



**Lewisham  
Safeguarding  
Children Board**



# Annual Report 2017/18

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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 2017 to March 2018. 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 draft Working Together to Safeguard Children guidance published and consulted upon. We await the final publication of this document, which is anticipated in July 2018, which will influence and govern what new Multi-agency Safeguarding Arrangements will replace LSCBs by the Autumn 2019. With reduced capacity in many of the agencies due to reorganisation, we are looking at how we can reduce duplication and join 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. Our challenge over the next year will be to ensure that

replacing the LSCB with the new arrangements, is done carefully and builds on what we know works well. The next year will be challenging for all agencies 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 smooth 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



**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 2017/2018.

## The Executive Board

The Executive Committee 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 CYP appoints the Chair.

## Lewisham Borough Council

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

The Executive Director of Children Services 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 role of Lead 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 in Lewisham are committed to ensuring the effective operation of the LSCB. 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 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 are Designated Doctors and Nurse Role's in post for 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.

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## Effectiveness of the Board

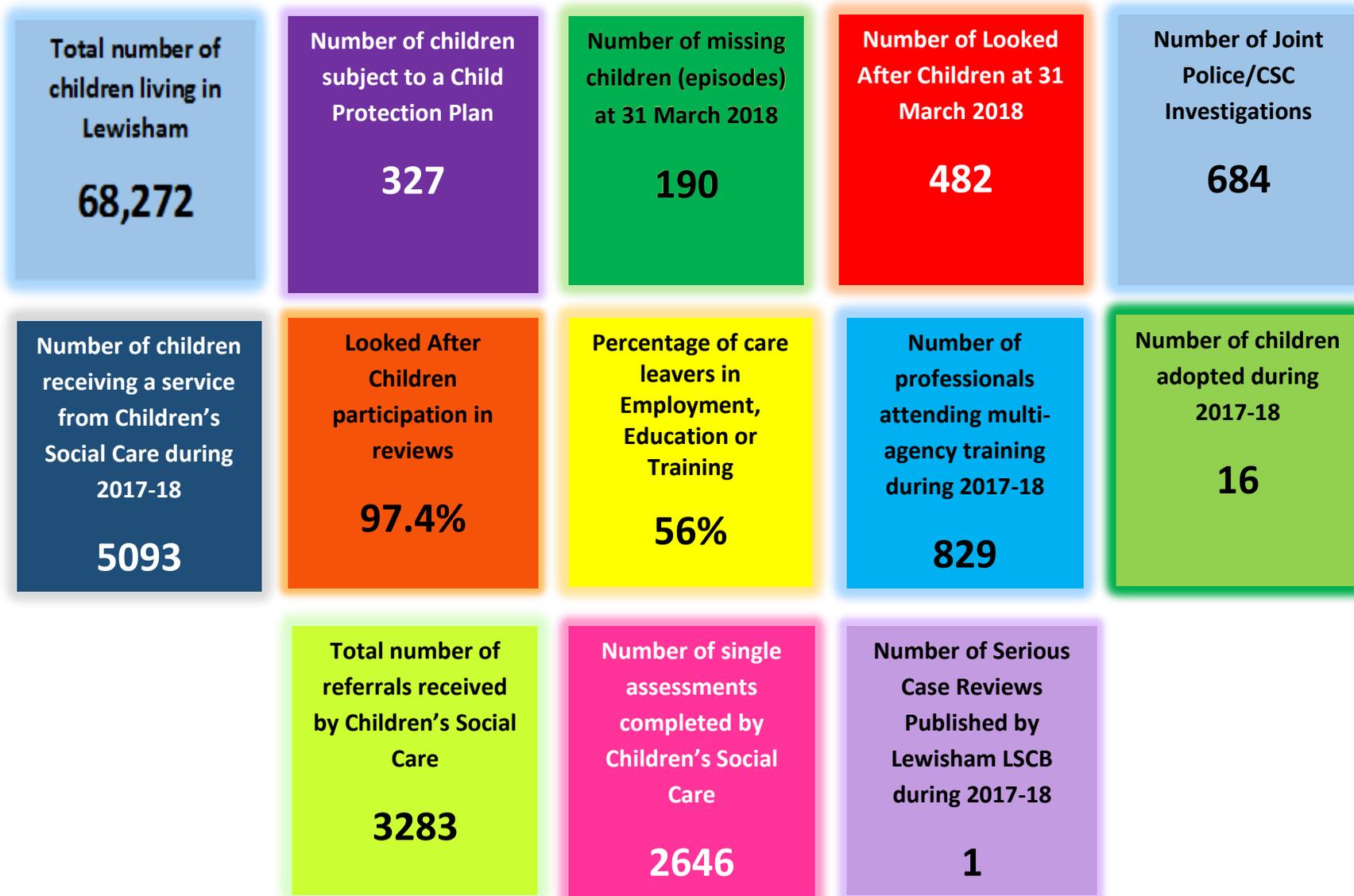
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The Board is required to report on progress against the priorities set for the previous year, look forward and plan any changes to the safeguarding priorities for the local area for the next year. We also take into account national priorities and local 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.

A summary of our key Priorities for 2017-2018	A summary of our key achievements for 2017-2018
<p><b>Priority 1:</b> <b>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>• A Neglect Task Group met regularly and updated the multi-agency risk assessment, monitor partnership focus groups, and assisted with the outcomes of the neglect audit action plan.</li><li>• Neglect audit commissioned and completed in 2017/2018</li></ul>

<p><b>Priority 2:</b> <b>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>• Revised LSCB Performance Framework ensured key indicators from across the partnership were captured.</li> <li>• Consistent audit schedule ensured the monitoring of single and multi-agency audits.</li> <li>• New Audit Sub Group ensured all multi-agency audits were completed on time.</li> <li>• Section 11 audit proposal accepted by the LSCB, and was implemented during 2017-18.</li> <li>• Regular scrutiny and challenge of partnership agency data.</li> <li>• Regular meeting of Chairs of Partnership Boards, ensuring consistent safeguarding messages</li> </ul>
<p><b>Priority 3:</b> <b>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>• Increased the number, and variety, of training packages on self-harm, on the LSCB training programme.</li> </ul>
<p style="text-align: center;">A summary of our key Priorities for 2017 -2018 <span style="float: right;">A summary of our key achievements for 2017-2018</span></p>	
<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>• Regular interface with Young Mayor’s Forum</li> <li>• Development of the LSCB website to use as an interactive tool with children and young people.</li> <li>• New Introduction to LSCB Presentation for professionals, young people and community.</li> <li>• New LSCB website commissioned to improve communication with professionals, parents and carers, schools and the community and to ensure it raises the profile of safeguarding matters and the work of the LSCB</li> <li>• Monthly themed briefings to ensure key safeguarding messages reaches professionals across the partnership.</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>• Week-long activity to raise awareness of sexual exploitation – coinciding with national CSE awareness day, including drop-in sessions, targeted visits.</li> <li>• Audit of CSE cases known to the police and CSC.</li> <li>• Agreement of a MET Information Sharing Protocol</li> <li>• Weekly MET operational meetings to discuss individual cases, monthly MET tactical meetings to look at trends / hotspots etc.</li> </ul>

# LSCB PERFORMANCE DATA 2017- 2018



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# LSCB Task Groups

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

Chaired by: Tom Stevenson, Service Manager Quality Assurance, Lewisham Children Social Care (until October 2017); Nicky Pace, LSCB Independent Chair (from November 2017)

### What did we do?

Following a development session, proposals for a new meeting structure were introduced to provide greater capacity for challenge and scrutiny of safeguarding issues across the partnership by refocusing the Monitoring, Evaluation & Service Improvement (MESI) group. The Independent Chair now chairs this group, which reports directly to the Main Board. An operational Audit group was set up, separate from and report to MESI to provide greater focus on multi-agency audit function.

The aim of this newly focussed 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?

The new arrangements were put in place in January 2018 and therefore it is too early to identify any impact at this point. It is anticipated that the scrutiny and focus on wider safeguarding issues will enabled the board to have wider discussion and focus on practice issues where there would not be the opportunity in 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. The Children's Social care data has slowly evolved so that areas can now be reported upon around Early Help, but there is more still to be done. Analysis of the data and understanding the impact continues to be a challenge.

### S11 Process

Section 11 (4) of the Children Act 2004 requires each person or body to which the duties apply to have regard to any guidance given to them by the Secretary of State and places a statutory requirement on a range of organisations and individuals to ensure their functions, and any services that

they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

Working Together to Safeguard Children 2015 states that one of the key functions of a Local Safeguarding Children Board is:

*“Monitoring and evaluating the effectiveness of what is done by the authority and their board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve”*

One of the ways in which Lewisham Safeguarding Children Board (LSCB) ensure that this function is fulfilled is by undertaking an annual section 11 audit to provide partner agencies with an opportunity to focus on their arrangements for safeguarding children and to identify any need for improvement. LSCB began using a new process for the section 11 audit. Formerly this was completed via a written report which would be compiled by each agency and presented to the board for scrutiny. For the 2017/18 audit it was decided that a more robust approach would be to directly ask all members of the workforce, including frontline workers, about their safeguarding knowledge and confidence.

The proposed new process has four phases which provides both qualitative and quantitative information and supports a comprehensive analysis of compliance with Section 11 responsibilities across a wide and diverse range of agencies. As a result of the self-assessment, where the agency identifies areas for learning and improvement, they then complete an action plan and return it with their audit analysis to the LSCB. The LSCB will then interview a sample of agencies to identify gaps, strengths and weaknesses in

safeguarding practice across agencies as well as identifying areas for improvement through learning and development. The agencies action plans would be scrutinised and monitored 6 months into the year with requests for updates. The Board would then produce an overarching report following analysis of the results including an action plan for the Board of learning from the audit process. If the process is then repeated on a regular basis, it forms a baseline and template to measure agencies progress. It was agreed to undertake this in phases across the partnership. The outcomes of this will be reported to the board.

## Multiagency Audits

The board set the annual themes for multi-agency audit from April 2017 to March 2018. These were: Neglect, MET and Children with Complex needs (CWCN). The new operational audit group for MESI met from September 2017 bi-monthly, chaired by the Quality Assurance Manager in Children’s Social Care. The three audits were completed by May 2018; two audit reports (Neglect and Children with Complex Needs) were signed off by the board. All audits were endorsed by the main MESI.

## Neglect Audit

This audit considered a random sample of seven children’s cases agreed by partners. Records were then audited by involved partner agencies using 12 key questions developed by the partners. The children ranged in ages from new-born to aged 15 years, while four of the children were under the age of 4.

Main audit findings and recommendations identified that the MARAC pathway needed more embedding in agencies, there was a lack of sharing of information between agencies about 'toxic trio' risks, GPs were not always receiving key information about children from social care. Children's plans from social care needed to be more routinely shared with partner agencies at key stages of the work. It was recommended that Children's Social care should consider analysing repeat referrals on known neglect cases. This audit highlighted that audit activity and methodology needed to develop further. Partner engagement at an operational level needed to improve, particularly with the police CAIT and GPs.

### Children with Complex Needs Audit

Following recommendations of one unpublished serious case review (SCR) in January 2017 in relation to a child with complex needs (CWCN), it was agreed that an audit to look at how the multi-agency partnership worked together in relation to CWCNs was required.

A small cohort of 7 children or young people with complex needs was identified from social care records; before selection all partners were asked to consider a multi-agency casefile audit tool recently developed in consultation with a neighbouring Local Authority. Recommendations for education saw that supervision processes for complex cases may need to be further strengthened and that audit work needed to be more embedded with capacity improved in use of audit tools in schools. Actions agreed were for the Designated Safeguarding Lead Education to develop an improvement

plan and mechanism and report on this to LSCB by December 2018 and to discuss in operational and strategic MESI from July 2018 onwards. Recommendations for health were that improvements were needed around working with fathers and in supporting staff to engage and communicate with children and recording better these examples. Actions agreed were for Health Safeguarding Leads to develop a plan and report to LSCB December 2018 and to the operational and strategic MESI from July onwards.

### Missing, Exploited and Trafficked Audit

This was an audit theme the board set previously when the MET operational and strategic work was being developed in Lewisham. Originally the police and Children's Social Care were to carry out an audit. Due to time constraints in completing the audits for the year a similar case file 'deep dive' approach was taken on a seven cases known to both partners. CSC and the police audited a small sample of MET cases using an audit tool and a worker made contact with parents of the cohort and tried to speak to the young people.

The LSCB sought to ensure that the MET operational group were meeting the needs of Lewisham children who are known and identified at possible risk for being missing, exploited and trafficked and that they had: multi-agency plans in place commensurate to their needs and status being reviewed regularly and well recorded regarding impact on this group of children, the role of the MET was understood and implemented, decisions about resources had a safeguarding emphasis.

The sample of young people were mainly living in residential care, with the exception of one young person.

For Children's Social Care and partners recommendations were: the development at a strategic level of specialist local services for this cohort to support them and their families, work to strengthen worker curiosity regarding diversity issues, the application of CSE toolkits, understanding of parental neglect on teenagers development, engagement of hard to reach parents should take place within CSC service areas and across the partnership. Greater sharing of early social care history with police should occur at operational weekly MET from partners and CSC.

Feedback was limited to two parents who provided useful feedback- mainly about worsening family relationships for young people in care, and the need for them to receive good co-ordinated information about their children.

One young person's case had been well worked and provided good examples of a social worker and partners working assertively with him. There was evidence of an interested and tenacious approach taken by the social work team, and the development of a trusting relationship for a young person who had had adverse earlier life experiences and experienced parental neglect. This was feedback to the worker and celebrated by senior managers.

