Annual Report on the Effectiveness of Safeguarding Children in Royal Greenwich 2016-2017
www.greenwichsafeguardingchildren.org.uk
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Foreword by Nicky Pace, GSCB Independent Chair

As the Independent Chair of the Greenwich Safeguarding Children Board (GSCB) I am pleased to present the annual report for the period April 2016 to March 2017. Local Safeguarding Children Boards (LSCB) 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 GSCB 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 Royal Greenwich. It is made up of senior managers within organisations in Royal Greenwich 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 GSCB monitors how they all work together to provide services for children and ensure children are protected.

This year has been a significant one for the Board, as there was an inspection of Children’s Service by OFSTED in May /June 2016 and the effectiveness of the GSCB was reviewed as part of this process. This provided external validation of the Board’s work and we were pleased that the Board was recognised as ‘Good’. It recognised that ‘the GSCB is successfully delivering against a substantial work programme to ensure that high-quality safeguarding services are provided to children and their families’ in Royal Greenwich.

The national review into LSCBs has also been published this year, the recommendations of which were accepted in full by Government. The changes to safeguarding boards and the functions they carry out will form part of the Children and Social Work Bill progressing through parliament. This will make significant changes to the organisation of the safeguarding partnerships and a number of functions that Boards currently fulfil. Our challenge over the next year will be to ensure that replacing LSCBs with something better is done carefully and builds on what we know works well. There will be key principles we must still adhere to when deciding the structure and form of local arrangements and agreement on the core functions of multi-agency partnership.

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

Nicky Pace
GSCB Independent Chair
### The Chair’s Call to Action

#### Board Members

- Identify and act on child protection concerns.
- Work effectively to share information appropriately.
- Collectively make decisions about how best to intervene in children’s lives where their welfare is being compromised and collectively monitor the effectiveness of those arrangements.

#### Chief Executives and Directors

- Show the GSCB that your agency is committed to a culture of safeguarding children.
- Ensure your workforce contributes to the provision of GSCB multi-agency safeguarding training.
- Have an open dialogue about any barriers that may impact on your organisation’s ability to safeguard children and young people.

#### Staff working in GSCB partner agencies

- Be familiar with national and Pan-London Safeguarding Procedures.
- Be familiar with Greenwich’s Threshold document to ensure an appropriate response to children and families.
- Attend GSCB Multi-agency training and learning events relevant to your role. Help evaluate the impact of these events by providing feed-back on the quality of the training and how you applied the learning from training in your work with children and families.
- Use your Safeguarding Lead to make sure the voices of children, young people, their families and the workforce are heard.

#### The Community

- You are in the best place to look out for children and young people and to report any of your concerns.
- Safeguarding children and keeping them free from harm is everyone’s responsibility. If you are worried about a child or young person please follow the steps on GSCB’s website: www.greenwichsafeguardingchildren.org.uk

#### Local Politicians

- Help the GSCB respond to the voices of vulnerable children and families in your ward.
- Keep the protection of children and young people at the forefront of thinking when scrutinising and challenging any plans for Royal Greenwich.

#### Commissioners

- Scrutinise and challenge governance and planning arrangements by your providers for children, young people and their families in Royal Greenwich.
- Make sure that the providers you commission understand their responsibility in relation to safeguarding children, that they have the right policies in place and that their staff receive appropriate support and training.
- Discharge safeguarding responsibilities fully to ensure services are commissioned for the most vulnerable children.
- Monitor how information is shared across and between your providers.

#### Children and Young People

- You are at the heart of what the GSCB and its partners do.
- We want to make sure that your voices are heard and that we know how you are experiencing the services in our Board partner agencies. If you would like to know more about how you can influence the work of Greenwich SCB please contact us at safeguardingboard@royalgreenwich.gov.uk
How effective is the GSCB in improving the safety of children in Royal Greenwich?

This Annual report highlights progress and improvements across the partnership over the past year and evidences both effective joint working and single agency focus on safeguarding and promoting the welfare of our children and young people in Royal Greenwich. This Annual report covers the work of all the subgroups of the Board and the activity over the last year and evidences the concerted and proactive actions taken to address areas identified in audits or data where practice may not be effective. The report comments on the key areas of statutory responsibility of the Board: the work of the CDOP (Child Death Overview Panel), multiagency training and the impact on front line staff’s practice, Private Fostering and allegations against professionals.

The Board regularly reviews the performance of professionals working with children through its programme of multi-agency audits and by examining the results of single agency audit work. This year the Board has examined progress and understanding of Child Sexual Abuse and there has been an online survey of practitioners regarding confidence and awareness of self-harm. The Deep Dive Audit in 2016/17 focused on High Risk Adolescents. More details of this work can be found in the main body of the report.

The Board revised its processes for undertaking section 11 audits last year and has repeated this process again this year. Section 11 of the Children Act 2004 places duties 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. The S11 self-assessment questionnaire designed by the GSCB is one of the key tools being used by the Board to assess and monitor whether staff in all agencies are able to properly safeguard children. It has given the board the opportunity to understand how well front line staff understand safeguarding across the partnership.

The Board has not completed any Serious Case Reviews (SCRs) in the last year, though three cases have met the criteria to initiate the process. These SCRs will be completed during 2017 and will be published during the year. However, early learning from these cases has resulted in actions being undertaken prior to publication of the report and will help shape the Boards priorities for the next year.

Following a development session in January 2016, proposals for a new meeting structure were introduced to provide greater capacity for challenge and scrutiny of safeguarding issues across the partnership by the introduction of a new Monitoring and Challenge group, which reports directly to the Executive Board. During the last year this group has received and scrutinised reports from a range of services.

Priorities 2016/2017

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.

The priorities focused on safeguarding and promoting the rights of children in relation to the following topics:

Address the challenges and risks to children from exploitation (including cyber bullying/ e-safety, sexual exploitation,
going missing, trafficking and involvement with gangs).

There has been significant progress in this area of work by the Board’s subgroups and all the partners. There has been focussed work to promote resilience to exploitation and grooming through raising awareness with children. The Board has funded Chelsea’s Choice, an innovative powerful play in secondary schools; designing questions that were included in the recent school health education survey and through integrating key messages about healthy relationships and staying safe in Personal School Health Education lesson plans. We have also produced guidance on accessing on-line resources that are educative and tools for direct work with children around staying safe on-line. We have contributed to the Metropolitan Police led activities raising awareness of CSE. We have promoted the use of the CSE Fact Sheet and Risk Assessment Tool with professionals to support the recognition and timely response to possible exploitation and abuse. Our targeted prevention work recognises that children can sometimes be victims and perpetrators of CSE and there has been innovative school based interventions and the development of protocols, guidance and arrangements for working with Harmful Sexual Behaviour.

OFSTED found that the multi-agency strategic and operational response to child sexual exploitation is good, with strong links to the local priority of tackling gangs and gang culture.

There is a separate Missing Work Group of the Board which links with the CSE MASE to ensure that the work of the two groups is streamlined and effective.

Tackle abuse and exploitation linked to faith, culture or belief (including Female Genital Mutilation (FGM) physical chastisement and radicalisation) by working with partners and community/faith groups to promote the safeguarding of children.

The Board recognised last year following the survey of front line practitioners on FGM that this was an area of work that needed greater multi-agency focus. A task and finish group was set up to address this. This group has reviewed the information from the authorities involved in the FGM pilot project as well as the recent best practice guidance – Communities Tackling FGM. Local agency protocols in relation to FGM have also been reviewed and the Board has been reassured that they are fit for purpose. The group have coordinated a significant awareness raising campaign across the partnership and challenged agencies about their current processes. We are now confident that where FGM is identified as a current risk to children the multi-agency response is robust and timely.

The schools group undertook a pupil survey on physical chastisement to further enable the voice of Greenwich children to be heard. 799 young people took part in the anonymous survey between school years 2 and 13. The findings were shared with schools, along with appropriate resources, reminders of how to support young people who make disclosures and a re-launch of the model home/school Physical Chastisement agreement. We have seen a reduction in the numbers of parents being charged with physical assault in the last two quarters of the year, which we believe may be connected with this initiative.

Children not living with their parents - including Looked After Children and Privately Fostered – by ensuring high quality support, experiences and outcomes.

Over the year there have been between 16 and 25 privately fostered children in Royal Greenwich at any time. At the end of the year, on 31 March 2017, there were 21 children under a Private Fostering arrangement, a decline of 4 children when compared to 15/16. Clearly there are links between trafficking and private fostering and we need to continue to promote Private Fostering as a safeguarding issue along with concerns about child trafficking and child exploitation. We ensure admissions teams, GPs and housing providers are all requesting proof of identity and asking the question ‘is this your child?’.
The OFSTED inspection of Children’s Services found that services for Looked after Children (LAC) in Royal Greenwich were Good. There has been a reduction in the number of LAC in Greenwich, a high number of children were placed in permanent placements and those in other placements were more stable than in previous years. Performance against key indicators has continued to improve. The corporate parenting arrangements have been reviewed to improve the opportunities for children to get the support they need and their voices heard, with a new Corporate Parenting Board being established which will be co-chaired by the lead member and representatives from our Children in Care Council, and will improve the engagement of officers across the wider council and with partner agencies.

