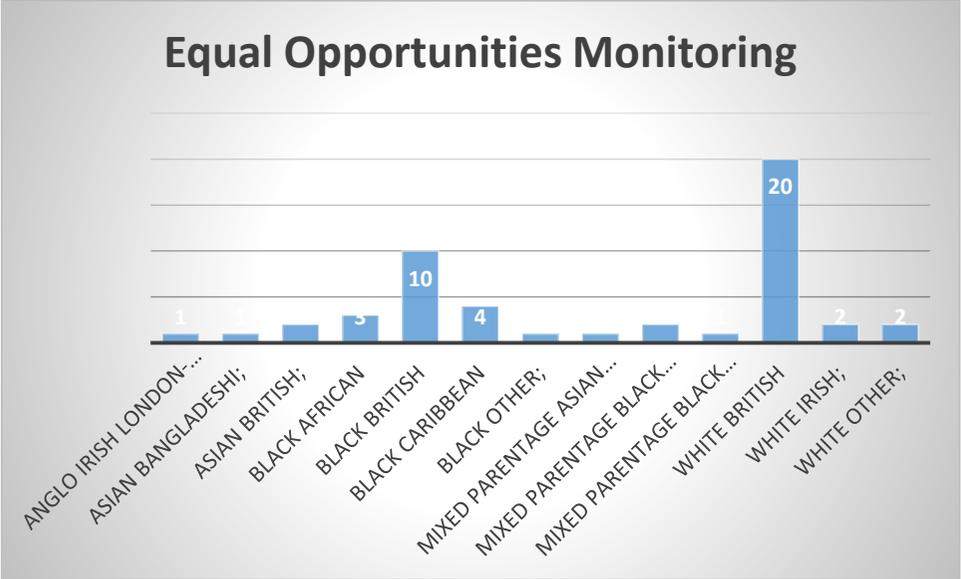
**901** Individuals viewed the course on the LSCB Website

**3x** courses were completed in 2018-19

**89** Individuals booked to attend the training, out of a possible **90** spaces available

**50** individuals attended training. (55.6%)

All delegates agreed to share the learning with their colleagues and line manager.



Delegates said they would go for additional advice and support from:-

**LSCB Website**  
x16

**Line Manager**  
X4

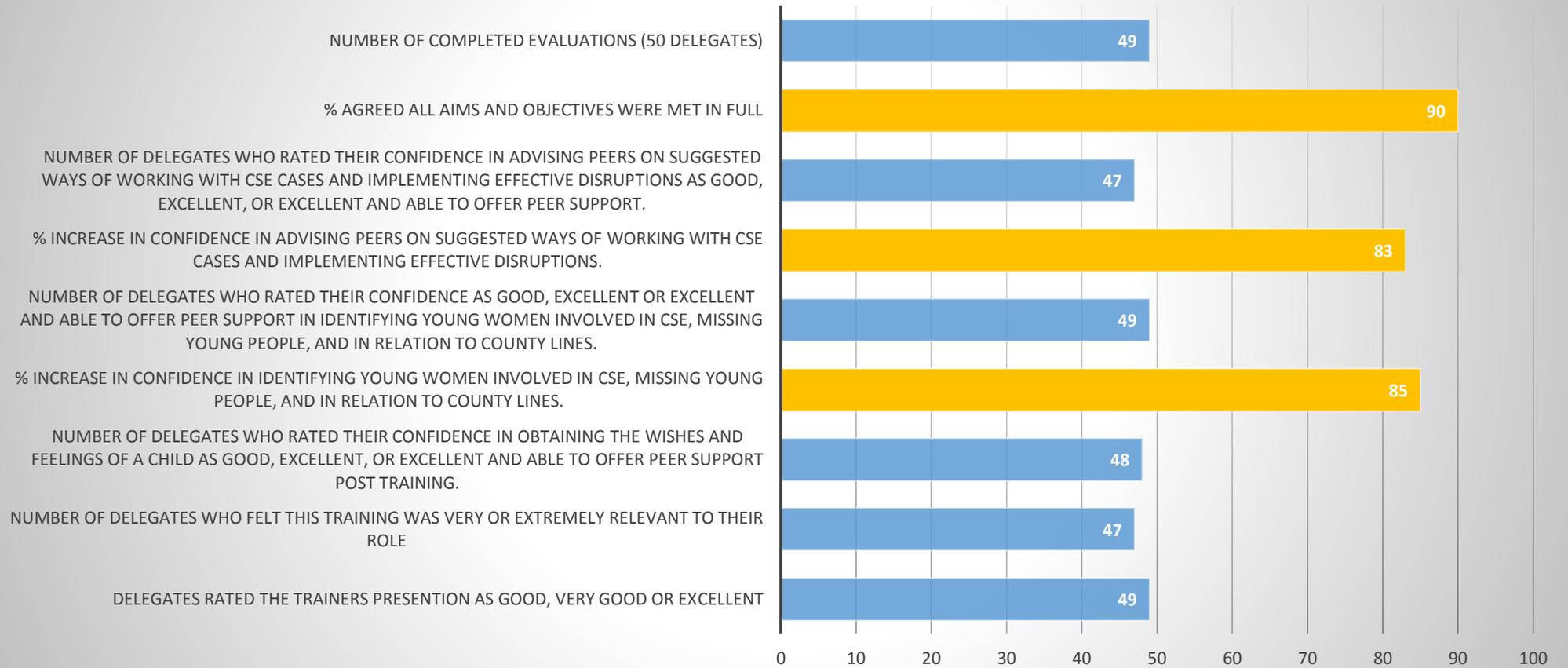
**Safer London**  
X32

**MASH**  
X11

**CEOP Website** x27

Key: Orange = % Blue = Numbers

## Learning Evaluation Statistics



“I will be able to identify signs and symptoms of trauma in CSE.”