The findings from this audit were presented and discussed at the MET LSCB task group. It was proposed to identify a small group of children on the edge of entering care, so that more intensive community based interventions could

be offered, with risk shared by the multi-agency group. This would include commissioning in services and working with the third sector. In summary the last two audit themes have progressed the methodology used in audit work, through introducing an audit tool and briefings, and introduced some feedback from service users. Future audits plan to extend audit methodology and introduce the voices of practitioners and service users, and there will need to be work to engage the Police and the GP group in this work.

### What do we plan to do next?

The MESI will continue to monitor all the statutory areas of practice of the Board including the dataset, ensuring 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 Board partners to account for the delivery against the identified priorities for the next year.

## Policies Procedures & Training Task Group (PPT)

Chaired by: Maureen Gabriel, Designated Nurse,  
Lewisham CCG (until July 2017); Adé Solarin, VAWG  
Programme Manager, Lewisham Council.

### What did we do?

The PPT oversees safeguarding training to a wide range of professionals, volunteers, and community groups who work with children and families in Lewisham. Every year, the PPT reviews and approves a comprehensive training programme. Training is diversified through face to face sessions, lunchtime briefings, half-day seminars, and e-learning, and is informed through serious case review recommendations, practitioner surveys, and multi-agency audits. For example, Level 2 Safeguarding, which is face to face, was reviewed and deemed to be more appropriate to be offered as e-learning. This was not only found to be more useful by practitioners, but also led to a saving of £800 per year for the LSCB.

We have ensured an improved training programme by adding useful courses such as '*Children Missing from Education*', '*Introduction to LADO*' and '*Parental Mental Health & Effect on Young People*'. This year, 829 delegates utilised our training programme, a slight increase of 15% on the previous year. The PPT have set an ambitious target to increase training attendance by 20% next year.

The PPT also works to review policies and procedures. This year, the Task Group reviewed and approved;

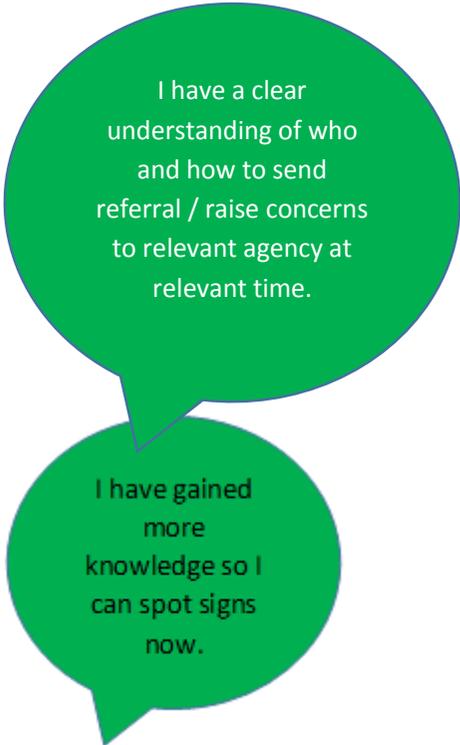
- Multi-agency FGM guidance.
- Anti-bullying guidance
- E-safety guidance
- Escalation / Resolving Professional Differences Policy
- Protocol for the management of actual or suspected bruising in infants.

The PPT also receives requests from community and voluntary groups, to aid in updating their safeguarding policies. The VCS groups benefit from the expertise of PPT members.

### What was the impact?

The PPT evaluates training in a 3-stage format. Stage 1 evaluation is taken at the point of application so the trainer has an understanding of the delegates' level of need. Stage 2 is taken immediately after the course in exchange for a certificate, and tests the delegates' level of knowledge and understanding. Stage 3 is taken at the 3 month stage by a telephone survey for training on our comprehensive topics such as Domestic Violence, Neglect, and Working with Challenging & Hard to Help Families.

Some of the feedback and comments about our training;



I have a clear understanding of who and how to send referral / raise concerns to relevant agency at relevant time.

I have gained more knowledge so I can spot signs now.

Our most popular courses continue to be the Safeguarding Level 2 and 3 courses, with evaluations commonly positive. **95%** of delegates reported that the Safeguarding Level 3 course was extremely helpful to their role, and **34%** increase in confidence on previous year, in obtaining the wishes and feelings of the child.

### What we plan to do next?

The PPT have recently produced an Introduction to LSCB lunchtime briefing suitable to all professionals as well as children and young people. We hope to create an interactive online version, which can be shared widely and

easily, across multiple social media platforms. We have also been working with all our trainers, to ensure contracts are updated, in line with tax regulations. We will continue to work with our trainers regarding this area.

## Communications and Publicity Task Group (C&P)

Chaired by Pat Barber (from January 2018), Governors Association

### What did we do?

The Task Group works to provide a communication channel to the wider Lewisham community, by sharing resources, toolkits, updates, and also raising awareness on key safeguarding events.

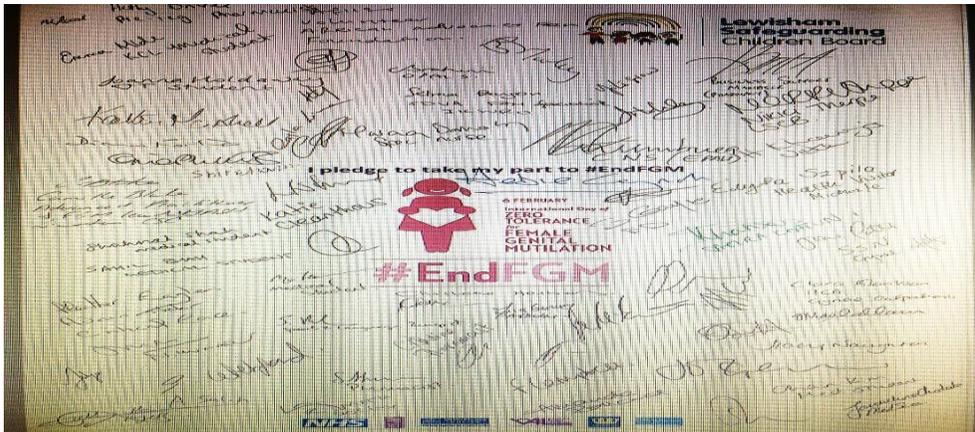
Building on the successes of the launch of the website last year, which had over 8,000 visits to our training page, professionals now access our website for training, tools and resources. The website is reviewed on a regular basis, to ensure content is kept updated.

### LSCB Awareness Raising Campaigns

On 6<sup>th</sup> February, 2018, to coincide with International Day of Zero Tolerance to FGM, we hosted a Drop-In at two sites across Lewisham. The aim of the day was to speak to raise awareness on FGM practice in Lewisham, including clarifying the difference between a concern, and a disclosure.



Over 200 professionals including doctors, social workers and police officers, signed our pledge and commitment to end FGM.



In March 2018, a range of activities took place to raise awareness on Child Sexual Exploitation week, a key priority for the LSCB. There were drop-in sites at Lewisham Hospital and the Lewisham Shopping Centre, as well as

presentation to parents and carers. Our police colleagues also worked with local hotels, taxi firms, and pharmacies, equipping them to look out for signs of vulnerable young children.

The Task Group has also resurrected the monthly safeguarding briefings, with key topics such as domestic violence, neglect, CSE, and FGM, all featuring in this reporting period, and published on the website.

### What was the impact?

The Drop-In sessions proved hugely successful with practitioners, who found the approach useful for their work. Those surveyed reported feeling more confident in discussing safeguarding topics like neglect and CSE, with their colleagues. The return of the monthly safeguarding briefings have helped raise awareness with professionals, as well as the public.

### What we plan to do next?

We need to work more closely – and directly – with young people, and empower them to have a voice on decisions which affect them.

We need to communicate with young people through mediums they frequently use, such as social media platforms like Instagram, WhatsApp and Twitter.

We will be working closely with Lewisham Children Social Care, with the commitment to have an apprentice working with the Board and the Leaving Care team, to champion young people's voices.

## Case Review Panel (CRP)

Chaired by: Nicky Pace, until November 2017; Karen Neill, Interim Service Manager, Quality Assurance, Lewisham Council Children Social Care until March 2018

### What did we do?

In 2017/2018 the Terms of Reference of the group were reviewed to ensure appropriate membership. The group met on four occasions during the year and undertook the function of:

- Determining whether cases met the Working Together 2015 criteria for a Serious Case Review (SCR).
- Making a recommendation to the Chair of the LSCB in relation to type of reviews to undertake.
- Commissioning Learning Reviews and/or SCRs
- Managing the process of completing of completing the SCR report
- Ensuring actions and recommendations are implemented fully, and learning is embedded within agencies.

This work enables the LSCB to undertake its statutory functions in relation to SCRs. The process is to review what is known about a case, gather initial information from agencies, such as chronology and then make a recommendation on whether the criteria for an SCR is met. If a SCR is commissioned the group manages the production of the SCR report, and considers any potential media interest.

When the criteria for a serious case review is not met but there are possible learning / key issues arising from the case, the Panel might recommend a multi-agency case review to ensure actions are taken and lessons are learnt from the case to ensure children are safeguarded.

### What was the impact?

As a result of more structured meetings, in 2017/2018 the group met four times to consider five serious incidents and make recommendations to the LSCB Independent Chair. Three of the five cases met the criteria for a SCR. All three were commissioned to have independent reviewers, who have plenty of experience. Although not yet public, the final reports will be placed on the LSCB website.

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. Two Lewisham SCRs were published anonymously on the NSPCC website in 2017/2018.

### What we plan to do next?

The Learning from SCRs is currently overseen by this task group, to ensure that recommendations are implemented, however, we will be working on establishing a Learning Hub, as a central place to promote a culture of learning and improvement across the partnership.

Also, 2018/2019 should see the publication of all 3 current SCRs. In addition to the 2 published anonymously, we will be working to create

combined key messages, and whether any themes cut across multiple SCRs.

## Child Death Overview Panel (CDOP)

Chaired: by Pauline Cross, Consultant Midwife, Public Health Lewisham

Chapter 5 of Working Together to Safeguard Children 2015<sup>1</sup> 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.

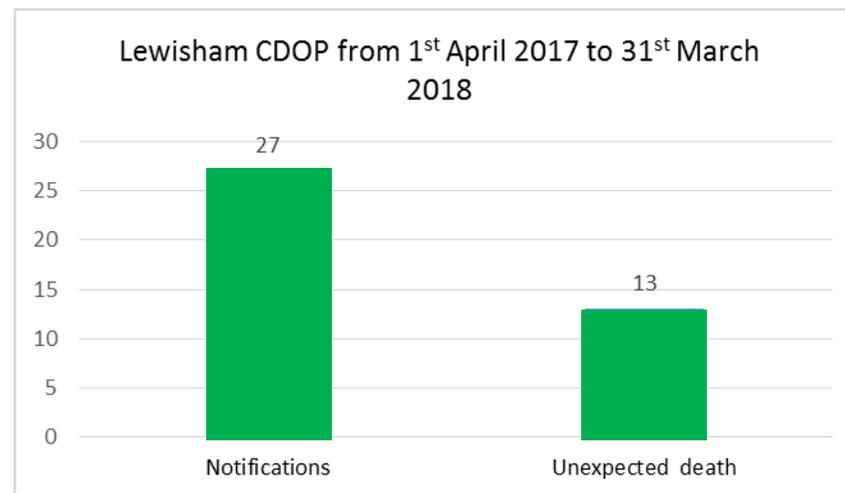
Currently, Child Death Overview Panels (CDOPs) are the means by which local LSCBs discharge this responsibility. Babies who are stillborn and planned terminations carried out within the law are excluded from the review.

LSCBs must collect and analyse information about each death with a view to identify:

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

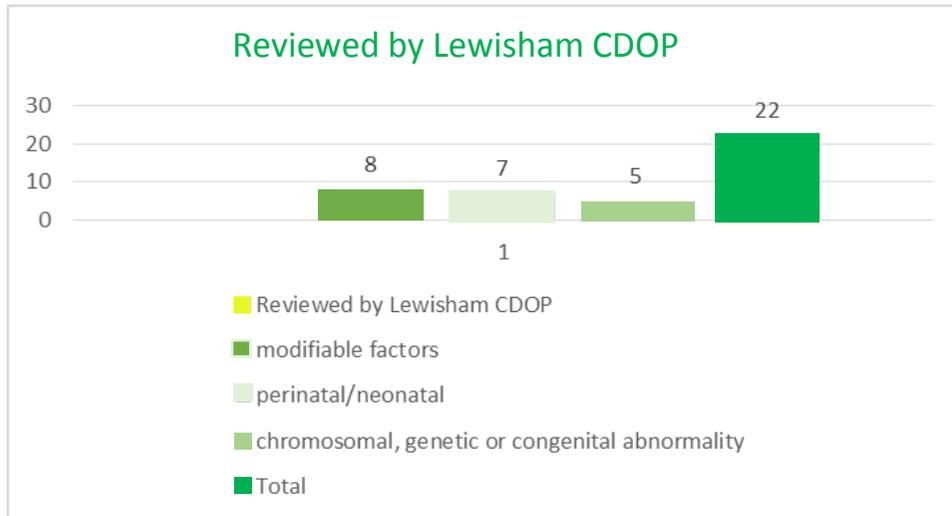
- Put in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

Notifications to Lewisham CDOP are received from a number of sources including A&E departments, police, hospice and paediatricians. Information is collected and collated on each child prior to the child death review where panel members will discuss whether the death was preventable, that is, whether there were modifiable factors that may have contributed to the death. 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 4 deaths to the SCR panel during 2017-18, two of which were taken forward by the SCR panel and 2 were not.