There is significant oversight of the safety of LAC through the Corporate parenting arrangements, which have been strengthened this year. Areas of concern such as missing are still contained within other priority areas, therefore we are replacing the LAC priority with a new priority called ‘unseen harm’. Private fostering will be incorporated into this priority area.

**Ensure that the issues of neglect receive due prominence in prevention, assessment and intervention especially where there are issues of adult mental health or learning difficulties, domestic abuse and substance misuse.**

There has been a great deal of targeted work undertaken around neglect by the Board subgroups and partner agencies. We have developed Practice Guidance for practitioners to support them in recognising, responding and working with children affected by neglect and their families. We have also monitored the impact of the GSCB Neglect Strategy Action Plan and reviewed the strategy itself. We have looked at activity and performance where neglect is identified as a factor in a child’s case and have worked closely with other GSCB Work Groups around implementing practice tools and developing the Neglect Matters communication campaign.

However, more children started child protection plans during the year where neglect was a feature. Significant resources are involved in responding to and investigating domestic abuse and alleged neglect. The co-presence of domestic violence with parental mental ill health and substance misuse is a key feature of repeat referrals and repeat child protection plans. For some children agencies are still struggling to break the cycle of poor parenting leading to neglect and emotional abuse. The challenge going forward is to identify problems early enough to educate and support reasonable safe parenting before children’s health and development is affected by the care they receive. Early help services through children’s centres are relatively successful at diverting children from a pathway to children’s social care. The challenge continues to be to achieve sustainable change for children. An on-going priority is to strengthen our practice in preventing and responding to the neglect and emotional abuse of teenage children and improve safety planning for teenagers who as a consequence of the parenting they receive are more likely to be pulled into exploitation and abuse. We will also focus on strengthening work where children with disabilities or health problems are not having their needs met by their parents and improve our response where children are not brought to the health appointments they need.

**Deliberate self-harm – raise awareness of and monitor the response to children at risk of self-harm and suicide and the services provided to them.**

The CDOP chair has worked across SE London to look at suicide prevention following a number of SCRs across the region involving young people.

The Samaritans “Step by Step” service offered training to schools facing suicide.

We launched the self-harm protocol in 2016 and audited front line staff awareness and confidence in using this document during the year. As a result we are revising and extending this to cover suicide ideation. We will also publish a shortened version / flow chart to accompany it. The self-harm
campaign was re-launched to coincide with the international self-harm awareness day.

Promote awareness of and address the issues relating to intra familial sexual abuse and sexually harmful behaviours

This was a new priority for the Board this year. We held a well-received conference for professional staff on child sexual abuse (CSA) and harmful sexual behaviour in November 2016. The GSCB Audit group undertook a multi-agency audit on CSA to assess how well agencies and practitioners work together in this area of practice.

The past year there has been a task and finish group working to produce a framework and procedure for addressing Harmful Sexual Behaviour, incorporating specific toolkits for schools and others to use to decide whether the behaviour is harmful or otherwise. Part of this will also look at helping schools assess risk.

Priorities for 2017/2018

As stated above we continue to work on the priorities we identified last year acknowledging that there has been considerable progress but there is still more for the Board and its partners to achieve. We acknowledge that this is a comprehensive work plan for the next year. We have added a new priority, ‘Actively and robustly seek to identify children and young people who experience "unseen harm" to ensure they receive/access appropriate services including children who are Privately Fostered and Children who care. This priority will cover a number of groups and areas including how we work with male carers and fathers who are often ‘unseen’ in assessments and the work we undertake.

Much is being done to keep children and younger people safer in Royal Greenwich. There is a strong focus on improving practice to reduce risk and secure better outcomes for children. Agencies are not complacent and recognise where there is a need to improve systems and processes to ensure more consistent and effective practice.

The full report gives a detailed picture of how all partner agencies have worked together to keep children and young people safer. The report is structured as follows:

- Work group reports provide more detail on how the GSCB Work Groups delivered against the agreed Business Plan for 2016-2017.
- Reports on the statutory functions of the GSCB including private fostering, allegations against professionals, missing children and those children at risk of child sexual exploitation.
- Individual statutory and voluntary agency reports describe how they contributed to safeguarding children in the borough – successes, challenges and plans.
- The Appendices set out details of the attendance of the Board Executive, financial contributions, multi-agency training attendance, current GSCB structure and membership.
Greenwich Safeguarding Children Board Annual Report 2016 – 2017

GSCB Strategic Priorities 2017-2018

In addition to the statutory requirements set out in Working Together 2015, the Greenwich Safeguarding Children Board (GSCB) has identified six local strategic priorities for 2017-18.

The priorities were informed by:

- Feed-back received from GSCB members during the Development session
- GSCB quality assurance activity and analysis of performance data
- Views of front-line practitioners who responded to multi-agency survey
- Learning from SCRs, both local and national
- The local needs identified in the Joint Strategic Needs Assessment (JSNA)
- Feed-back provided by children, young people, parents and members of the community
- Views of children and young people gathered via the SHEU survey, audits and questionnaires

Safeguarding children and young people is a key overarching priority for all partners working together in Greenwich. Hearing the voice of children and young people is an overarching focus for all Board partners, to inform the Board of issues that are important to them and to hear how well we are safeguarding them. The GSCB brings together senior leaders to promote partnership working and cooperation, identify and promote a learning and development culture, whilst overseeing efforts to improve safeguarding services for children through active challenge and scrutiny.

GSCB Strategic priorities for 2017-18

1. Address the challenges and risks to children from exploitation (including cyber bullying/ e-safety, sexual exploitation, going missing, trafficking and involvement with gangs).

2. Abuse and exploitation linked to faith, culture or belief including Female Genital Mutilation (FGM), physical chastisement and radicalisation by working with partners and community/ faith groups to promote the safeguarding of children.

3. Ensure that the issues of neglect receive due prominence in prevention, assessment and intervention especially where there are issues of adult mental health or learning difficulties, domestic abuse and substance misuse with particular focus on the role of fathers and men.

4. Deliberate self-harm – raise awareness of and monitor the response to children at risk of self-harm and suicide and the services provided to them

5. Promote awareness of and address the issues relating to intra familial sexual abuse and harmful sexual behaviours

6. Actively and robustly seek to identify children and young people who experience "unseen harm" to ensure they receive/access appropriate services including children who are Privately Fostered and Children who care.
GSCB Underlying Principles

The GSCB is a child centred partnership that is independent from all organisations. It provides system wide leadership and has responsibility for the scrutiny and challenge of safeguarding practices throughout agencies in the Royal Borough of Greenwich.

The interests of children and young people and their experience of services are central to the work and strategic decisions made by the Board.

Throughout the work of the Board, the emphasis is on facilitating continuous learning with the aim of constantly improving practice so that children, young people and families are receiving effective services and support as early as possible.

Safeguarding and Promoting the Welfare of Children is defined as:

- Protecting children from maltreatment;
- Preventing impairment of children’s health or development;
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care;
- Taking action to enable all children to have the best life chances.

Working Together to Safeguard Children 2015
Greenwich LSCB in numbers in 2016-2017

**66,043** children living in Royal Greenwich

**90%** of children who received Early Help were not subsequently referred to Children’s Social Care

**3541** - Number of Children’s Social Care referrals.

**13%** - percentage of re-referral to Children’s Social Care

**59%** - percentage of MARAC cases where a child is known to be involved

**88%** of Children and Family Assessments completed within 45 days.

**294** children subject to a child protection plan

**320** - average number of days a child has a CP Plan

**12%** of children had a second or subsequent CP Plan

**100%** of Review Child Protection Conferences were held within timescale

**3** - Number of Serious Case Reviews initiated by the GSCB

**123** children missing for more than 24 hours from home or care during the year.

**496** - number of Looked After Children (as at end of March 2017)

**2328** practitioners attended a GSCB multi-agency training event in 2016/17

**800** - children and young people participated in the GSCB Pupil’s voice survey
GSCB Work Groups
Monitoring and Challenge

MAC Group Chair: Nicky Pace, GSCB Independent Chair

What did we do?

The last Annual report highlighted changes to the Board structure following a development session in January 2015, to introduce greater capacity for challenge and scrutiny of safeguarding issues across the partnership by the introduction of a new Monitoring and Challenge group, which reports directly to the Executive Board. The Monitoring and Challenge (MAC) group is chaired by the Independent Chair of the GSCB. This group strengthens the process of monitoring, scrutinising and evaluating safeguarding practice by all GSCB partner agencies both individually and collectively to safeguard and promote the welfare of children. The MAC focusses on the quality assurance of multi-agency arrangements, practice and service delivery. It identifies areas of development and barriers to learning, improvement and change.

The MAC is responsible to the GSCB for establishing, coordinating, implementing and monitoring quality assurance activity and performance issues on a multiagency basis in respect of safeguarding children and young people. It monitors the GSCB Business Plan and dataset. The MAC also reviews the multi-agency training programme to ensure multi-agency safeguarding training meets the local workforce needs and that the quality of this training is monitored and evaluated. Its focus is also to identify priorities for multi-agency child protection training in the local area and feed these into the local workforce strategy. The MAC also reviews and analysis the S11 Safeguarding Arrangements within Greenwich.