“Consider CSE in younger children i.e. 12+ and consider the impact of trauma.”

“I have a deeper understanding of trauma and CSE, plus contextual safeguarding.”

“It will help me in working with children where there are CSE and county lines concerns.”

“Numerous toolkits available online and can be used with young people for direct work.”

## LSCB Training Analysis

The training data above provides an outline of some key elements of the larger LSCB Training Program in 2018-19.

### Core Safeguarding Training

As outlined on pages 49-52 above, the LSCB has managed to train large numbers of people who work with children and young people in Lewisham across a wide range of safeguarding topics.

### Me-Learning (E-Learning)

The Me-Learning (Online learning) for Safeguarding Children Level 1 course trained 1069 individuals in 2018-19, with safeguarding partners in Primary and Secondary Schools, Adult Social Care, Child Care, Early Years and Charities being some of the agencies that most frequently utilised this safeguarding training offer. The Me-Learning Level 2 Safeguarding Children course has now transitioned to being an online course, which has led to a resultant increase from 40 individuals trained in 2017-18 to 430 individuals in 2018-19. This has provided greater reach for this more advanced safeguarding course, with Child Care professionals, Early Years Providers, Primary and Secondary Schools and members of the public being those who most frequently accessed this e-learning training offer.

The LSCB also offers a wide array of additional safeguarding Me-Learning courses, having trained hundreds of additional individuals online around a range of safeguarding issues ranging from Safeguarding Children with Disabilities, Sexual Abuse and Online Safety, Human Trafficking & Modern Day Slavery, Data Protection and Information Sharing and Consent being some of the more heavily subscribed e-learning courses. Overall, 2995 individuals were trained in Me-Learning courses across the LSCB training offer in 2018-19.

The LSCB also offers Level 3 Safeguarding Children for Designated Safeguarding Leads 'classroom' learning. This training is targeted at professionals who are the identified lead for safeguarding within their organisation (eg. School Designated Safeguarding Leads). The LSCB trained over 60 designated safeguarding leads in 2018-19, with a take-up rate of over 80% for this course. When taking into account all other LSCB Classroom Learning courses, 741 individuals received LSCB training in 2018-19.

### LSCB Priority-Linked Training

The LSCB maintains a range of safeguarding priorities and information relating to a sample of courses that link directly to LSCB Priorities have been listed above at pages 54-58. Attendance has varied at some courses and work will be ongoing in 2019-20 to enhance awareness of LSCB training courses to continue to share information to develop practice around areas such as Neglect, Suicidal Ideation & Self-Harm and Child Sexual Exploitation alongside Core Safeguarding Training. Feedback from delegates who have attended priority-linked training has been very positive, with noted increases in knowledge, confidence and the ability to support others when confronted with these issues when working with children and families.

### Training Program Development & Improvement

Over 2018-19, the LSCB has expanded its training program on safeguarding issues such as Breast Ironing, Child Sexual Exploitation Champions, Lunchtime Introductory Safeguarding Briefings for safeguarding partners and expanded the number of Safeguarding Children Level 3 – Designated Safeguarding Leads from 2 to 4 sessions annually and commissioned additional training on Working with Challenging and Hard to Help Families and Safeguarding Children affected by Parental Substance Misuse.

Moving forward, the LSCB is looking to support professionals to develop their knowledge and skills within a Trauma-Informed Approach to safeguarding, in line with Lewisham's wider Public Health approach to key issues such as violence reduction for young people. A series of courses will be provided by Solace Women's Aid on a pro bono basis to enhance practice around Working with Perpetrators of Domestic Violence. A Gaming & Gambling Harm Prevention Program will also be offered by YGAM (charity) and the LSCB will implement a LADO Awareness Lunchtime Briefing for safeguarding professionals.

# LSCB Task Groups

Aims to safeguard children and young people from harm as a result of going missing; child sexual exploitation; or trafficking for exploitation arising as a consequence of being the victim of trafficking including County Line drug dealing.



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



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.



Responsible for considering cases in light of the Serious Case Review criteria as set out in Working Together to Safeguard Children 2015 and making recommendations to the Independent Chair



Responsible for developing policies and procedures to safeguard children and ensuring that multi-agency training on safeguarding is provided in order to meet local needs



Reviews the deaths of all children in Lewisham: this became a statutory duty in April 2008

The Business Unit also co-ordinates a meeting of the Task Group Chairs, who meet before each LSCB Main Board Meeting.