<sup>1</sup>

Lewisham CDOP received 27 child death notifications from 1<sup>st</sup> April 2017 to 31<sup>st</sup> March 2018 of which 13 were unexpected deaths. This was an increase on the previous two years. 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.



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 and is due to report in February 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 audit aims to identify any gaps and provide a consistent offer of support to promote good mental health and enable young people and their parents to be informed about support available when they are discharged.
- Following the tragic death of a young person on a school trip abroad, CDOP contacted a number of agencies with a particular focus on recognition of the signs of drowning and careful, context-framed risk assessment of swim trips on school holidays. In response PHE sent out a national alert. CDOP recommendations were also shared with the Lewisham schools lead and the LSCB for the out of borough school attended by the young person
- In response to meetings with some bereaved parents, CDOP initiated a survey of bereaved parents to ascertain the effectiveness of bereavement support, timeliness and gaps. This is due to report in September 2018.

## Plans for next year

The new Working Together statutory guidance was issued in July 2018 and CDOPs are required to have their plans agreed by October 2018 with view to being up and running by October 2019. Lewisham CDOP have led on arranging partnership meetings. Currently, the favoured option is to have a tri-borough CDOP between Lewisham, Greenwich and Bexley CDOP which will review approximately 75 child deaths per year in line with the new guidance which stipulates panels to review a minimum of 60 deaths. However, arrangements for the immediate response to the death of a child are those which will have a significant impact on acute health care providers and these processes are also still in discussion.

## Missing, Exploited and Trafficked (MET) sub group of LSCB

Chaired by/Agency Representative: Stephen Kitchman  
Director of Children's Social Care and Geeta  
Subramaniam Head of Public Protection and Supporting  
People

## What did we do?

The sub group has struggled to get traction and complete partnership action on a number of areas in the strategy action plan.

There was a review of the sub group in July 2017 which identified the following:

- Lack of consistent and meaningful data from all agencies
- Lack of analysis of the information
- Clarity of transition and cases post 18
- Lack of detailed information from provider services to inform the work
- Not enough detail about education , exclusion and other issues of note

There have been positive feedback and review of the model and approach to MET and linking to the Serious Violence work and groups. The weekly case monitoring was valued and enabled good partnership solutions.

The sharing of the work undertaken by Bedfordshire university on contextual safeguarding and embedding this into assessments has begun, with all agencies agreeing to ensure this is done by practitioners.

The development of an electronic referral form was completed to assist with consistency and support analysis. The form has received really positive feedback, but more work needs to be done with our colleagues to enable data extraction and analysis as anticipated. This is still being progressed.

There has been a comprehensive training programme in place for all agencies on CSE, Missing, exploited and trafficked, serious violence. The

CSE toolkit has been promoted across all agencies and agreement at LSCB for its use by all.

### What was the impact?

- A storyboard has been completed to capture the Lewisham picture and interventions and support resources to assist professionals
- The work undertaken by Christine Christie in relation to interviews and qualitative feedback from young people completed and this is to be shared to inform practice. (2 of the cases were Lewisham children).
- There are currently no red actions on the action plan – however impact on outcomes for children need to be assessed through improved data capture, analysis and input from children and families.

### What we plan to do next?

- Improve the feedback from children and parents into the sub group through children's social care and providers to be developed
- Reinforce the CSE toolkit alongside the contextual safeguarding checklist to be used by all agencies.
- Continue the training offer for all LSCB agencies
- Working with the police with their organisational changes to ensure the focus on MET and its interconnection to serious violence is maintained.
- Delivering a harmful sexual behaviour programme of learning and restorative skills for practitioners

# LSCB Statutory Functions

## Local Authority Designated Officer (LADO)

This LADO Annual Report shows the following activity for the time period of 1<sup>st</sup> April 2017 to 31<sup>st</sup> March 2018:

- Contacts In to LADO
- Advice & Guidance
- Referrals
- Allegations against Staff and Volunteers meetings (ASV)
- Outcome of Allegations (ASV) Meetings

2017/18	Contacts received N	Contacts received %
Q1	65	19.6
Q2	58	17.5
Q3	101	30.4
Q4	108	32.5
<b>Total contacts</b>	<b>332</b>	<b>-</b>
OUTCOME of CONTACTS		
	N	%
No. for advice and consultation only	60	18.1
No. Taken Forward to Referral	160	48.2
Other (those not taken forward)	112	33.7
<b>Total</b>	<b>332</b>	<b>-</b>

Table 1 Source: LADO Database 2017/18

2017/18	Advice and consultation
Q1	8
Q2	7
Q3	10
Q4	35
<b>TOTAL</b>	<b>60</b>

Table 2 Source: LADO Database 2017/18

### Contacts In & Advice and Guidance

Tables 1 and 2 above show contacts into LADO and those in receipt of advice and guidance in 2017/18. This is the second year the LADO has made use of the contacts tab on the Allegations Spreadsheet in an attempt to show the range of work. As shown, the high level of contacts in to LADO do not always result in a referral.

In total there were 332 contacts in to the LADO through the year. This resulted in 160 (48.2%) being taken forward for referral and 60 (18.1%) for advice and guidance from the LADO only. This compares to 215 contacts received in 2016/17 when 130 (60.4%) were taken forward to referral. In essence, there were fewer referrals in 2016/17, but a higher proportion were taken forward to referral.

The remainder of the contacts in (n=112, 33.7%) were largely no

further action or directed to another more relevant service.

### Referrals to Allegations (ASV) Meetings

2017/2018	REFERRALS RECEIVED (n)	STRATEGY or ASV MEETINGS HELD (n)	ALLEGATIONS
			SUBSTANTIATED (n)
Q1	36	17	1
Q2	25	16	3
Q3	48	25	7
Q4	51	25	3
<b>TOTAL</b>	<b>160</b>	<b>83</b>	<b>14</b>

Table 3 Source: LADO Database 2017/18

Table 3 above shows the total number of referrals, ASV meetings and allegations substantiated in the year by quarter. As can be seen, the total number of referrals received is 160 and through quarters 3 to 4, these referrals increased by n=38 (62%) from the previous two quarters.

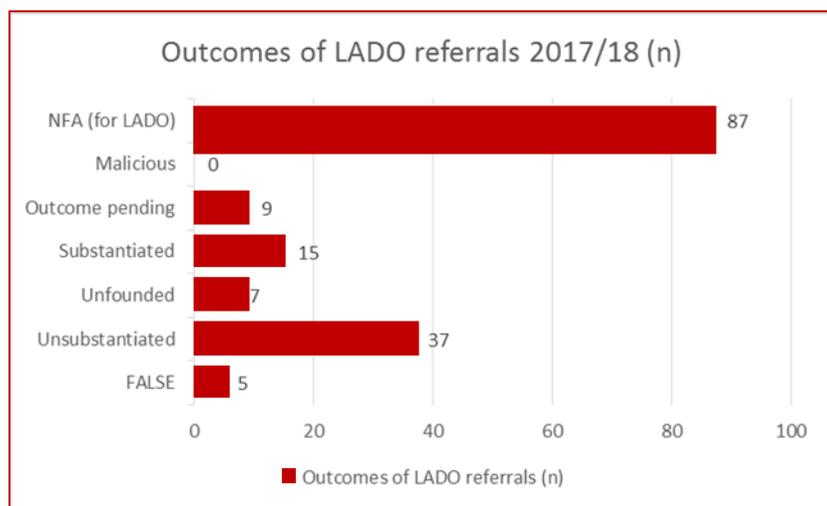
In 2016/17, the total number of referrals received was 130 (vs 160 in 2017/18) and the number of ASV meetings was 87, whilst substantiated allegations was 27.

There has been a drop in substantiated allegations from 27 to 14 despite the increase in referrals. As each case has to be addressed in terms of its own merits, it would be difficult to draw any inference from this decrease. The role of the LADO continues to be embedded amongst the

Safeguarding Partnership (LSCB agencies) in Lewisham.

Quarter 2 covers the school holiday period, and so figures habitually drop for this period. Roughly half of the referrals result in Allegations (ASV) meetings, the others involve discussion and consultation, usually ending in no further action by LADO but internal investigative or disciplinary processes are followed by the organisation concerned.

### Outcome of Allegations



**Graph 1** Source: LADO Database 2017/18

The graph above shows the outcome of LADO referrals received in 2017/18. Most referrals (n=87, 54%), resulted in no further action to the LADO, but may have required further action by another agency. The outcome of

'unsubstantiated' (n=37, 23%) is the second highest proportion in the graph above.

Whenever a referral to the LADO is received, it must be processed no matter if it appears to be lacking evidence to progress to a substantive outcome. The LADO must review the referral, and if it is deemed to be necessary, progress to an ASV meeting.

These are cases where a referral is completed and on receipt of all the information, it becomes clear that the matter can be dealt with internally by the referring organisation. In these instances, the information gathered by the organisation provides the evidence to counter the allegation or it is a practice related concern. There were 5 false allegations this year, both from children and adults whereas there was only one in 2016 -2017.

2017/18	REFERRALS RECEIVED	CONCLUDED REFERRALS	LIVE REFERRALS
N	160	151	9

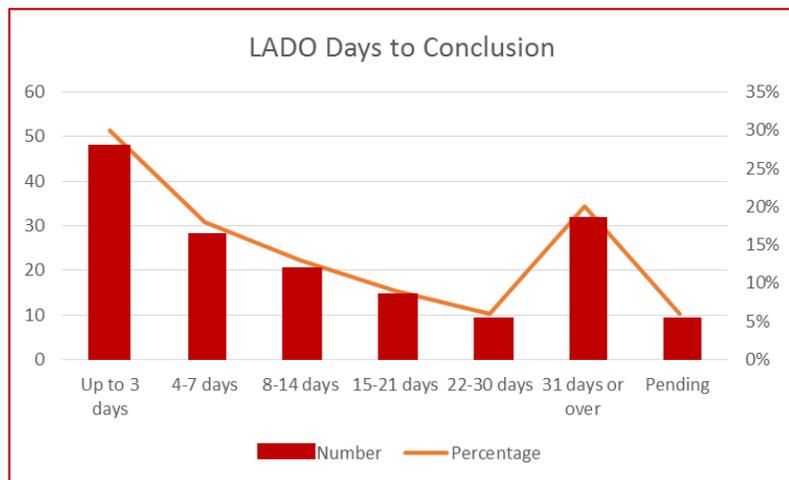
**Table 4 Source:** LADO Database 2017/18

Table 4 above shows those referrals concluded in 2017/18 and still live in 2018/19. The vast majority were obviously concluded (n=151, 94%), with a small number (9) still live in 2018/19.

### Timeliness of LADO Process

The majority of allegations (94%) were concluded in 2017/18 with only 6% pending. Four of these are currently with police teams and pending criminal

proceedings, 2 involve faith groups, 3 involve disciplinary procedures in schools.



Graph 2 Source: LADO Database 2017/18

Number of days until referral concluded 2017/18	n	%
Up to 3 days	48	30
4-7 days	28	18
8-14 days	20	13
15-21 days	14	9
22-30 days	9	6
31 days or over	32	20
Pending	9	6
<b>TOTAL</b>	<b>160</b>	<b>-</b>

Table 5 Source: LADO Database 2017/18

The vast majority of referrals (76%) were concluded within 31 days. Guidance recommends that 80% of referrals conclude within one month. Reducing the time to conclude the majority of referrals is a development goal for 2018/19.

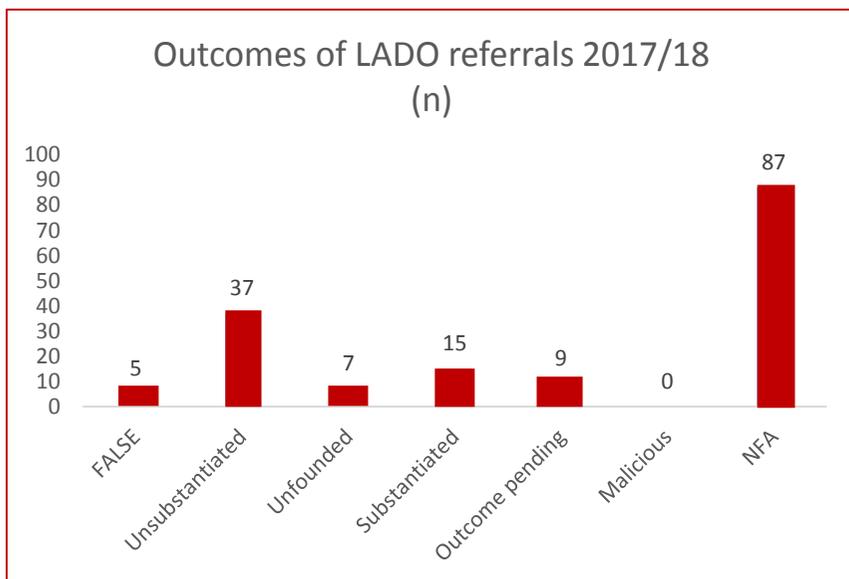
The majority of referrals took under 14 days to conclude (61%).

### Outcomes of LADO Referrals

The graph below shows LADO referrals by outcome in 2017/18. As stated previously, over half of all referrals resulted in NFA to the LADO (n=87, 54%).