Over the last year the MAC has received the following reports:

- Early Help Annual Report,
- Elective Home Education Annual Report;
- Children with Disabilities Review Report;
- OFSTED review feedback;
- IRO Annual Report;
- CSE annual report;
- Implementation of VAWG;
- LAC Education and Health;
- CDOP Annual report;
- FGM T&F Group update;
- Multi-agency Audit CSA;
- Evaluation of training (FGM);
- Metropolitan Police Service changes – One Met Model;
- Gangs integrated report;
- MARAC;
- MAPPA;
- Child Protection Annual Report;
- CQC inspection & Health Action plan;
- CAMHS and safeguarding;
- Safeguarding Young Carers;
- Updated GSCB Escalation policy;
- Young People who sexually offend;
- Early Help Deep Dive Audit;
- GSCB Deep-dive; and

On a routine basis the MAC receives the GSCB Dataset and reviews the Overarching Action Plan. The S11 audit is coordinated and agreed by this group, as well as monitoring actions and recommendations.

Section 11 audit

The section 11 audit 2016-17 was completed at the beginning of the year using a new 4 stage methodology intended to provide a more robust, evidence-based overview of safeguarding performance within Greenwich. The new approach adopted involves conducting a
wide scale survey of as many employees as possible from organisations providing services to children and their families. The survey aims to build an impression of safeguarding confidence and competence. Following the survey each agency is provided with their raw data to form the basis of a self-assessment to identify strengths and areas for development, and following on from that an SMART action plan which clearly states how any necessary improvements will be made. In the final stage representatives of key agencies meet with a multi-agency section 11 panel for a conversation about their findings and impression of the process, and an opportunity for constructive challenge where necessary.

What was the impact
There were 3,062 responses to the survey which was a positive response for the first time using this format, although response rates varied. The survey highlighted a strong awareness of safeguarding procedure from most agencies and that the majority of professionals (83%) were confident to challenge others over safeguarding concerns. The main area for improvement was around escalation, as almost half of the respondents were not aware of escalation policy and 23% did not know what to do if they were unhappy about the response of their safeguarding lead. A number of agencies identified actions in relation to this and it was also included in the action plan for the Board. Action plans were followed a number of months later to ensure that actions had been completed.

Ofsted completed a review of the Board in May-June 2016 and were positive in relation to the approach being taken by the GSCB:

“An innovative approach to completion of section 11 audits this year has led to a broad range of relevant learning for the GSCB and individual agencies, to improve safeguarding services for Greenwich children further”.

The scrutiny and focus on wider safeguarding issues has enabled the Board to be clear about priorities for the Board in the coming year. It has also enabled the Board to have wider discussion and focus on issues where there would not be the opportunity in wider Board meetings.

What do we plan to do next
Following the completion of the S11 audit a decision was made to continue using this methodology with a few alterations to the process based on feedback received from partners. These include making future surveys anonymous, removing free text questions which are difficult to analyse and designing a filtering system by which those who have little or no direct contact with families are only asked questions suitable to their role.

The MAC 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 also 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.
Quality and Effectiveness of Arrangements and Practice

Audit Work Group Chair: Henrietta Quartano, Head of Quality Improvement Service, RBG Children’s Service

What did we do? Why?

The Audit Group supports the GSCB in evaluating the effectiveness of all agencies in Royal Greenwich in relation to their work in safeguarding and promoting the well-being of children. The Audit Group carries out this function through leading on a range of audits and reviewing single agency quality assurance activity. The audits are linked to the GSCB priorities and seek to answer probing questions about effective practice; challenging partners where required and seeking the views of parents, carers and children to better inform our understanding of a safeguarding issue. Audit activity needs to result in action to improve practice and the outcomes for children. The group presents its findings to the GSCB Executive and requests that each agency identifies improvement actions to incorporate into the over-arching GSCB action plan.

In 2016/17 a multi-agency case audit into our response to Child Sexual Abuse has been completed. There were clear areas of practice strength. Where a child had made a disclosure the responses of all agencies were robust and timely and children were protected from further abuse. Longer term interventions were sensitive, appropriate and effective. The outcomes for these children have been significantly improved as a result of intervention. Schools were seen as a strong protective factor. Good use was made of expert assessments and opinions in relation to sexual abuse, child development and communicating with children. There was evidence of effective multi-agency working. Areas for further development included that practitioners and their managers need to increase their understanding of non-disclosure led sexual abuse work. They need to be more confident in understanding what falls into the “normal” range of sexual behaviour in children and where they need to be concerned. Practitioners need to be more curious about all the possible explanations there might be for sexualised behaviour in children and young people. Practitioners need to become more confident in how to talk to children and young people about sexual behaviour.

The Audit Group has led on the online survey regarding practitioner confidence and awareness of self-harm and how well the GSCB Self-Harm protocol is being used. It was found that the protocol has not reached as many professionals as the Board would have hoped in the 18 months that it has been in place, and of those who are aware of it only a quarter have actually used it in their practice. Almost a third of the respondents were not confident in working with self-harm and 8% (22) did not know who they would talk to if they were concerned. The recommendations included that the protocol be expanded for a more inclusive audience, to include advice for all those who work with young people. The GSCB will also develop a short briefing for practitioners highlighting key points from Self-Harm protocol.

The Deep Dive Audit in 2016/17 focused on High Risk Adolescents. It was completed in a very different way from previous Deep Dives. Drawing on the SCIE methodology for SCRs, a new process was designed in order to step away from the traditional auditing of case files and instead to actively engage key people, including parents and the young person, in guided conversations about the young person and the work that is being done to safeguard...
them. There was also a group meeting with the involved practitioners to share and agree auditors identified themes and learning. Areas of practice strength included the clear commitment of practitioners from all agencies across Greenwich to working with these young people and to improving outcomes for them, and evidence that high quality, relationship based work had a positive impact. There was good communication between agencies. Young people and parents experienced the Youth Offending Service workers as positive and helpful. Education was a strong protective factor.

Using the areas identified for further development the Audit Group presented a number of challenge questions to the GSCB Executive and asked for represented agencies to identify both single agency and multi-agency improvement actions.

- How can we make multi-agency meetings, which are seen as helpful by professionals, more positive and helpful for parents and young people?
- How can our processes be more adaptive to the needs and wishes of individual families while keeping within statutory requirements?
- How will professionals ensure that their roles and responsibilities are understood by all?
- How will we ensure that the support needs, protection needs and risks of siblings are considered and addressed?
- Can practitioners be helped to work in ways to allow them to have more time to build relationships with young people and families?
- How can we ensure that the needs of young people on the edge of statutory services are better addressed?
- How will the GSCB link with the Fairness Commission in their review of the anti-poverty strategy to ensure that the safeguarding of children is considered?

The last audit, that is nearing completion, is the re-audit of our multi-agency response to Child Sexual Exploitation.

What was the impact?

Through the audits completed we have a much clearer understanding about the strengths and areas for development for agencies across the partnership. These can be used to inform improvement actions for all the key agencies involved in the safeguarding and promoting the welfare of our children.

Last year the Audit Group members set themselves the challenge of achieving greater involvement from practitioners so that they could contribute to our understanding of complex issues and have a greater sense of ownership in relation to the learning and actions. The practitioners involved in the Deep Dive reported that it was helpful to have an opportunity to reflect on how it feels to work with this cohort of young people outside of a specific case based discussion. They said that they experienced the Deep Dive Audit as something that was done “with” them not “to” them.

We also wanted to better secure the views of service users and children. Again the Deep Dive achieved this. Through talking directly to them, the Audit Group really understood how people felt about our services; how they experienced them and was provided with a different perspective on areas where we had previously thought we were doing well.

What we plan to do next?

In consultation with other GSCB work group chairs and the Independent Chair, we have agreed the following audit activity for next year. The multi-agency audit will be on safeguarding babies. We will be focussing on cases where safeguarding concerns only became known at a few months old; the role of fathers and the impact of mobile families. The Deep Dive audit will be on cases which crossover adult and child safeguarding issues. Are practitioners in each of the services sufficiently aware of the safeguarding and welfare needs of the other client group? The online audit will focus on the multi-agency understanding of thresholds. The re-audit will focus on the impact of the actions identified in the domestic violence and abuse audit.
Multi-Agency Training

Learning and Development Work Group Chair: Louise Mackender de Cari, Assistant Director Commissioning & Resources, RBG Children’s Services

What did we do?

We identified learning and development priorities through a thorough needs assessment which included feedback from front line practitioners; training impact evaluations, section 11 reviews and recommendations from local serious case reviews and multi-agency audits. We developed and delivered a comprehensive programme of multi-agency safeguarding training in line with the GSCB and Children and Young People Plan strategic priorities, Working Together to Safeguard Children, Ofsted thematic reviews and independent inquiries.