The next highest proportion of outcome from referrals is 'unsubstantiated', (n=37, 23%). Fifteen referrals were found to be 'substantiated', in that there was sufficient evidence for the LADO to reach this outcome, whilst a total of 13 were unfounded or found to be false. No referrals resulted in outcome of 'malicious'.

Of those cases substantiated they involved such matters as, criminal proceedings or police involvement in the personal lives of professionals working with children, harmful practice with children in the work environment and Ofsted notification to suspend operation (early years setting).



Graph 3 Source: LADO Database 2017/18

The tables below show NFA to LADO breakdown. As stated, whilst over half of referrals received in 2017/18 resulted in NFA to LADO, there was outcome in respect of action taken by either the agency or organisation employing the individual and those organisations working alongside LADO, such as other Local Authority LADOs and Children’s Social Care Services, and Ofsted.

Therefore, a good deal of the referrals to LADO result in some other action being taken (even if action is not taken by the LADO). As can be seen from the table below, No Further Action at referral stage are cases that do still involve LADO reviewing the material and making a decision that the referral can be dealt with through internal disciplinary processes, requires no further action by any agency or passed to Ofsted, if a nursery or childminder or passed to another Local Authority LADO.

12 cases were passed to Ofsted for the matter to be dealt with by that organisation. LADO is pleased to report a positive, collaborative relationship with Ofsted for early years settings and with the Early Years department in Lewisham. These partners work effectively to identify safeguarding concerns within the early years setting, consult, meet and resolve the safeguarding practice concerns and reach a final outcome. One such example was the rapid identification of a setting where practice was harmful through early years and Ofsted. Through the LADO processes the practices were identified and outcome reached within 2 months, ensuring that children were safeguarded throughout the process.

### Areas for development:

- Improvement in timescales for conclusion of LADO cases – 80% upwards
- Publicity of allegations processes in relation to faith groups and religious organisations
- Training of Chair of Governors in relation to managing allegations against Headteachers
- Further promotional work with Faith and Community Groups regarding awareness
- LADO Module on LCS
- Internal promotion of LADO processes

## Lewisham Early Help & Multi-Agency Safeguarding Hub (MASH)

The overall aim of Early Help in Lewisham is to *Provide children, young people and families with the right help, at the right time, in the right place and much* work has been carried out in 2017-2018 to consolidate and build on the progress made last year.

The Early Help Strategy sets out the strategic approach to Early Help in Lewisham. This includes how our Early Help approach aligns with our aims and priorities set out in the Children and Young People Plan 2015-18. It also outlines the way that professionals will work to understand, assess and describe need and how professionals will work together with families to meet that need. It contains an overview of the current service offer, as well as the practical steps that will be taken to translate the vision into practice. A copy of the [Early Help Strategy](#) is available via the LSCB website.

Levels of need in Lewisham are described in the Lewisham Continuum of Need (CON). The CON also acts as the Lewisham Threshold document, determining which cases meet the criteria for Children's Social Care at level four. It has been designed to be used as an intuitive working document for all professionals to consult and work to and as such has been designed to be practicable, easy to understand and interpret. The CON is the product of a very high level of partnership collaboration and is reviewed annually by the

partnership. This last happened in April 2018 and a revised CON is being written.

Lewisham has taken a clear position that commissioned Family Support Services will be centred on Targeted Early Help at level three of the CON. In Lewisham we define Targeted Early Help as:

*'Those children and young people at risk of harm (but who have not yet reached the 'significant harm' threshold and for whom a preventative service would reduce the likelihood of that risk or harm escalating) identified by local authorities and partners.'*

The Early Help Team, based in Lewisham Children's Social Care, is responsible for promoting Lewisham's Early Help strategy in relation to children and families which require targeted support at level three of Lewisham's Continuum of Need (CON). It receives partnership referrals for targeted support through the Lewisham MASH. Its job is to determine if the referral meets the criteria for level three of the continuum of need, ensure that a coordinated support package is put in place for these cases and track the outcomes of this work.

The Early Help team are responsible for promoting Lewisham Early Help processes and tools across the partnership through consultation, support and training. This includes support to effectively use the CON, manage the TAF process, act as a lead professional and utilise the Early Help Assessment, Plan Review and Closure documents. The team has a

consultation line for practitioners who have questions about these processes and have been promoting the Early Help agenda through LSCB led training and bespoke training to those agencies who request it directly. The team is currently engaging in a programme of identifying and training champions within the partnership to promote and lead on Early Help activity in their respective agencies. A total of 108 practitioners have attended the Early Help training sessions so far.

The team evaluates the impact and effectiveness of Targeted Early Help activity through tracking and identifying gaps in service delivery to meet need and obtaining user feedback.

From 1<sup>st</sup> April 2017 to 31<sup>st</sup> March 2018 414 cases have been presented to the Early Help panel. The Agencies that have completed the largest number of referrals for Targeted Support have been the Police and Lewisham Primary schools. The Early Help Team has records of 196 Early Help Assessments completed by the partnership and 189 initial Team around the Family Meetings having taken place.

## Multi-Agency Safeguarding Hub (MASH)

The revised Lewisham Multi Agency Safeguarding Hub (MASH) has been operating in Lewisham since January 2017. A 'single front door' approach has been implemented as part of the development of the MASH for access to a statutory service, however the Children with Disability Team, also have their own front door. The MASH receives referrals from professionals and

members of the public. Its job is to determine need, harm and risk in relation to all contacts received and to make sure that an appropriate and timely response is made. Referrals are sent into the MASH by professionals when they have determined that the level of need is at either level three or four according to the CON. For those professionals who have an ongoing relationship with the child and family there is an expectation that activity will have taken place, using early help tools, to assess and evidence the level of need and that work has taken place with the child and family to meet this need appropriately. It is acknowledged that children's circumstances are unique and the factors raising concerns about them are often complex. For this reason the MASH operates a telephone consultation service where professionals can talk through their concerns and advice will be given about the next steps to be taken. Any immediate concerns about a child's safety or welfare is dealt with in the usual way through an urgent telephone call to the MASH and in some circumstances directly to the police.

The MASH determines if a referral received meets the threshold for Children's Social Care. This was previously determined by team managers in the Referral and Assessment service. In the year 17-18 approximately 900 more cases crossed the threshold into Children's Social Care compared to the previous year.

The MASH now contains a greater number of partner agencies with clear processes and information sharing protocols in place. The ability to share

information and increased communication between partner agencies within an information secure environment helps to ensure that the MASH is making more informed decisions about how need is determined and met. The MASH now has full time partnership representation from Health, Housing, Education and the Police, and part time representation from the Independent Domestic Violence Advocate (IDVA), Community Drug /Alcohol services and Probation. MASH also has virtual representation from the Youth Offending Service. The MASH Team also consist of a Team Manager, six Advanced Practitioners and six Social Workers.

The MASH operates a screening system so that any referrals received are seen by a qualified Advanced Practitioner, Social Worker within two hours and any cases which clearly meet the level four criteria for a Statutory Assessment are transferred to the Referral and Assessment Service straight away. In all other cases the Lewisham Mash is working to make decisions on all contacts received within 24 hours. This is an ambitious target but the timeliness of decision making is continually improving.

The number of contacts received by the MASH during the period April 2017 to March 2018 is set out below. These figures also show the percentage of contacts which are subsequently allocated to a social worker. The figures include however contacts submitted to the MASH for statutory Information Sharing and Early Help. We will be able to report in future on conversion rates for Early Help and Children’s Social Care against the referrers RAG rating of the concern or issue. This will give a better indication of how

partners are interpreting the CON and making appropriate referrals for both Targeted Early Help and Children’s Social Care interventions.

Months	April 2017	May 2017	June 2017	June 2017	Aug 2017	Sept 2017
<b>Total number of contacts (children) received in the month</b>	1268	1265	1364	1412	1116	1246
<b>% No. of contacts converted to a referral to CSC</b>	22.8	14.9	19.1	18.1	20.0	18.1

Months	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018
<b>Total number of contacts (children) received in the month</b>	1079	1024	1081	1756	1506	1437
<b>% No. of contacts converted to a referral to CSC</b>	12.9	14.3	21.0	23.9	19.7	23.0

There are clear service standards in place for the timeliness of information being provided.

All activity within MASH and Early Help is recorded and processed through the Early Help Module (EHM). The system is currently being upgraded to enable better reporting on MASH and Early Help activity and to assist the workflow in the MASH and Early Help operating systems.

## Looked After Children (LAC)

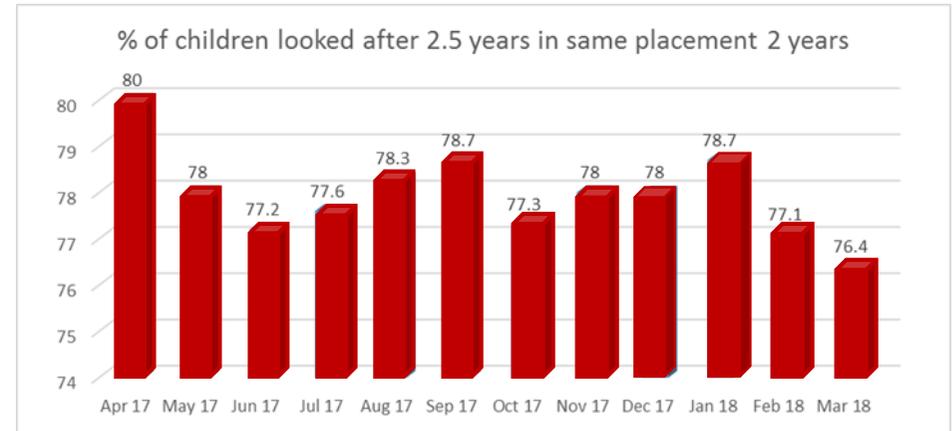
### Number of Looked After Children

The number of Looked After Children remained stable throughout 2017-18, at a figure of 482, which brings Lewisham closer in line to its statistical neighbours. At March 2018 Lewisham had 70.3 (per 10,000) of the child population who were Looked After Children compared to our statistical neighbours at 63.8; nationally the comparable figure is 62.0 (March 2018).

### Placement Stability

The stability of Looked After Children is a priority for Lewisham Council and continues to be among the highest priorities for the service. Achieving placement stability for children in long-term care is key to improving their outcomes in other areas. Where this can be achieved in foster-care, Lewisham is also encouraging Staying Put arrangements, which allows a

more supported transition for Care Leavers whereby young people remain with their foster cares post the age of 18. As at March 2018 we had 72 young people who were in Staying Put arrangements, representing an increase from 44 in the previous year.

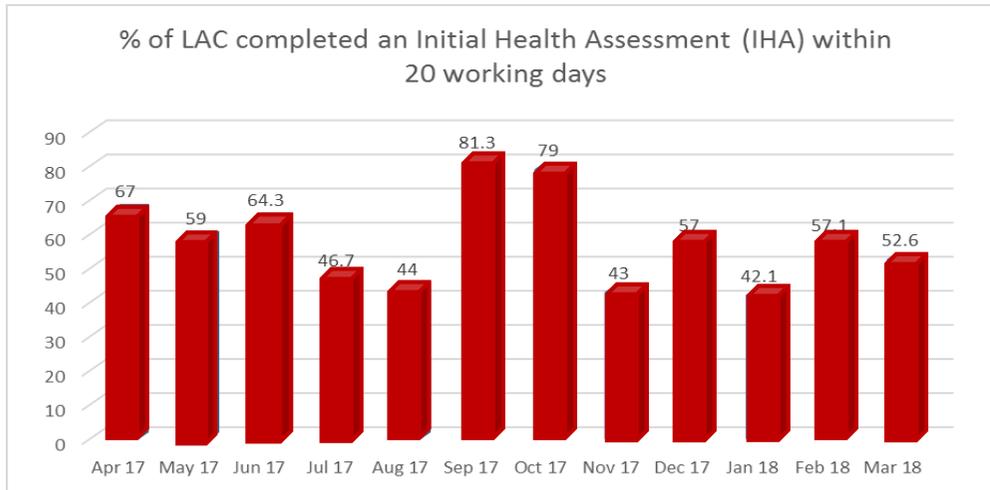


### Health Outcomes

The health of Lewisham Looked After Children remains a priority for all professionals involved in their care. A number of our children and young people experienced neglectful parenting prior to becoming looked after. Consequently they may not have accessed appropriate primary health care including services such as immunisations and dental care. In order to mitigate these difficulties all looked after children should receive an initial health assessment within 28 working days of becoming looked after. Depending on their age, these are followed up at 6 and 12 month intervals. We are striving to ensure we meet our target of 97% timeliness, it is important

to note that due to small numbers of entrants to the care system one young person can have a dramatic effect on monthly percentages for timeliness.

This area is a performance priority for Children's Social Care to ensure that the Initial Health Assessment for children and young people improves in a timely manner.



The emotional well-being of Looked After Children is a key component of their Care Plan. In order to measure this, one of the tools used by Lewisham is a Strengths and Difficulties Questionnaire (SDQ). This is a standardised test based on key areas of behaviour and development in age related bands. These are completed by carers on an ongoing basis and used as part of the care planning for children. In March 2018, the average SDQ score for Lewisham LAC was 12.8 this is in line with statistical neighbours and the England average.

Lewisham currently has a team, known as Symbol within our Child and Adolescent mental Health Service CAMHS, which is dedicated to supporting looked after children and promoting placement stability. Additionally, there is a family therapist and clinical psychologist based within our Virtual School, whose focus is to promote education achievement. They work with the professional network around the child rather than directly with the child or young person in a clinic-based setting. This has worked well for some young people and it is positive to be able to offer a range of interventions to meet some of the challenges and complexities these young people face.

## Safeguarding Looked After Children

Children who go missing and the possible link to CSE are a key concern for the Adoption, Looked After and Leaving Care service. Unfortunately, for a number of this cohort, going missing has been an established pattern of behaviour prior to them coming into care. All of the young people have individual plans to manage this risk but for some it can be a difficult pattern to break particularly during the early stages of their care history.

For some young people missing activity is linked to gang affiliation and offending, including county lines, which is the practice of young people from urban areas working with established drug dealers to transport drugs to more rural and coastal areas. Lewisham commissioned a new independent service, the St Christopher's Runaways project, to provide independent return interviews to young people who go missing. The total number of Return Home Interviews conducted by St Christopher's in January, February and March 2018 is 31.

In March 2018, 21.7 % of Lewisham LAC were placed in residential provision.

Of those placed, a further 20.2 % live more than 20 miles from Lewisham, this is below statistical neighbours at 19% and the national average of 14%.

This in part reflects the lack of specialist provision in the Greater London area. In relation to Offending, 1.25 % of the LAC population have been convicted or are the subject of a youth caution. The Looked After service is working closely with the Youth Offending Service.

2017-2018	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% CLA, who have had an initial health assessment within 20 working days of BLA	75 %	59 %	64 %	40 %	47 %	81 %	79 %	43 %	57 %	19 %	67 %	53 %
No .CLA who have had an initial health assessment within 20 working days of BLA	18	10	9	6	7	13	15	6	4	3	12	10
No of IHA due in the month	24	17	14	15	15	16	19	14	7	16	18	19

## Private Fostering

A privately fostered child 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.

A child who is looked after in their own home by an adult is not considered to be privately fostered. Children who are privately fostered are amongst the most vulnerable and the Local Authority must be notified of these arrangements.

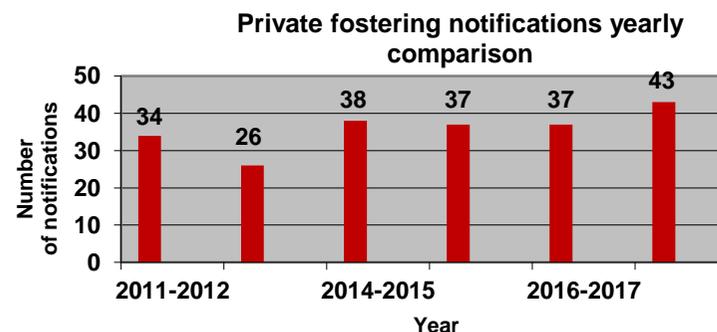
From the period 01/04/2017 to 31/03/2018 Children’s social care received 43 notifications of new private fostering arrangements in Lewisham. This is an increase from last year where we received 37 notifications.

From 2016 the DFE no longer published statistics on notifications of private fostering arrangements and they have closed the private fostering data collection for local authorities. This means that we are unable to report on the official published private fostering activity of our statistical neighbours, however we do note that in the last published figures by the DFE on private fostering, Lewisham had the

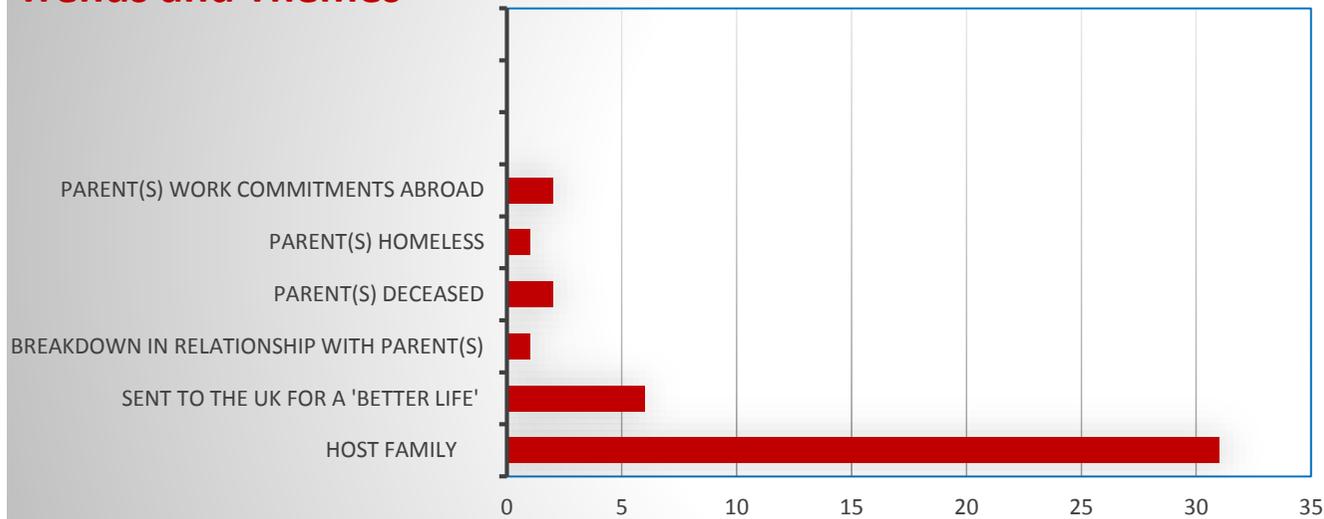
2nd largest number of private fostering arrangements in London, with only Croydon having a higher number.

As detailed in the pie chart, a majority of the notifications during the period 01/04/2017-31/03/2018 were from Host agencies. We also received referrals from education admissions. We received lower numbers of notifications from health and no referrals from housing this year.

From these 43 private fostering notifications, 33 went on to be private fostering arrangements. These arrangements have been carefully assessed to ensure they meet the criteria of private fostering and that they are suitable arrangements where the children’s needs will be met. In addition, as part of the assessment we also identify if there are any ‘child protection’ or child in need’ concerns which would mean that the case would need to be escalated to the referral and assessment team.



## Trends and Themes



- Host family
- Sent to the UK for a 'better life'
- Breakdown in relationship with parent(s)
- Parent(s) deceased
- Parent(s) homeless
- Parent(s) work commitments abroad
- 
- 
- 

The chart above illustrates the reasons why children were in private fostering arrangements. As seen in the chart, within Lewisham we have a large number of international students staying with Host families, this totalled 72%. This number is more than double of the total 'mainstream' private fostering arrangements.

We continue to have a significant number (12%) of children who have been sent to the UK to stay with distant family members for a 'better life'.

It is anticipated that the numbers of international students staying with host families in private fostering arrangements in Lewisham will increase as it appears to be a growing business in Lewisham.

Growing awareness of private fostering may be a contributory reason for the large number of private fostering notifications during this period.

The promotion of private fostering has been an area of significant development for the private fostering team and this will continue to be a priority for 2018-19 in order to increase awareness and notifications of private fostering arrangements across partner agencies.

### What Did We Do In Relation to Missing Children?

This summary focuses on the work in relation to children missing from care and home.

The LSCB Annual Report 2016/17 served to identify that the volume of children missing from home was three times that of those going missing from care. It further revealed some deficits in the way in which missing activity for these same children was being dealt with and a need to ensure that the response was consistent and timely across CSC for all children in line with the London Child Protection Procedures.

It was identified that the lack of consistency was linked to a number of factors including;

- the need to clarify the current guidance and embed it across the service
- the need to review the way in which MASH/Referral and Assessment were dealing with children missing from home
- the need to ensure that compliance with the required actions was being monitored across CSC in partnership with the multi-agency, particularly with Police

In January 2018 a Missing Children Trial took place in the Referral and Assessment service to streamline the relevant processes.

The trial served to demonstrate the frequency of children missing from home in the borough and the need to ensure that timely risk assessments and liaison was taking place with Police in live time to promote their safe return. The Missing children trial had a beneficial effect across the whole service as it also served to reintroduce a more consistent approach to missing children particularly in relation to how missing episodes were defined and acted upon to ensure children's safety. The trial has now been adopted as standard practice.

### What was the impact?

Missing data for the year 2016/17 revealed that there were 360 children reported missing and a total of 1625 missing episodes during the same period. There was triple the volume of Lewisham's children missing from home than from care which reflects the national picture as the reasons for the missing behaviour is often linked to the pressures of family life and/or external influences.

LAC children (69 children in total) accounted for 16% of all missing activity, with children missing from home (291 children) accounting for the remaining 84%.

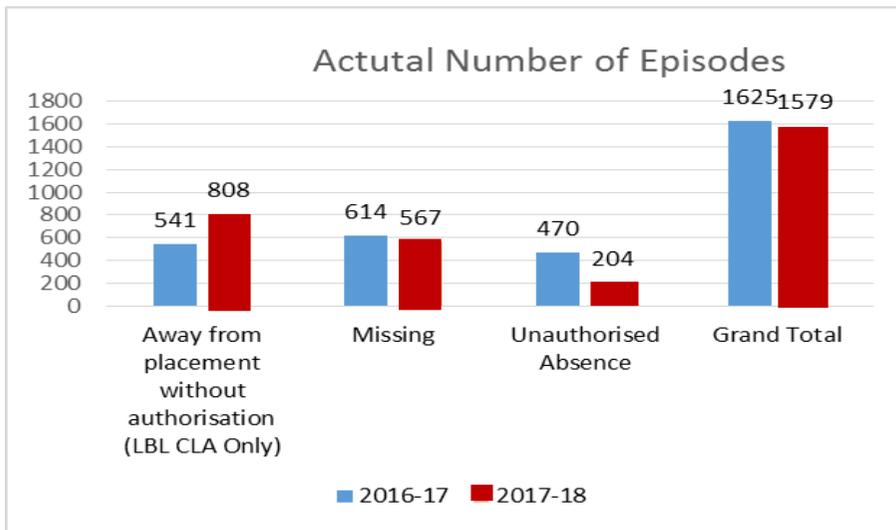
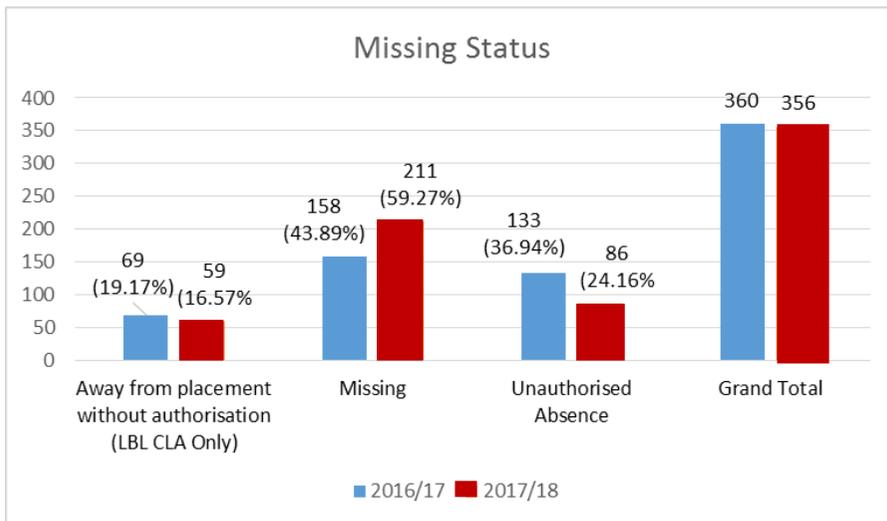
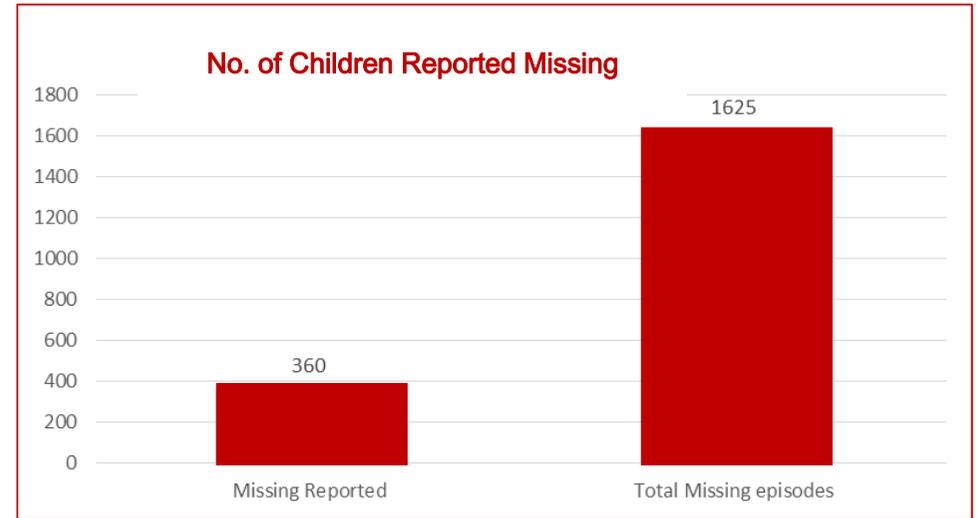


Table 1 - LCS data



(59.27%), and 86 (24.16%) children reported as having an unauthorised absence; a total of 1579 episodes.



The numbers of children being reported as “missing” has increased by 25% over the last reporting year from 158 to 211. There has also been a corresponding 50% decrease in the number of episodes of children being reported as “unauthorised absent” and an overall drop in the actual number of episodes generally from 1625 in 2016/17 to 1579 in 2017/18.