Our comprehensive multi agency training package was revised to meet emerging needs and to support the delivery of all the GSCB priorities. Additional courses and briefings added to the 2017/18 programme include those to:

- increase the awareness of the LADO role and procedures related to allegations against staff;
- Improve understanding and support to children who exhibit harmful sexual behaviour;
- a more preventative and proactive approach to working with child sexual abuse concerns;
- increase awareness of the vulnerability of babies and recognising safeguarding concerns;
- recognising safeguarding issues affecting a diverse population;
- working with teenagers to recognise different forms of abuse

More multi-agency trainers have been trained to ensure our comprehensive multi agency programme remains resilient. This year, 2328 staff and volunteers attended the 129 training events. This was a lower number of attendees than the previous year. We have continued to use a range of delivery methods, including training courses, briefings, bite-size lunchtime sessions and e-learning. This year Applied Theatre’s production ‘Chelsea’s Choice’ was commissioned to deliver 11 performances in 8 secondary schools.

The GSCB annual conference ‘Thinking the unthinkable: preventing, identifying and responding to child sexual abuse’ was attended by over 130 delegates from across the partnership, with local and national speakers (from the Children’s Commissioner’s Office and the Lucy Faithful Foundation) and workshops focused on practice in working with parents and young people.

We have remained focused on the quality of our training offer. All multi agency courses are continually improved; informed by delegates’ feedback and courses that specifically link to the GSCB priorities have also been evaluated by participant observers. The work group has also contributed to the delivery of the GSCB neglect and exploitation action plans.

This year we have also begun a review of our e-learning and single agency training programmes, to evaluate their scope, quality and effectiveness. Changes have been made to e-learning courses to ensure that they meet our needs and priorities.

What was the impact?

Feedback shows that the training we deliver has impact on those who work with children and young people in Greenwich that they can take into their practice. All of our courses continue to receive positive feedback. Courses related to the GSCB priorities improved the knowledge and confidence of participants and were reviewed positively by participant observers, with suggestions identified for improvements including...
communicating the voice of the child and greater exploration of equality and diversity. Monitoring and evaluation of training has shown the voice of the child is communicated through case studies and films, continues to be effective and stays with participants beyond the training session.

This year we have seen again that whilst training courses delivered by external trainers are very effective and can bring in national expertise, having Greenwich practitioners develop courses that are relevant to Greenwich provides the local context and knowledge which supports the application of learning in practice. We’ve also made changes to external trainers’ courses to ensure links are made to our local safeguarding procedures.

94 of the 134 annual conference delegates provided feedback on this year’s event; 90% rated it as excellent or very good and 89% found it extremely or very valuable for their professional development. Respondents commented that they would share their learning with their colleagues, and discuss the issues raised with parents and children they work with.

180 of the 1827 young people who saw ‘Chelsea’s Choice’ in their school provided their views on it. 91.8% said they had a better understanding of the issues around CSE and the forms it can take and 98.2% said they had a better understanding of safe internet use and why they should stay safe online.

What we plan to do next?

One of our challenges is ensuring we have sufficient in house trainers to deliver our comprehensive programme, so recruitment and support of new trainers remains a focus. In addition, our priorities for 2017/18 are:

- Ensuring the voice and experience of children is consistent throughout our training offer;
- Embedding our single agency training evaluation programme;
- Implementing our revised online training evaluation;
- Continuing to improve our understanding of the impact of learning and development on practice in the longer term;
- Delivering our first joint conference with the Greenwich Safeguarding Adults Board ‘Working together to keep everybody safe from modern slavery, forced marriage, honour based violence and FGM’.

Example of effective practice:

The trainer is a national expert and extremely knowledgeable, having worked on numerous cases and undertaken substantial research in the field. The course was very interesting and the use of real life scenarios was very helpful. Participants could have benefitted from more time for discussion and reflection - the course would have to be lengthened for this.

Good exploration on how to prevent child sexual abuse and who can support this within the community and wider multi-agency groups

I am more able to recognise neglect & address it in future with more clarity. More confidence. Will definitely help me to think more holistically about what is happening. Always have child as focus.

Improve my ability to discharge my role more professionally & meticulously. Help me to evidence around neglect.
Child Death Overview Panel

Chaired by: Nikesh Parekh, Public Health Medical Associate

What did we do?

Working Together to Safeguard Children (2015) provides the most recent framework for reviewing all child deaths at a local level. The process of reviewing all child deaths at a local area level has been a statutory duty since April 2008. The process involves:

A Rapid Response Meeting of key professionals, within days of the unexpected death of a child, for the purpose of enquiring into and evaluating the circumstances of death.

A comprehensive overview of all child deaths up to the age of 18 years (excluding babies who are stillborn as well as planned terminations of pregnancy carried out within the law), where the child was resident in the borough. This is undertaken on a quarterly basis by a multidisciplinary panel and involves data collection and inter-agency discussion to identify where lessons can be learnt to prevent future child deaths and improve the health and safety of children in the area. If necessary then a recommendation for a Serious Case Review (SCR) is made.

Note: The Child Death Overview Panel (CDOP) Annual Report 2016/2017 will be available later this year.

How have we made a difference to children?

This report is based on the learning from 5 CDOP meetings in the financial year 2016-2017.

Rapid Response Meetings

There were 8 rapid response meetings held for the unexpected deaths of children, led by the Designated Paediatrician for Child Death Reviews. This enables key professionals to respond in a timely manner and share information effectively concerning an unexpected child death.

Two cases have progressed to a Serious Case Review (SCR) due to concerns of non-accidental injury. Once the SCR and other parallel investigations have been completed the case will return to the CDOP for review.

The CDOP reviewed 32 child deaths in this financial year, of which 9 were unexpected. The 32 cases were categorised as follows:

<table>
<thead>
<tr>
<th>Category of Death</th>
<th>Number of Cases (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide or deliberate self-inflicted harm</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Acute medical or surgical condition</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Chronic medical condition</td>
<td>2 (6%)</td>
</tr>
<tr>
<td>Perinatal/neonatal event</td>
<td>15 (47%)</td>
</tr>
<tr>
<td>Chromosomal, genetic and congenital anomalies</td>
<td>5 (16%)</td>
</tr>
<tr>
<td>Trauma and other external factors</td>
<td>2 (6%)</td>
</tr>
<tr>
<td>Malignancy</td>
<td>3 (9%)</td>
</tr>
<tr>
<td>Sudden unexpected, unexplained death</td>
<td>3 (9%)</td>
</tr>
</tbody>
</table>

Six case reviews were of child deaths that occurred in the 2016/17 financial year. Reviews are delayed for various reasons including pending investigations and reports. Cases are only reviewed once all necessary information has been received and no further enquiries are pending. At the end of March 2017 there were 47 outstanding cases to be reviewed, which will be brought to CDOP in due course.

Of the 32 cases reviewed this financial year, modifiable factors were identified in 6 (19%).
Learning and actions in response to these are on-going.

What have we learned from CDOP review over this financial year?
Key learning points from CDOP review of these child deaths include:

- The importance of on-going public health primary prevention efforts to reduce the incidence of maternal obesity, to address the increased risks in such cases of pregnancy to both mother and child. ‘Making every contact count’ is crucial in supporting healthy behaviour and preventing the development of obesity.
- The increased risk of life-limiting genetic anomalies in children born in the context of a consanguineous relationship. Sensitive measures to raise awareness of this issue in certain ethnic communities, where the prevalence of consanguinity is higher, are being considered by the Public Health Department.
- The importance of ensuring senior obstetric clinic review and guidance on the management of pregnant women with pre-existing complications to prevent new and potentially avoidable complications.
- Sudden unexpected deaths of infants remain an important contributor to infant death. There are on-going efforts to raise awareness of and reduce known modifiable risk factors, including household smoking, co-sleeping, and excessive heating and blankets during sleeping.

Learning and Impact of work
CDOP training is delivered annually by the Designated Paediatrician for Child Death Reviews and the CDOP Co-ordinator to professionals working in healthcare, social care and child education. We have also contributed to the National Confidential Inquiry into suicide and homicide by people with mental illness.

What do we need to do better?

- Emphasise the responsibility of professionals to inform the designated person for child death notification immediately following the death of a child. This enables the CDOP review process, including bereavement support, to commence in a timely manner.
- Consider at a London-wide level the development of a protocol for the review of children that die whilst outside of the UK.

Example of effective practice

- The RBG CDOP is regularly in communication and holds meetings with neighbouring CDOP Chairs and Designated Paediatricians in South-East London to share important information and recognise and respond to concerning trends in child mortality.
- Co-opting professionals with specific expertise where indicated to comprehensively review select cases of child death and learn key lessons.
- Ensuring that bereaved parents are offered immediate support, and are fully informed of the child death review.
Case Review Function: Serious Case Reviews

Serious Case Review Work Group Chaired by: Simon Pearce, Director of Health and Adult Social Care, Royal Borough of Greenwich

What did we do?

In 2016/17 the Terms of Reference of the group were reviewed. It was agreed that the group would no longer meet on regular basis and that a meeting would be convened in the event of a serious incident. The group met on two occasions during the year and undertook the function of:

- Determining whether cases met the criteria for a Serious Case Review (SCR).
- Making a recommendation to the Chair of the LSCB in relation to SCRs
- Commissioning SCRs
- Managing the process of completing the SCR report, including publication.

This work enables the LSCB to undertake its statutory functions in relation to SCRs. The group is multi agency and very well attended.