For children missing from home and care during the period of 01.04.17 – 31.03.18 there were 59 children reported away from placement without authorisation (16.57%), 211 children reported missing from their placement

The increase in children being reported as missing is likely to be due in part to greater awareness across CSC, foster carers and parents within the community of the need to report missing children immediately to the police as the lead agency for missing classifications. This awareness has been heightened by the briefings and practical day to day advice from the First Response manager, CSE Coordinator, CSE Social Worker, and the Missing Child Liaison officer. The use of the Missing Tracker has also played an integral role in providing key management performance data to improve practice across the service.

During this reporting year 2017/18 we have seen an increase in the numbers of children missing from home and care being reported for younger children in both areas.

For children missing from home, there has been reports for children as young as 7 or 8. It is acknowledged however that some of these reports reflect some cases where there were some simple parental misunderstandings with children that were reported to Police rather than a serious risk.

It is also acknowledged however that the borough has some serious gang and county lines issues and that the process of grooming often coincides with the transition of children from primary school to secondary school which is where the numbers of children being reported missing from home begins to significantly escalate.

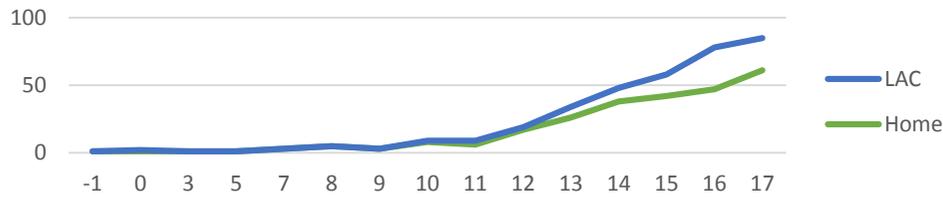
The age that children start to be reported missing from care also appears to have gotten younger, from age 12 last year to 10 this reporting year. We also know that children are three times more likely to go missing from care than home and this is borne out in national research. For these children, the risks of them being drawn into county lines activity also cannot be discounted as this represents a national problem today.

**See Tables 7& 8.**

Count of Case Number			
Age at Missing date	Home	LAC	Grand Total
-1 (unborn)	1		1
0	1	1	2
3	1		1
5	1		1
7	3		3
8	5		5
9	3		3
10	8	1	9
11	6	3	9
12	17	2	19
13	26	8	34
14	38	10	48
15	42	16	58
16	47	31	78
17	61	24	85
<b>Grand Total</b>	<b>260</b>	<b>96</b>	<b>356</b>

**Table 7- LCS Data**

### Age (at missing date 2017/18)



**Table 8- LCS Data**

Slightly more boys than girls have been reported missing during this reporting period although the national trend reflects that this is usually quite an even number. This may also be linked to the tendency of boys being more likely to be involved in county lines activity than girls, which is a feature in Lewisham. The data shows that the number of boys going missing from home forms the largest group overall which lends additional weight to county lines concerns but this is unlikely to be the sole reason. **See Tables 9 & 10**

Count of Case Number	
Gender	Total
FEMALE	165
MALE	190
UNBORN	1
<b>Grand Total</b>	<b>356</b>

**Table 9 - LCS**

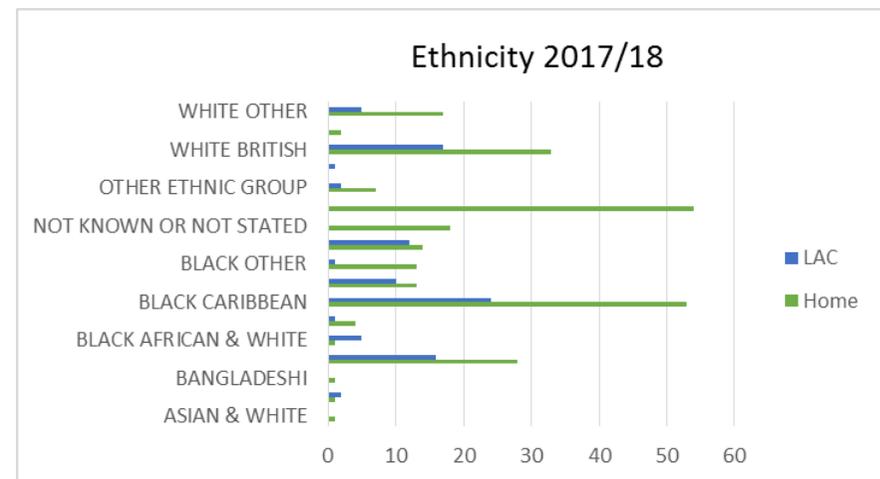
### Gender 2017/18



**Table 10 - LCS**

The overrepresentation of Black and mixed parentage children who go missing from care and home remains a serious concern. It is thought that this is likely to be gang related and it is evident that young Black African/Caribbean and mixed parentage males are more likely to be targeted specifically by local gangs in this borough.

Our ability to gain a fuller understanding of these vulnerable children is however made more difficult by continued difficulties in obtaining reliable data about the ethnicity of the entire cohort primarily in relation to children missing from home. This will need to be addressed going forward to ensure that the provision of intervention and support services are effectively targeted. **See Table 11.**



**Table 11- LCS Data**

Return Home interviews continue to be a key part of the overall Missing from Care/Home Protocol to ensure that every child is given an opportunity to speak to someone independent of their care arrangements about the reasons for going missing. The aim is to promote greater understanding of their needs to reduce the likelihood of them going missing again.

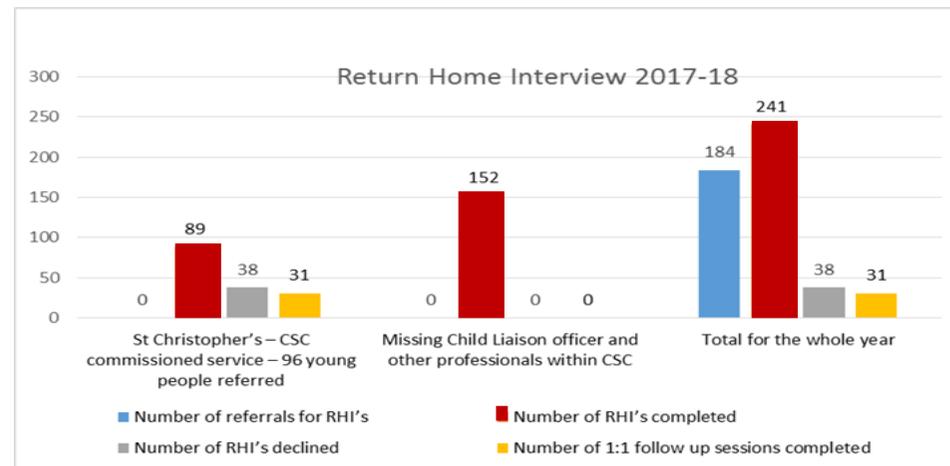
At the time of the last annual report, 2016/2017, the total number of RHI's was 247; 20 were conducted by St Christopher's and a further 19 were declined by young people.

A further 227 were completed by CSC professionals, primarily the Missing Child Liaison Officer.

During this current reporting period 2017/2018, the total number of RHI's has been 241; 89 completed by St Christopher's and a further 38 declined by children/young people through the same service.

It is however important to note that the number of completed RHI's does not always directly correspond to the exact number of missing episodes especially for young people who are frequently missing where this makes it impossible for the interview to be completed in a timely way. In some instances, a single RHI could be used to cover more than one missing episode where they occur in close succession.

A further 152 return home interviews were completed by CSC professionals, primarily the Missing Child Liaison Officer. **See Table 12**



**Table 12 - LCS**

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# Partnership Activity to Safeguard Children

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## Lewisham and Greenwich NHS Trust (LGT)

### How have we made a difference for children?

In terms of children and young people, Lewisham and Greenwich NHS Trust provides acute, community and maternity health care services at:

**Queen Elizabeth Hospital (QEH) - Woolwich, Queen Marys Hospital - Bexley (community maternity services only), University Hospital Lewisham (UHL) and community health services within the London Borough of Lewisham.** These child community health services include:

- Child Looked After services
- Health Visiting
- School Health Service
- Sexual and reproductive health services (acute services at QEH)
- Physiotherapy
- Occupational therapy
- Speech and language therapy provision
- Community Children's Nursing Team
- Special needs nursing team

- Paediatric oncology inpatient unit at QEH
- Safeguarding advisors from the team represent Health in the Lewisham MASH
- The community paediatricians also carry out child protection medicals for children resident in Lewisham
- Family Nurse Partnership - in the London boroughs of Lewisham and Greenwich

The main objective of both hospitals is to respond to acute health needs, prevent long periods of hospital admissions and improve overall health and emotional wellbeing outcomes for children and young people. The community services main objective is health promotion and provision of community-based care which limits hospital attendance.

In April 2017, a significant change took place in regard to School Nursing in Lewisham. The service is now referred to as the School Health Service and operates a targeted model of working which means that they will only see:

- Looked after child
- home educated only until 12 years of age,
- subject to a child protection plan
- subject to a \*child in need plan with a health condition

<b>Lewisham Summary Report: 89%</b>	<b>Non-Compliant</b>	<b>Compliant</b>	<b>Eligible</b>	<b>Overall Compliance 31/03/18</b>
Safeguarding Children & Young People Level 1	0	612	612	100%
Safeguarding Children & Young People Level 2	147	1394	1541	90%
Safeguarding Children & Young People Level 3 -	25	152	177	86%
Safeguarding Children & Young People Level 3 -	101	384	485	79%
Safeguarding Children & Young People Level 4	0	6	6	100%

This has had an impact on the discharge process in that – the safeguarding children team no longer have a community-based health professional to liaise with and follow up on individual young people who present at UHL or other hospitals but attended a Lewisham school. These changes have also had an impact on LGT’s ability to actively participate in multi-agency meetings in which children of school age are discussed. In addition, these changes also mean that there is a gap in the continuum of need or early help response for school age children living in Lewisham.

In the last year the main workflows concentrated on were Child Sexual Exploitation (CSE), Domestic Violence and Abuse (DVA) and Self Harm. These workflows along with female genital mutilation (FGM), neglect and harmful practices will be the main focus for the next year.

### **Evidence for and evaluation of effectiveness**

Safeguarding training guidance is in place to ensure that staff including volunteers, are trained and competent to be alert to the potential indicators of abuse and neglect in children as well as knowing how to act on concerns.

Training compliance for the last year:

Due to active involvement with three safeguarding children boards the Safeguarding team undertook a range of audits this past year. Two were undertaken independent of the safeguarding children boards – these are supervision and training. They both indicated a need to review the overall

training strategy for the Trust. This is because the learning has been similar – mainly a need for training and supervision to focus on specialist safeguarding children topics, contextual safeguarding and the role of fathers or men in children’s lives. This will be reflected in the 2018/19 training strategy – which is currently being drawn up as the training programme is also under review.

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. Following discussions in 2017/18 the Trust lead Named Nurse extended the range of data being collected for the Emergency Department. It will now be broken down to enable further analysis of trends and themes. The first stage commenced on 1<sup>st</sup> April. In the summer of 2017 a maternity safeguarding database was established to capture the live cohort of safeguarding women and their unborn babies referred to the Maternity Safeguarding team at any one time. Each notification is uploaded onto iCare. The database is RAG rated weekly according to the severity of risk and cases are discussed at a weekly multidisciplinary meeting.

The safeguarding children and adult team hosted the first Safeguarding Conference in February 2018 – with key note speakers covering various areas of specialties. The conference had over 150 delegates and was very well evaluated.

The three local boroughs of Lewisham, Greenwich and Bexley have now implemented Child Protection Information Sharing (CP-IS).

The priority for the next year is 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. In addition, priority will be given to encouraging a safeguarding culture, which promotes the engagement of children and young people i.e. an understanding of the importance of the voice of all children, including children with complex health and social needs.

## Safer Lewisham Partnership

Lewisham is home to over 306,000 people. In terms of population size, it is the fifth largest Inner London borough and the 13<sup>th</sup> largest in London. In terms of the demographic profile, children and young people make up about 25 per cent of Lewisham’s population. Over the years Lewisham’s population has become increasingly diverse; currently some 54 per cent of residents describe themselves as White, compared to 46 per cent who are of Black & Minority Ethnic heritage. Residents from more than 70 nationalities, covering five continents, make their home in the borough

## Joint Actions That Made a Difference in 2017- 2018

There are strong partnerships established over many years in the Borough which provide a strong foundation for effective working as well as constructive challenge of services and response. The following is a list of achievements for Joint Action that made a difference in 2017-2017:

- Significant partnership operations taking many individuals off the streets who were grooming and trafficking children for drug dealing
- Stop the violence campaign was launched
- Launch of the Universal schools safety programme
- Trauma-informed practice - Lewisham YOS is recognised by the DfE as 'a trauma informed service' meaning it is a relationship and trauma based model delivered as a direct intervention and as a workforce development program.
- The development of parent Hubs working with community based services like the youth services to build trust and confidence
- Community based trauma informed model. Developing a geographical model to help distress an environment that has been impacted by trauma. Building a trusted adult peer support model helping each other in the community with issues and concerns.

## Violence

Violence was the single focus for the Partnership in 2017/2018. Areas of peer on peer abuse, gender based violence, and other violence were prioritised recognising the significant harm.

However violence remains a significant concerns with its rise in Gun and Knife crime. Knife crime for under 25 has however seen a 2% reduction which suggests the approach adopted to tackle serious youth violence (including under 25 year olds) is having an impact.