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.

Once commissioned the group manages the production of the SCR report.

What was the impact?

In 2016/17 the group met to consider three serious incidents and make a recommendation to the GSCB Independent Chair. All three cases triggered a Serious Case Review.

The Learning from SCRs is overseen by the Learning and Development Work Group. However the SCR group, with its oversight of the process, identifies patterns and this year there have been two SCRs which may relate to vulnerable babies and abusive head trauma. We have agreed to coordinate publication of these reviews to maximise the impact and opportunity for learning.

What we plan to do next?

To continue to review potential SCRs and manage the process of commissioning and report production.

Ensure lessons are identified and disseminated early.
Improving multi-agency practice to safeguard children affected by domestic violence, parental substance misuse and/or parental mental ill health

Toxic Trio Work Group Chair: Andrew O’Sullivan, Senior Assistant Director, RBG Children’s Services

What did we do?

We have reviewed the draft NICE guidance and undertaken desk top research on practice guidance and tools supporting effective practice in working with neglect. We have looked at findings and messages from relevant Serious Case Reviews and how these can be applied.

We have considered the findings from the GSCB Child Sexual Abuse audit that highlights the link with neglect, raises issues around disclosure-led practice and ‘hidden harm’ that are relevant to improving practice in relation to tackling neglect. We have also considered findings from the GSCB High Risk Adolescents Deep Dive. We have developed Practice Guidance for practitioners to support them in recognising, responding and working with children affected by neglect and their families.

We have monitored the impact of the GSCB Neglect Strategy Action Plan and reviewed the strategy itself. We have looked at activity and performance where neglect is identified as a factor in a child’s case.

We have worked closely with other GSCB Work Groups around implementing practice tools and developing the Neglect Matters awareness campaign.

We have reviewed the Guidance for joint targeted area inspections on the theme: children living with neglect as a basis for developing our shared understanding of What Good Looks Like in multi-agency arrangements and practice.

What was the impact?

Neglect and emotional abuse related to domestic violence continue to be the most predominant form of child maltreatment in Royal Greenwich. The police incident reports about domestic violence and repeat victimisation continue to remain relatively high. The numbers of children referred to children’s social care where neglect was a presenting factor increased compared to the previous year.

The numbers of children referred to children’s social care where emotional abuse, which in most cases arose from domestic violence in the home, decreased as a presenting factor compared to the previous year.

More children started child protection plans where emotional abuse was a factor.
More children started child protection plans during the year where neglect was a feature

A key challenge is to intervene before patterns of parenting behaviour or abusive relationships within the home become entrenched. Significant police and children’s social care resources are involved in responding to and investigating domestic abuse and alleged neglect. The co-presence of domestic violence with parental mental ill health and substance misuse is a key feature of repeat referrals and repeat child protection plans. For some children we are still struggling to break the cycle of poor parenting leading to neglect and emotional abuse. The challenge is to identify problems early enough to educate and support reasonable safe parenting before children’s health and development is affected by the care they receive. Our early help services through children’s centres are relatively successful at diverting children from a pathway to children’s social care. The challenge continues to be to achieve sustainable change for children.

What we plan to do next?

We are looking at ways of identifying and providing targeted support to children and families where there are emerging problems related to the co-presence of parental conflict and abusive relationships with substance misuse and parental health problems. We are looking to apply innovative strengths-based best practice interventions. The aim is to reduce the demand on the police and children’s social care through providing targeted help to achieve timely change in parenting behaviour.

We also need to promote effective multi-agency practice through the use of practice resources such as the new practice guidance and NICE guidance. We will review the Neglect Strategy and our multi-agency arrangements for working with children in families where there is domestic violence and abuse.

A priority is to strengthen our practice in preventing and responding to the neglect and emotional abuse of teenage children and improve safety planning for teenagers who as a consequence of the parenting they receive are more likely to be pulled into exploitation and abuse.

We will focus on strengthening work where children with disabilities or health problems are not getting what they need from their parents and improve our response where children are not brought to the health appointments they need.
Communication and Engagement

Chaired by: Roy Gopaul, Development Officer, Greenwich Action for Voluntary Services

What did we do?

The Work Group has continued to give high priority to making information about safeguarding more accessible to the public as well as workers across our partner agencies. The GSCB website is one of the key tools for disseminating information to the public as well as staff and partner agencies. We ensured that the website was reviewed on a regular basis so that content was up-to-date and relevant, and that documents and information were uploaded in a timely fashion.

We disseminated the GSCB Escalation Policy, Self-harm Protocol, neglect factsheet, and the GSCB Annual Report 2015/16. We also participated in the Take-Over Challenge when one young person spent a day with the GSCB team, reviewing training and website content.

GSCB awareness campaigns

During this reporting year the Work Group planned and launched a number of awareness campaigns on topics that reflect the GSCB priorities. In December we started to develop a major campaign on neglect with help from the Local Campaigns Manager at the NSPCC.

The Group also re-launched an e-safety/cyber bullying campaign in February 2017, aimed to ensure children and young people have access to e-safety information, tips, advice and resources to help them stay safe on the internet.

The Group implemented a self-harm campaign in support of Self-harm awareness Day (1st March 2017), to help young people, parents, carers and professionals understand what self-harm is and how to access support. The event aimed to reduce stigma surrounding self-harm and publicise the range of help available locally and nationally for children and young people who may be contemplating self-harm.

As part of this campaign the Group developed an information and advice hub, hosted on the GSCB website. Self-harm was identified as a key concern by children, young people, parents and other members of the community during the Great Get Together event. The campaign was also informed by findings from a local SCR regarding Child T, as well as the views expressed by over 4000 children who participated in the SHEU survey.

Reaching children and young people

The Communications and Engagement Group understands the importance of listening and responding to the voice of the child in undertaking its work and recognises the need to meaningfully engage with the children and young people of Royal Greenwich through the work of its partners.

The Group worked with Participation People to ensure representation by young people. As a result the Communication and Engagement Group now has a young person attending from the GYPC who is also a Safeguarding Champion. As in previous years, representatives of Greenwich Young People’s Council (GYPC) and Children in Care Council (CiCC) met the GSCB Independent Chair as part of a regular event to ask questions and discuss some of their priorities.

The Group also oversaw the production of a young person friendly version of the GSCB Annual Report 2015/16 with the help of the GYPC and Participation People. An electronic copy of the report can be found on the GSCB website.

Engaging with the Community and Voluntary Sector

The voluntary sector remained actively engaged in the work of the Engagement and Communication Group, which was chaired by GAVS in 2016/17. Other voluntary sector groups represented included the Woolwich Mosque, World of Hope and MOSAC.
This has enabled the Group to engage with the sector to promote GSCB campaigns and safeguarding messages within the community. GAVS in particular continued to use the CYP Newsletter for the sector to provide regular updates on the work of the GSCB generally as well as on specific campaigns. GAVS also made effective use of its CYP Forum, to engage with community groups on some of the key GSCB safeguarding issues; for example, neglect, early help and e-safety.

What was the impact?
By ensuring that a young person is represented on the Engagement and Communication Group who is also a young Safeguarding Champion, we ensured that children have a voice in the Group’s work. Thus, the priorities and information we produce and disseminate for the public are better informed and done in such a way as to be accessible for children and young people.

Our campaigns during the year on self-harm and E-safety addressed two key safeguarding concerns for children and young people. Therefore, they contributed to keeping children safe in the borough by raising public as well as professional awareness on these issues. The self-harm protocol was disseminated widely to professionals to help them better understand self-harm and how to access help and support for young people at risk.

What we have learned?
The presence of a young person in the Group has taught us a great deal about communicating with young people. We have also learnt about some practical changes that we need to make in the way that we manage our business, in order to facilitate active participation by young people in the work of the Group.

We have learnt that safeguarding relies as much on good practices as on good communication and engagement with local communities, including children and young people. We feel more confident about the Group’s work with their input.

What do we need to do better?
We need to continue to empower young people to have a say on decisions that affect them through active engagement and participation. Getting safeguarding information to children and young people especially is a challenge and we need to do more to develop child and young person friendly ways of reaching them. We also need to evaluate and evidence impact more systematically.
Tackling Child Sexual Exploitation

CSE MASE: Co-Chaired by Andrew O’Sullivan (Senior Assistant Director, RBG Children’s Services) & Richard Vandenbergh (Detective Chief Inspector, Greenwich Borough Metropolitan Police)

What did we do?
We have worked closely with other GSCB Work Groups, particularly the Schools Group, to promote resilience to exploitation and grooming by raising awareness with children through supporting Chelsea’s Choice, an innovative powerful play; designing questions that were included in the recent school health education survey and through integrating key messages about healthy relationships and staying safe in Personal School Health Education lesson plans. We have also produced guidance on accessing on-line resources that are educative and tools for direct work with children around staying safe on-line. We have contributed to the Metropolitan Police led activities raising awareness of CSE.

We have promoted the use of the CSE Fact Sheet and Risk Assessment Tool with professionals to support the recognition and timely response to possible exploitation and abuse. We have reviewed with commissioners how they address the importance of raising awareness about identifying and responding to CSE.