Sources: Metropolitan Crime and Stats Dashboard Financial Year 015/2016—2016/2017 | ON



## Gender Based Violence

A detailed analysis has been undertaken on all 8 strands of the Violence against Women and Girls agenda alongside a detailed deep dive into Domestic Abuse in 17/18.

The focus on Domestic abuse and Sexual violence due its volume remains a focus, however through greater understanding of the other strands increased actions is required across all the strands.

Through the deep dive it highlighted that 4 out of 10 incidents related to male victims with psychological and violent incidents were predominantly within family relationships not intimate relationships.

In the period analysed 368 children witnessed Domestic abuse with almost half witnessing violence with girls and under 5s being significantly represented.

The impact of witnessing violence causes significant trauma.

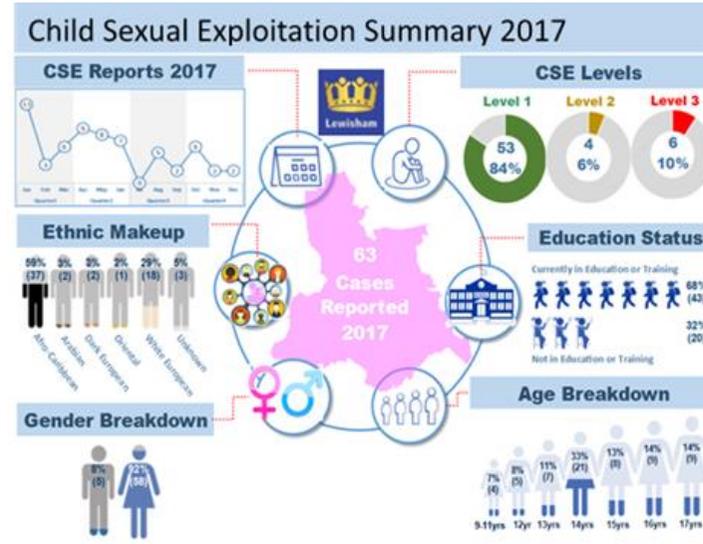
Sources: Athena |Lewisham Police Incident Reports

## Peer on Peer Abuse

This was a specific focus in 2017/2018 with greater understanding of the drivers including Trafficking of Children to deal drugs of exploitation both sexual and emotional.

Considering these aspects together linking Missing, Exploitation, Trafficking & serious violence including Drug Dealing has enabled an approach focusing on safeguarding, Risk, Harm and Vulnerability.

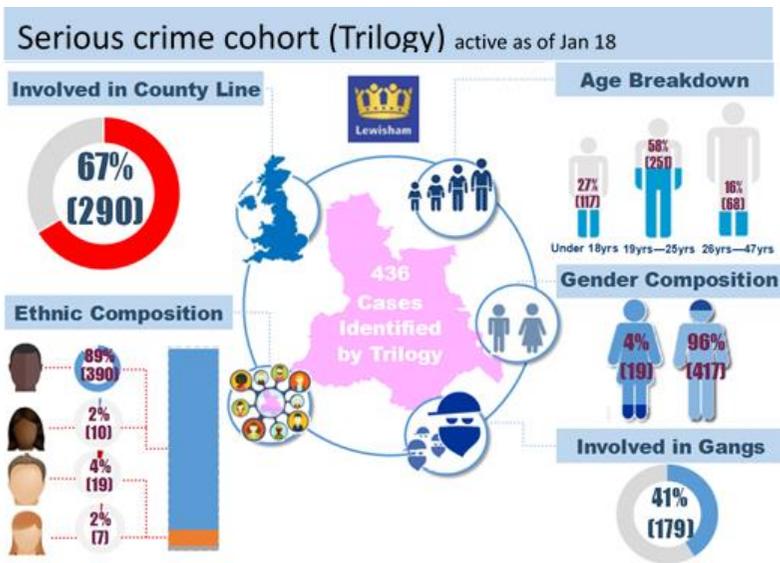
The issues of drug dealing in London and out of London has been a significant driver of violence and harm to young people. With clear multi-agency grip, support and proactive approaches there is some evidence of shift in these issues



In setting the 18 – 19 direction of travel a number of aspects have been taken into consideration. The Partnership is adopting an approach that challenges and ensures that issues are not normalised asking difficult questions to tackle the hardest issues.

There are a number of drivers for the approach which include:

- The London Mayors Police and Crime Police 2017-2021 which has been adopted by Lewisham as the 4 year statutory Strategy. (Strands include A better police service, A Criminal Justice System for London, Keeping children and young people safe, VAWG. Hate crime and counter terrorism).



- Regional work being undertaken in respect of the London Landscape, devolution options and future projections in respect of harm and vulnerability and any regional and sub-regional commissioning across agencies
- Reviews in respect of disproportionality and cohesion including Baroness Young, MP David Lammy, and Dame Louise Casey
- Findings from reviews being undertaken by central and regional government and partners including MET police drugs strategy, London VAWG refresh, DIP review, IOM review, Youth Custody prison reform etc.
- Inspection outcomes and identified learning from Domestic Homicide Reviews and Serious Case reviews that relate to the Partnership
- Information from our local strategic needs assessment and local residents survey Lewisham's local assessment profiles (LAP)

The Borough partners and residents have identified the following as being essential for our collective approach:

- Reduction in harm and vulnerability being critical as part of an overall prevention, intervention and enforcement approaches
- Reducing fear, harm and Revictimisation is critical.
- Considering contextual and geographical risks.

- Improving trust, confidence and satisfaction in this agenda
- Considering systemic approaches that link to agency changes whilst improving outcomes and impact
- Using data and analysis which is single, collective and cumulative whilst also considering future foresight modelling

For 18-19 the Partnership seeks to answer further the following:

- How do we have less violence in our society?
- How do we shape a safer place and space?
- How do we understand and ensure negative bias is reflected upon and protected against?

## Children and Adolescent Mental Health Service (CAMHS)

Lewisham CAMHS is Tier 3 Service offering therapeutic interventions to children and young people up to the age of 18 who experience enduring moderate to serious/complex mental health concerns that impact on daily living.

## Services are located across three sites within Lewisham Borough:

- **Kaleidoscope:** CAMHS Generic Team (Horizons), Neuro-Developmental Team (NDT), CAMHS Paediatric Liaison Service Team (PLS) and Crisis Team

- **Lewisham Park:** Lewisham Young People’s Service (LYPS), Symbol (Looked After Children), Virtual Schools Team (VS), Hospital Outreach Service (HOP) & Children’s Wellbeing Project (CWP)
- **Holbeach:** Adolescent Resource Team – forensic (ARTS)

Lewisham CAMHS continues to evolve and enhance its systems and processes to meet pressures and prioritise cases as appropriate. However, clinical capacity is currently unable to match demand resulting in a waiting list for all but the most pressing cases in the generic and neurodevelopmental teams.

Investment in Crisis provision has resulted in CAMHS providing a swift and consistent service for acute and high risk presentations.

CAMHS is in the process of re-structuring senior clinical positions and team managers within the service to provide more equitable and balanced support to teams. There is also consideration being given to more closely aligning duty, intake and crisis functions to provide enhanced efficiency and effectiveness at ‘the front door’ of the service.

Work has gone into creating weekly ‘referral’ meetings with the generic team (who receive about 60% of all CAMHS referrals), the CWP provision and third sector agencies, to enable smoother, more coherent distribution of referrals that do not meet CAMHS thresholds.

### Lewisham CAMHS Activity:

- Number of referrals received: 1,563
- Number of referrals accepted: 1,048
- Number of Children and young people seen: 1488

- **Appointments:**
- Offered: 10,958
- Attended: 8,397
- DNA: 1,449
- Cancelled: 683
- Other: 631

### Safeguarding Children Supervision arrangements:

CAMHS staff have regular clinical and management supervision, which includes discussions of safeguarding children. CAPA clinical discussions groups include safeguarding issues which are recorded onto Trust Electronic Clinical Records (ePJS).

Advice is also given to duty senior clinicians or by booking into a weekly 2 hour forum facilitated by the safeguarding lead for consultation, advice and escalation if necessary – as per the LSCB Resolving Professional Difference policy. When necessary the safeguarding lead seeks consultation from, and has monthly supervision with the trust Named Nurse.

This year the SLAM Level 3 safeguarding children training was delivered to all Lewisham CAMHS staff by the Lewisham CAMHS safeguarding lead and safeguarding Doctor.

### Identified areas of concern / challenges and priorities for the coming year:

- Identified Concern: Lewisham CAMHS Waiting List

The total number of children waiting to be seen for treatment once they have been assessed has increased during the end of 2017-2018. In particular the generic service where waiting times are high due to demand, staffing and complexity of cases.

Action: Lewisham CAMHS is currently enhancing its intake screening to identify safeguarding risk at referral stage. The CAPA model enables timely 'priority' assessment and treatment allocation. The wait between assessment and treatment is planned to reduce to reasonable levels.

- **Increasing level of risk to mental health connected to gang related activity and CSE.**

Clinicians are reporting an increase in complexity of cases and increased levels of risk due to exploitation using social media.

Action: Regular attendance at the weekly Missing, Exploited and Trafficked meeting, the Serious Youth Violence meeting and the hospital Emergency Department meeting have been, or are being, put in place to ensure good multi agency working.

## London Ambulance Service (LAS)

### London Ambulance Service (LAS) NHS Trust Safeguarding Statement

2017-18 has been another busy year for the London Ambulance Service NHS Trust. We have seen an increase in incidents and an increase in safeguarding Concerns raised by our staff. Safeguarding continues to be a priority for the Trust and we have this year recruited a full time administrator to assist with the increased workload.

During the year we have introduced two new policies Safeguarding supervision and Chaperone policy. We continue to provide annual safeguarding training to clinical staff which this year was delivered via e learning and reflected learning from Safeguarding Adult Reviews, Serious Case Reviews or audits undertaken.

The Trust has undertaken a number of quality audits throughout the year these include

- Auditing knowledge and retention of staff learning
- Quality of concerns/referrals raised
- Quality of training delivery
- Modern slavery referrals
- Child sexual abuse and child sexual exploitation
- Adult sexual abuse
- Child female genital mutilation

## 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 2017/2018, 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 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.

Sonia Chambers said;

*I joined the LSCB as a lay member in 2016 having experience in Youth and Community Development and supporting families within the faith community. I feel privileged to have the opportunity to see how the partners from the different agencies work together and to be party to the work which the Board does in improving and the lives of children and young people and keeping them safe.*

*In 2017/2018, I sat on the Panel for 2 Serious Case Reviews this has helped me to recognise and acknowledge the need for looking at and improving the programmes working with Black families who become known to children services, finding ways to engage and work with their wider social networks and community organisations. More collaborative initiatives could be developed to draw upon the expertise owned by these social networks and communities. I am expecting that in the coming year I be given the opportunity to support the work in bringing stronger ties between the local community and children services encouraging them to become more involved in child safety issues.*

## 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 sexual and violent offenders
- Approved Premises
- Victim Contact Service
- Foreign National Offenders

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 800 cases, two thirds of whom are in custody and a third in the community.

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 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.

- 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 to share information and ensure holistic management of an offender and that risk to children is minimised.
- Senior Management participation in strategic boards including the Lewisham Safeguarding Children's Board.
- 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. A new system is currently under development and in future it will be possible to provide assurances that all staff have completed the required training.

- A Lead Practitioner who participates in Lewisham MASH. Also provides advice and support to Probation colleagues in the form of workshops and case discussions.
- Case Audits. Practice is audited using Her Majesty's Inspectorate of Probation (HMIP) criteria, this is due to be reviewed by the end of 2018. Learning is shared with practitioners across the borough.
- Work with the Youth Offending Team to improve transition from youth to adult services.

## Youth First

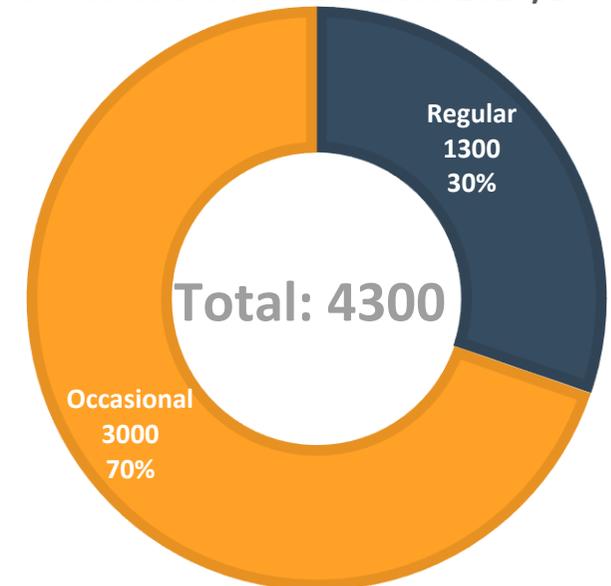
### Youth First – a vital element to Lewisham safeguarding

Youth First has been delivering youth provision under contract with LBL for two 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 five directly run youth clubs, three commissioned youth clubs and five directly run adventure playgrounds. Sessions are sometimes broken into specific age and/or gender.

In 2017/18 we have undoubtedly seen real growth in attendance by young people year on year. With c.65,000 visits in 2017/18 compared to an

approximate 62,000 in 2016/18. This year's attendance includes c.4,300 individual young people of which around 1,300 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.

YOUTH FIRST PARTICIPANTS 2017/18



## 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. 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 Programme

In its first year the Universal school's safety program (USSP), funded by MOPAC, LBL and Youth First directly, was delivered by Youth First and Compass to 743 pupils in 32 year seven forms across four Lewisham secondary schools (Forest Hill boys, Addey and Stanhope, Bonus Pastor and Prendergast Hillyfields).