We recognise that different forms of exploitation leading to abuse are often co-present in the lives of children and the strong link with children going missing, especially when this happens more than once. We therefore are using analytical tools and information sharing processes to cluster known risk factors around individual children and groups of children who are associated with each other.

During the year the partnership work with the Metropolitan Police’s central CSE Team has strengthened. Officers have contributed to raising awareness, confidence and skills of schools based officers and staff in relation to CSE. Information gathered at a regional and national level by police is also shared and used in relation to disrupting the activities of groomers and people who abuse children (including peer abuse) and bringing individuals to justice.

Our targeted prevention work recognises that children can sometimes be victims and perpetrators of CSE. Innovative school based interventions and the development of protocols, guidance and arrangements for working with Harmful Sexual Behaviour are a basis for addressing behaviour early before it becomes entrenched.

The Ofsted SIF inspectors (report August 2016) found that the multi-agency strategic and operational response to child sexual exploitation is good, with strong links to the local priority of tackling gangs and gang culture. Staff across services work together closely to protect children and young people who are at risk of being sexually exploited.

We have effectively applied child protection processes and where required applied to the court for orders to protect children from CSE. We have tracked the progress of children and impact of intervention on reducing risk. This is reflected in the Ofsted finding that when children are at risk of sexual exploitation, or go missing or absent from home or school, there are highly effective arrangements to ensure a multi-agency response to support them and to take action to reduce their vulnerabilities.

Professionals work hard to build relationships with teenage children enabling them to recognise inappropriate relationships and unsafe situations. CSE Best Practice Workshops for social workers have focussed on developing confidence and capability in this area of practice. We have delivered training to semi-independent housing
providers. We have looked at how we apply learning from CSE multi-agency case audits to improve practice.

What was the impact?

On 31/03/17 there were 14 children identified as being at high risk of CSE - headline numbers of children identified as ‘high risk’ have been relatively stable. During the year 34 children were identified as being at risk of CSE and 40 children were deemed to be no longer at risk of CSE. The overlap between going missing and likely risk of CSE is well understood and a missing incident is often the trigger for an assessment that identifies CSE. We continue to bring together information about risk factors around children which also leads the identification of children at risk of CSE. This confirms the Ofsted Inspectors’ view that that progress was seen in most cases, and risk reduction had been demonstrated over time. We know from children and young people about the ‘push’ and ‘pull’ factors in relation to CSE and the importance of developing a strong trusting relationship with their social worker, teacher or another adult who can enable them to understand that they are at risk and that their experiences are abusive and harmful.

Over the year we have undertaken more mapping work and sharing of ‘soft intelligence’. We have developed guidance for practitioners who work with children about this so the police can get more valuable intelligence to inform their investigation. This includes getting information from return from missing interviews. The CSE MASE has also looked at themes emerging from complex strategy meetings where more than one child is being safeguarded through applying child protection processes.

We have a good understanding of not only our local CSE profile but also have considered the challenge of ‘hidden harm’ through analysing the London wide needs analysis, research and reports about CSE in other areas. We have over the year developed a better understanding of the links between gangs and CSE, especially County Lines. We have identified the additional vulnerability of children and young people with SEN/D and the challenge of protecting children when the police cannot proceed with criminal investigation.

What we plan to do next?

We recognise we need to know more about CSE in relation to teenage boys, especially those involved in gangs, and that in some cases teenage girls through on-line activity can rapidly find themselves in high risk situations when we have little or no information about their vulnerability before a serious incident comes to police or children’s social care attention. We also know that exploitative and concerning sexualised behaviour starts earlier in childhood than we had thought and that there is a strong link with domestic violence and childhood neglect.

There is also a challenge in that we are primarily focussed on safeguarding ‘our children’ and children placed by other local authorities in Royal Greenwich and tackling offenders who live in our borough. Although the Metropolitan Police central CSE Team provide a London wide perspective we are mindful that the challenge crosses borough boundaries.

A priority for us is to intervene earlier in children’s lives to both safeguard them and tackle attitudes and behaviour that often lead to exploitative sexualised behaviour. This means stepping up our work with children in primary schools, building resilience and targeting intervention with children to help change their perceptions and behaviours.

We know we need to improve how we understand the associations between children and with adults both in terms of safeguarding and in addressing perpetrator behaviour. These are often hidden through the use of social media.

We are introducing new High Risk Adolescent Meeting arrangements to strengthen the integration of activity to disrupt perpetrators and protect our highest risk children.
Keeping Children Safe in Health

Health Safeguarding Work Group: Chaired by Anita Erhabor, Designated Nurse for Safeguarding Children, Greenwich CCG (chaired by Derek Abel until December 2016).

What did we do? Why?

The Health Work Group met quarterly with strong representation from health organisations across the borough, Early Help and the London Ambulance Service (LAS). The Group maintained an overview of health risks related to the effectiveness of safeguarding children throughout the health economy and the partnerships. It also provided an additional forum for health operational leads to raise concerns that might result in risk to the network’s ability to safeguard children and young people.

The group continued with the work on Neglect which began in 2015/16. The work group reviewed each member organisation’s understanding of what constituted neglect, its identification, assessment and also the effectiveness of the work carried out with families to address identified issues. This piece of work led to the development of the Greenwich Child Neglect Tool, which is designed to assist frontline practitioners in identifying and assessing children who are at risk of neglect. The tool supports practitioners who are concerned about the quality of care a child is receiving from a carer. It also helps practitioners to reflect on the child’s circumstances, putting the concerns into context while identifying strengths and resources.

A Child Sexual Abuse audit report was presented and the group discussed how the findings from the audit could be embedded in practice within the organisation. The “Voice of the child” was a standing item on the meeting agenda and leads were reminded of the importance of ensuring the child’s voice is heard and documented at contacts.

Documenting the adult’s relationship to the child was identified as a key learning issue from a national serious case review. This was highlighted as a risk and was raised at various GP practice safeguarding meetings.

Consequently this has resulted in changes to the registration process in most practices. For example, the new patient GP registration form now includes a space to record the adult’s relationship to a child.

The learning from the CQC Safeguarding and Looked after Children inspection was shared and progress on action plan implementation will be monitored at future meetings.

What was the impact?

Health organisations, including General Practice, now record the voice of the child wherever possible and also involve children in their care. Frontline practitioners were reminded not to overlook the needs of the child especially when working with very vulnerable parents.

The learning from the “Not seen and Not heard” report and the “Triennial review of serious case reviews lessons for health” was presented to the group. Health leads were reminded of the need to be particularly vigilant about children who do not present for their appointments. The group agreed that health practitioners need to shift away from using the terminology DNA (did not attend) to WNB (was not brought). This will help ‘maintain a focus on the child’s on-going vulnerability and dependence and the carers’ responsibilities to prioritise the child’s needs, the impact of cumulative harm of neglect over time and also of any escalating risks. Our frontline practitioners are beginning to change their use of the terminology from DNA to WNB and this requires a shift in mind-set.

The other area of focus for the work group was the delay in children accessing child protection medical reviews. This was flagged with the Greenwich Safeguarding Children Board and performance was monitored by the group throughout 2016/17. The service achieved 100% compliance in the last quarter of the year.
The group also raised awareness of the self-harm protocol with health professionals, with the aim of improving identification and response.

Members of the group also contributed to the development of the Neglect Matters campaign.

**What we plan to do next?**

- Review the Terms of Reference for the Group to ensure we have representation from the whole health economy
- Develop a child protection medical factsheet

- Monitor health agency action plans arising from serious case reviews and CQC inspections
- Hidden harm – Work on risk of hidden harm to children
- Focus on children with special educational needs
- Monitor safeguarding themes emerging across health and feedback to the Board

**Example of effective practice - Neglect Tool Kit**

Child neglect is the most common form of child abuse in Greenwich and remains the main reason for a child to have a child protection plan. Health practitioners are well placed to identify neglect early and initiate an appropriate response. The Neglect Tool Kit will support frontline practitioners to recognise early neglect, categorise the level and help keep the focus on the needs of the child rather than the adult.
Keeping Children Safe in Schools

GSCB Schools Work Group: Chaired by Vicky Cuff, Head of School, Invicta Primary School

What did we do?

The Work Group provides a communication channel between schools and the GSCB, information sharing amongst the schools and a source of peer support in meeting safeguarding responsibilities.

The group reviewed the republished statutory guidance for schools in England - Keeping Children Safe in Education (2016) and the model policy for schools has been updated in light of the changes. We considered the key messages for education practitioners from the Triennial Analysis of Serious Case Reviews (2011-2014).

FGM

In order to raise awareness about FGM in schools the group put together a set of scenarios that schools can use in their own safeguarding training sessions to ensure their staff are aware of this type of child abuse.

Chelsea’s choice

Chelsea’s Choice was performed to 8 schools/secondary provisions. An estimated 1,896 children in years 9 and 10 saw the performance. 8 secondary provisions took part in this project, with approximately 1,800 young people accessing the production which highlights issues relating to Child Sexual Exploitation.

Early Help Contact Requests

The work group has worked closely with Early Help to develop this system whereby information from Police Merlins which wouldn't necessarily meet the Children's Services threshold is shared with schools for Early Help assessments where necessary. Most schools have welcomed this step although there have been concerns around timeliness. The group are looking into engaging with the Operation Encompass initiative to overcome this.