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.

The scheme will continue as currently funded for another year with three schools already booked in to receive the program in the Autumn/winter term and six others who have shown interest for 2019. Youth First and LBL are currently looking for funding to expand the program to more schools and, at schools request, to adapt the scheme for older young people.

## Appendices

### LSCB Main Board Attendance 2017/2018

Agency	No. of Reps	Attendance
Independent Chair of LSCB	1	100%
Lay Members	2	100%
Cabinet Member for Children	1	75%
London Borough of Lewisham, Executive Director, Children of Young People	1	100%
London Borough of Lewisham, Assistant Director of Children Social Care	1	100%
London Borough of Lewisham, Head of Housing Management	1	0%
London Borough of Lewisham, Head of Crime Reduction and Supporting People	1	75%
London Borough of Lewisham, Access, Inclusion and Participation	1	100%
London Borough of Lewisham, Service Manager, Quality & Assurance	3	75%
London Borough of Lewisham, Head of Targeted Services & Joint Commissioning	1	75%
Metropolitan Police Service	2	100%
National Probation Service	2	50%
NHS England	1	0%

Agency	No. of Reps	Attendance
Public Health	1	100%
Clinical Commissioning Group	3	100%
Lewisham & Greenwich NHS Trust	2	100%
Schools	1	50%
South London & Maudsley	1	100%
Children & Adolescence Mental Health Service	1	80%
Community Rehabilitation Community	2	25%
London Ambulance Service	2	0%
Children and Family Court Advisory and Support Service	1	25%
Lewisham Safeguarding Adults Board	1	50%
Lewisham & Southwark College	1	25%
Voluntary Action Lewisham	1	75%
School Governors	1	50%
Social Housing (Phoenix)	1	80%



## 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 2017-18

### LSCB Budget

#### Income:

Organisation	LSCB contribution 2015/2016	LSCB contribution 2016/2017	LSCB contribution 2017/2018	Contributed £500 towards SCR costs for 2017/2018
Lewisham CCG	45,110	45,110	50,110	Yes
LBL Children's & Young People's service	83,280	83,280	88,280	Yes
Cafcass	550	550	550	No
Community Rehabilitation Company	1,000	1,000	1,000	No
London Fire Brigade	N/A	N/A	500	No
London Probation	2,000	2,000	1,850	No
Metropolitan Police Service	5,000	5,000	5,000	No
Lewisham & Greenwich NHS Trust	22,555	22,555	27,555	Yes
South London and Maudsley NHS Foundation Trust	22,555	22,555	22,555	No
<b>Total:</b>	<b>182,350</b>	<b>182,350</b>	<b>197,400</b>	<b>N/A</b>

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 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

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



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

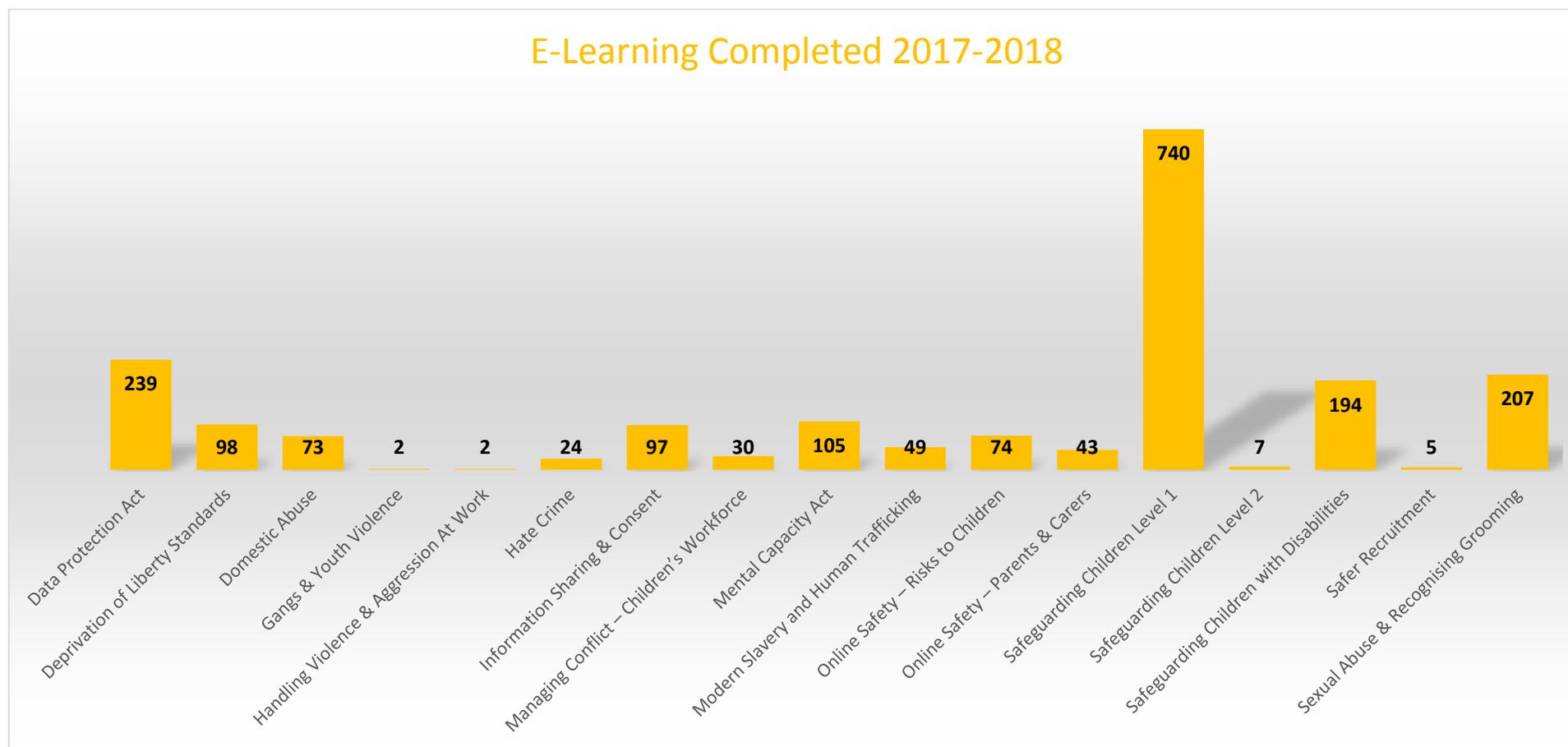
The Business Unit also co-ordinates a meeting of the Task Group Chairs, who meet before each LSCB Main Board Meeting.

## Training Summary

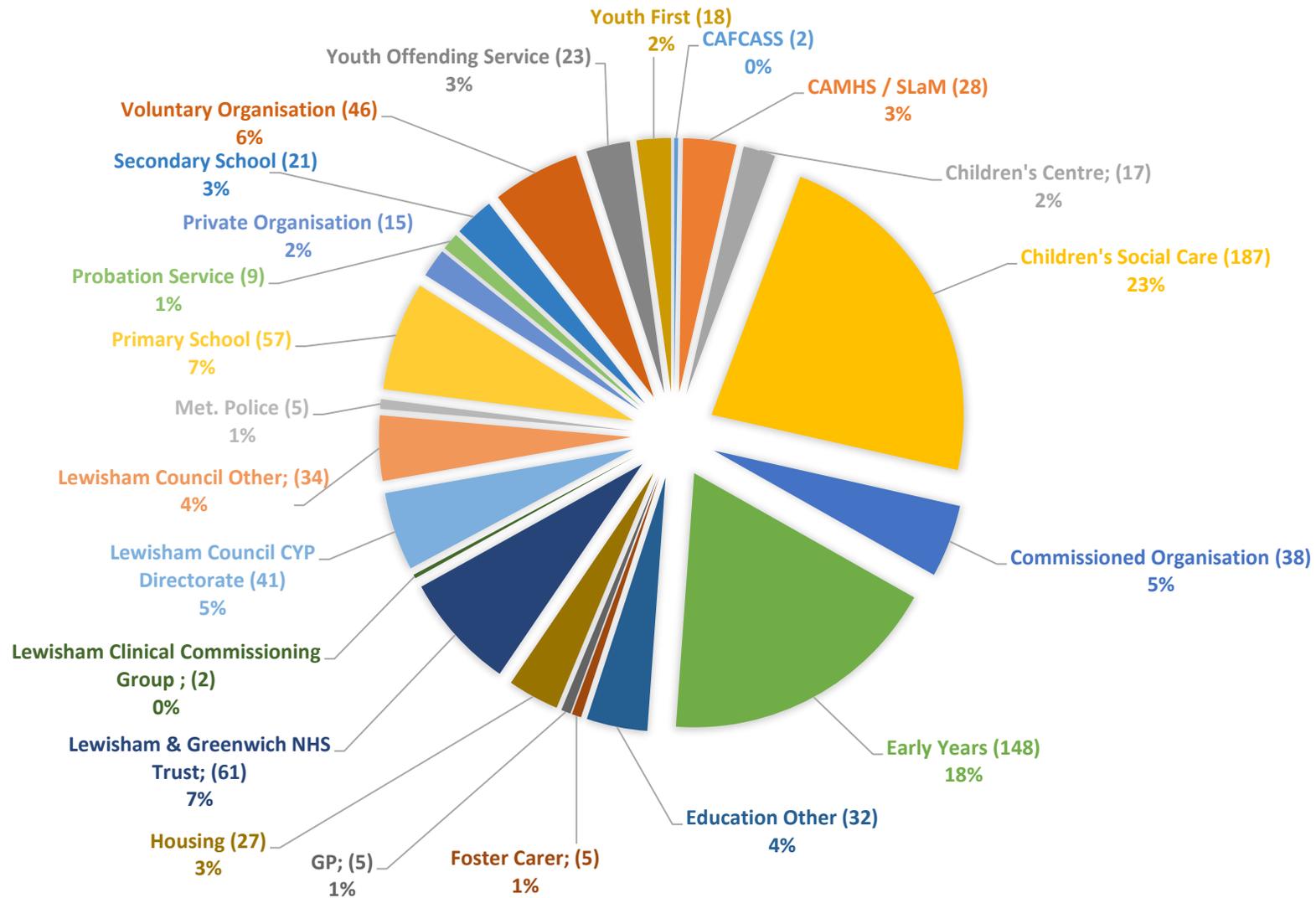
### 2017-2018

The LSCB commissions, monitors and quality assures the multi-agency safeguarding training for Lewisham. A two point evaluation process monitored the quality and impact of safeguarding training on practice though scaling measurements recorded pre course and post course completion. Evidence demonstrates an overall increase in confidence and knowledge across all safeguarding and child protection subjects covered in the programme. A detailed report is available separately.

#### E-Learning Completed



## 2017/2018 AGENCY ATTENDANCE



## INSPECTIONS

### Joint Local Area SEND Inspection in Lewisham

Between 2 October 2017 and 6 October 2017, Ofsted and the Care Quality Commission (CQC) conducted a joint inspection of the local area of Lewisham to judge the effectiveness of the area in implementing the disability and special educational needs reforms as set out in the Children and Families Act 2014.

The inspection was led by one of Her Majesty's Inspectors from Ofsted, with a team of inspectors including an Ofsted Inspector and a children's services inspector from the Care Quality Commission (CQC).

Inspectors spoke with children and young people who have special educational needs (SEN) and/or disabilities, parents and carers, local authority and National Health Service (NHS) officers.

The effectiveness of the local area in identifying children and young people's special educational needs and/or disabilities

The co-location of services at Kaleidoscope is valued by professionals and by many parents. This is because it enables professionals from different services to liaise effectively and this supports appropriate onward referrals. Parents feel that the ability to make one visit for a range of services is especially valuable. It cuts down travelling time and reduces the number of absences from school to attend appointments.

### Areas for Development

- Parents' views about access to services in the local area are inconsistent. While many are confident about the way their child's needs are recognised, others feel that service is poor.
- Where services have been recently recommissioned, local area partners are not always clear about what is included. For example, the current lack of clarity about the school health service means that there is a gap in the way some children's needs are identified in primary schools. This is because schools, school nurses and other partners do not have a common understanding of the recommissioned arrangements

## The effectiveness of the local area in meeting the needs of children and young people who have SEN and/or disabilities

- CAMHS participation with young people is strong and influences service design and delivery. Young people attend and contribute to the monthly CAMHS Advisory Board meetings as well as meeting with commissioners to share the views of young people. They work with professionals in the recruitment of staff, forming part of interview panels. As a result, the service meets the needs of Lewisham children and young people more effectively.

## Areas for development

- Children and young people identified with ASD wait too long for their assessment to be completed. Although this waiting time has been reduced significantly, it is currently nine months. Leaders recognise that more needs to be done to improve these waiting times.

## The effectiveness of the local area in improving outcomes of children and young people who have SEN and/or disabilities

## Strengths

Young people value travel training, which helps them to travel to school or college independently. They feel that the training has been successful. For example, a Year 13 student was proud that he could walk to school 'by myself'. Similarly, a Year 12 student currently going through the training was keen to finish so she could travel to college independently.

Children and young people who receive SEN support are more likely to be excluded from school than their peers. For example, 36% of all fixed-term exclusions were of those pupils identified as SEN support. This group makes up around 17% of the total school population and they are thus over-represented in the overall figures of fixed-term exclusions. While this is similar to the national picture, it nevertheless presents a challenge to the local area.

[The full report is available on here](#)