DSL Network

Having identified a need for clearer communication and opportunities to network and share learning between Designated Safeguarding Leaders in schools a thriving network has been developed with half termly meetings.

Suicide Support Training

The Samaritans Step by Step service offered suicide support training to schools. Not all places were taken up by schools which highlighted the difficulties schools have in releasing staff for high numbers of training days. The vacant places were offered to schools in neighbouring boroughs.

Preventing physical chastisement

The Work Group worked with the local Police and Children’s Services on an initiative to reduce the number of children experiencing physical forms of harm. A model agreement was developed and schools were urged to include or attach it to the home–school agreements in their admissions pack together with the GSCB Leaflet to support parents and carers to manage their children’s behaviour.

Views of children and young people:

Pupil Survey - Physical Chastisement

The group undertook a survey of pupils from Greenwich schools in order to further enable the voice of Greenwich children to be heard, to receive feedback on their understanding and experience in relation to parental practices and child discipline. Around 800 children responded and the results showed that smacking is a relatively regularly administered form of physical punishment.
Over a quarter (26.3%) of children surveyed reported that they had been smacked. This together with those who reported being hit with an object (16.4%) and the 11.3% who experienced stress positions indicates that a considerable proportion of children had received physical forms of punishment. More information about the results of this survey is available on the GSCB website. The findings were shared with schools, along with appropriate resources, reminders of how to support young people who make disclosures and a re-launch of the model home/school Physical Chastisement agreement.

What we plan to do next?

- We plan to further respond to views of young people with our second pupil survey around “Safe Spaces”.
- Prepare a model Lettings Policy for schools to help in safeguarding children who attend sessions run by outside clubs or coaches on school premises and support GSCB’s Safeguarding in Sport work
- Work with Early Help to develop a more timely system of information sharing with schools.
- Ensure that information is effectively transferred between secondary schools and post-16 education as currently there is no expectation for Safeguarding and child protection records to be passed on.
GSCB Statutory Functions
Allegations Against Staff  
Henrietta Quartano, Head of Quality Improvement Service, RBG Children’s Services

What did we do?

Working Together to Safeguard Children March 2015 (HM Government) sets out arrangements for sharing information about allegations of abuse made against staff or volunteers working with or in contact with children. The guidance is clear that allegations against people who work with children are not dealt with in isolation and that the needs of children are appropriately considered by staff in children’s social care. All allegations relating to people who work with children in Royal Greenwich are referred to children’s social care and there are Local Authority Designated Officers - (LA)DOs who offer advice and manage the investigation.

We have continued to:

- Investigate all allegations relating to staff working or volunteering in Royal Greenwich including in relation to their private lives where there are concerns that a member of staff has:
  - behaved in a way that has harmed a child, or may have harmed a child;
  - possibly committed a criminal offence against or related to a child; or
  - behaved towards a child or children in a way that indicates he or she would pose a risk of harm if they work regularly or closely with children.
- Ensure that any risk to children is always at the forefront of our decision making
- Keep parents and children appropriately informed of the outcomes of any investigation
- Maintain a data base to identify trends and any learning needs
- Disseminate learning across the partnership arising from (LA)DO investigations

In April 2016 there was a reorganisation of the Quality Improvement Service and this resulted in an increase in the number of people undertaking the (LA)DO role as part of their Quality Improvement Leader duties. Following a challenge during the OFSTED inspection further changes were made and this included a more robust recording and monitoring process. A (LA)DO leaflet explaining the role and the responsibility of agencies to refer was also widely disseminated.

There were 217 contacts to RBG (LA)DO during 16-17 of which 184 were RBG’s responsibility and 33 were other Local Authorities.

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<th>2014/15</th>
<th>2015/16</th>
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<tbody>
<tr>
<td>All contacts (RBG) only</td>
<td>113</td>
<td>97</td>
<td>184</td>
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<tr>
<td>LADO Process</td>
<td>77</td>
<td>56</td>
<td>62</td>
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<td>No LADO Process</td>
<td>36</td>
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All contacts with the (LA)DO are carefully assessed and information gathered to determine whether a (LA)DO process is needed. There has been a significant increase in the number of contacts with the (LA)DO. However there has not been a similar increase in the number of cases needing to be investigated in a (LA)DO process.

(LA)DOs across London have reported an increase in contacts with the (LA)DO. This is likely to be related to the highly publicised historical cases.

The local increase in contacts is also attributable to a greater understanding of the (LA)DO role but also the way in which cases are now recorded.
School still remains the main agency to contact the (LA)DO however there has been an increase in contacts from Early Years and particularly from nurseries and child-minders. In addition there has been a significant increase in contacts from social workers in relation to looked after children as well as where there are concerns raised in private life matters, which could impact on their work with children.

When there are allegations made by our looked after children who are placed in other boroughs, the responsibility lies with the (LA)DO in that Local Authority. However we monitor any allegations and the Greenwich (LA)DO works closely with the child’s Social Worker and other (LA)DOs to ensure a timely and robust response for our children.

During the year there were 33 allegations made by our looked after children placed in other authorities. The outcome can be seen in the table below.

Within RBG there were 62 contacts that resulted in a (LA)DO process. The outcome of these was as follows:

Other actions following the (LA)DO process included 11 disciplinary action, 12 dismissals, 11 referrals to DBS, 29 referrals to OFSTED and one to the HCPC.

What was the impact?

The significant increase in the number of contacts with the (LA)DO evidences a better knowledge of the role. However the stability in the number of contacts resulting in a (LA)DO process suggests that this does not mean that there is a greater risk to children from professionals.

It is positive that schools continue to be the highest referrer given they have the most contact with children. They are well supported by the Schools’ Safeguarding Officer who regularly delivers training to them on safeguarding, safer recruitment and the (LA)DO role. The direct contacts to the (LA)DO from non-statutory agencies, in particular private nurseries is positive and demonstrates a wider understanding of keeping children safe in settings.

What we plan to do next year:

While the increase in contacts with (LA)DO is positive it does demonstrate a lack of confidence in managers being able to determine when a process is needed, particularly in relation to practice complaints.

Therefore next year we plan to undertake a (LA)DO training programme across the wider professional network.
Effectiveness of early help
Rachel Egan, Interim Assistant Director, Early Help, RBG Children’s Services.

What did we do?
Disseminated good practice through the Early Help Partnership increasing the number of children receiving timely and effective early help (66% increase between 12/13 and 16/17).

We undertook an in-depth analysis of children who had come to the attention of children’s social care triggered by issues relating to domestic violence and abuse. We found that due to the often chronic nature of the underlying domestic violence and abuse within the household / family they are repeatedly referred, and although some reach the threshold for assessment, they don’t reach the threshold for a service. Needs escalate and they re-enter the children’s social care system at a later stage with more severe needs.

We identified the extent of the problem, illustrating how domestic violence and abuse is an issue for children in our CSC system, what ‘stop / start’ means in terms of escalated need, associated costs, and increasing incidents of DVA in Greenwich, this is illustrated below.

Evidence for and evaluation of effectiveness
SafeCORE will investigate and contribute to the evidence base about what works in Child Protection, initially piloting SafeCORE with children who come to the attention of children’s social care triggered by issues relating to domestic violence and abuse with a view to then scaling SafeCORE to intervene with other groups of children who experience neglect.

Changes made as a result of previous learning/priorities and new developments
Use of the Troubled Families Outcomes Plan to raise awareness of the positive impact of parents’ behaviour on change for children, continuing to encourage ‘think family, think employment’.

Analysis of cases through sampling and audit identified the components of effective step down resulting in a new practice process being agreed to support step down including:

- Case Consultation between the Social Worker and an Early Help Practice Manager prior to step down
- Joint working between children’s social care and early help as part of step down
- 12 week reviews for every child.

SafeCORE will contribute to giving prominence to the issue of domestic violence and abuse and develop our capacity to work differently, intervene earlier and apply the principles of prevention and early intervention to this issue.

What was the impact?
We have secured £1.95 million from the Social Work Innovation Fund to develop
SafeCORE an innovative approach to reducing both the occurrence and impact of domestic violence and abuse for children.

The step down process has not resulted in the expected improvements, step down is still effective for the majority of children however we need to understand more about why the improvements in impact haven’t been realised.

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

We sought children’s, young people’s and families’ views about how we should respond to domestic violence and abuse. They told us that help should be there for everyone and that victims, perpetrators and children should receive help and support like counselling/therapy to restore self-esteem and develop confidence and independence.

We have used these insights to develop SafeCORE which takes a ‘whole family’ approach, working with everyone in the family including the ‘perpetrator’, whether or not they are still living in the family home, to prevent the behaviour/issues repeating within other/multiple contexts.

SafeCORE supports families to create better environments for children; increasing positive experiences and decreasing risks to prevent children’s needs escalating and mitigate against the likelihood that they would re-enter the CSC system at a later stage with more severe needs.

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

Growth in early help is being facilitated so that it is sustainable with quality continually improving as a result of our investment in workforce development through training and our Early Help Practice Offer that incorporates evidenced based innovation such as Reflective Group Supervision.

This assertion is supported by both the increased number and proportion of children who had EHA/TAC and remained below the threshold for Safeguarding and Social Care and the improving quality of EHAs verified by the Early Help Practice Managers through quality assurance and our Early Help Practice Offer. Comparing the quality of assessments in 2015/16 to those in 2016/17 there is a noticeable increase in the amount of assessments that “fully met” the criteria noted.
Overall 63% of EHA’s that were quality assured in 2015/16 fully met the criteria whereas this has increased to 78% in 2016/17; this is a 15% increase in quality.

There is a need to increase capacity for whole family work; TACs are having unintended consequences of multiple professionals leading to a case management culture rather than intervention culture. Stress is emerging as a key reason for staff sickness.

What we plan to do next?

Example of effective practice:

Early help was provided to this family following a referral from Children’s Social Care as part of planned step down. The Early Help Family Worker worked with the parents to help them understand their daughter’s behaviour, identify triggers and work together to manage her behaviour using techniques provided by their Family Worker.

An important part of the change was for the whole family to better understand Bella’s behaviour in the context of her disability and to support her in developing her independence so that she was less isolated. Mum worked very hard to understand Bella’s behaviours and how to look for triggers. Once this was established, Mum was able to put in place boundaries and strategies to manage these.

Mum found ignoring minor behaviours worked well alongside a reward system for Bella to work on specific behaviours two at a time. This approach was easy for everyone to understand and worked really well for the whole family. Bella’s outbursts of anger towards the family greatly reduced and this had a positive impact on all the family relationships.

Working with the Family Worker the School Nurse provided support to Bella to help her improve her weight and personal hygiene giving her confidence to attend a social skills group at school. She began travelling to and from school on her own and she started to access the youth offer, this included day trips in the holidays and overnight stays and this helped her feel independent and make friends. Bella now has an Education Health and Care Plan which was completed with support from SENDiass and Mum is engaged with a local Children’s Centre which she attends regularly with her new baby. Taking part in the groups like Baby Massage has made a real difference and she feels more connected to her baby and to other mums.

Bella is doing well, her attendance at school is good and her behaviour is calmer. CAMHS is making a difference to her resilience and helping her develop strategies to stay connected and manage her feelings. Bella now has access to Disability Living Allowance and Mum is using this to support Bella in taking part in activities that she enjoys and that support her to feel happy and build her friendships.
Safeguarding Looked After Children
Nicky Crouch, Permanence Service Leader, RBG Children’s Services

What did we do? Why?

The Permanence Service works with looked after children and care leavers. The service includes the social work teams that work directly with looked after children, young people and care leavers. Additionally the adoption service, fostering service, our residential children’s home and supervised contact service are all delivered through the Permanence Service.

We were visited by OFSTED in the summer of 2016 as they carried out their Inspection of services for children in need of help and protection, children looked after and care leavers. They told us that:

“Children and young people looked after in the Royal Borough of Greenwich receive a good service. Decisions about whether children need to become looked after are appropriate and timely. Good assessments inform plans, which are reviewed regularly. Social workers know children well and visit them often, ensuring that their views are captured. The large majority of children looked after, including those placed out of borough, have much-improved outcomes as a result of the support that they receive. Children looked after are very well supported in all areas of their education by the excellent virtual school.”

The Permanence Service achieved a ‘Good’ grading in all three of its inspection areas:

- Children looked after and achieving permanence - Good
- Adoption performance - Good
- Experiences and progress of care leavers – Good

We are committed to ensuring that the right children become looked after at the right time and only where this is necessary to ensure that they are safeguarded and their welfare needs are met. The looked after children number at the end of March 2017 was 496 which represented the lowest number for over 15 years, however the number of care leavers we are working with has increased, due to a high number of older children in care turning 18 and also due to legislative changes which have resulted in extended duties up to 25 years of age.

There have been a number of successes over the last year as we have supported many children to achieve permanence. During 2016/17, there were 33 cases where care proceedings were concluded with children being placed under Special Guardianship Order arrangements, usually with a close family member or with their current carer. 22 children were adopted and this was achieved within improved timescales supporting positive longer term outcomes.

386 children (77.8% of our looked after children) were in foster placements at the end of March 2017 and our performance around placement stability was better than both the national and London picture. A priority for us continues to be to increase our in-house fostering provision, as we know this is where our children do well. We continue to work hard to support the excellent foster carers we do have and to recruit new carers who can meet the needs of our children through our recruitment activity and fostering information days. We are particularly keen to encourage applications from people who could look after older teenagers, sibling groups or offer parent and child placements. Where possible we aspire for our children to be in well matched local placements.

Our children’s home maintained its OFSTED ‘Outstanding’ judgement and continues to support our children to achieve positive outcomes. The children talk fondly of their
experience there and even after they have moved on, keep in touch and continue to be supported by the dedicated staff team.

During the year we positively supported children, who were unaccompanied asylum seeking children resettled from camps in Europe. This was part of a PAN London response to the emerging humanitarian crisis.

We are aspirational for our young people and want to see them achieve and have positive choices as they transition into adulthood. A priority over the last year has been to support more young people to be engaged in education, employment and training (EET). At the end of March 2017 10.3% of care leavers were attending University and 64.1% were engaged in EET, both figures reflecting better performance than the national and London picture.

We have reviewed our current corporate parenting arrangements to improve the opportunities for children to get the support they need and their voices heard. Statutory guidance on the roles and responsibilities of the Director of Children’s Services (DCS) and the Lead Member for Children’s Services (LMCS) outline that the DCS and LMCS in their respective roles: “have a shared responsibility with all officers and members of the local authority to act as effective and caring corporate parents for looked after children, with key roles in improving their educational attainment, providing stable and high quality placements and proper planning for when they leave care”.

We are establishing a new Corporate Parenting Board, which will be co-chaired by the lead member and representatives from our Children in Care Council which will improve the engagement of officers across the wider council and with partner agencies.
Private Fostering
Sharon Pearson, Senior Quality Improvement Leader, RBG Children’s Services

What did we do?

Any child under the age of 16 years (under 18 for disabled children) who is being cared for by someone who is not their parent or close relative for over 28 days is in a Private Fostering arrangement. The agreement for care is between the carer and the parents of the child with the parent retaining parental responsibility. The Private Foster Carer becomes responsible for the day to day care of the child and must safeguard and promote their welfare. There are regulations setting out how the local authority assures itself that the Private Foster Carer is meeting their responsibilities, and for identifying children in need including those in need of protection. The designated monitoring officer in Children’s Services has lead responsibility for assuring that the Private Fostering arrangements are working well and they provide an annual report to the GSCB Executive.

Over the year there have been between 16 and 25 children privately fostered in Greenwich at any time. At the end of the year, on 31 March 2017, there were 21 children under a Private Fostering arrangement, a decline of 4 children when compared to 15/16. The main reasons for the children being in Private Fostering arrangements are: coming from abroad to live with extended family or family friends and be educated in the UK; relationship breakdown between parents; parents in prison; parents with immigration issues not in the UK and parents working unsocial hours. Children are referred by a range of agencies including Children’s Services (the Schools Admissions Team), schools, health, third sector organisations, and other local authority services. For most, Private Fostering is a short term arrangement, hence the cohort changing over the year. However, some the arrangements are clearly seen as longer term.

Consideration of permanence in promoting stability for children in Private Fostering arrangements continues to remain a focus for social workers alongside making sure those children are seen and able to talk to a social worker where it is known or believed a child is living in a Private Fostering arrangement. There remain relatively few notifications of Private Fostering arrangements. A clear barrier to identification is concerns about immigration status and ‘the authorities’. We have sought to promote awareness of Private Fostering and the responsibility to notify the Local Authority as a safeguarding not an immigration issue. Information about Private Fostering is targeted to those who have the greatest reach in the community. If notification clearly identifies the case as a Private Fostering arrangement then the initial visit will be undertaken by the Fostering Team. If it is unclear that the arrangement is Private Fostering then the visit is carried out by children’s social care Assessment and Support Teams in order to determine status of the case.

Responsibility for subsequent visits to children in Private Fostering arrangements and taking action to safeguard children and support carers occurs within the Fostering Service. Having the Private Fostering managed within one service has given a stronger focus to Private Fostering, and has enabled workers to gain a better understanding about what Private Fostering entails and so is better able to advise and offer needs led support for Private Foster carers. It has also improved performance in meeting statutory timescales.

Most children are seen within the required timescale and this is particularly evident in the 6 weekly visits where 92% are seen and visited on time. The 12 weekly visits are at 100% and most subsequent visits are within timescale.

Performance has continued to improve. All children are seen. A small number of children are identified as being children in need and a smaller number of children were removed from what was an undeclared Private
How have we made a difference to children?
Private Fostering Awareness Week was promoted during the week beginning 06/07/2016 and included advertising the event on the big screen in Woolwich Square, a table and stand in the Reception area of The Woolwich Centre; the Woolwich Library, Children Centres and Schools and has been helpful in raising public awareness.

Private Foster carers continue to get good support from the Social Work Team which has helped them as carers for children who are not with their parents.

What have we learned?
Concern about ‘the authorities knowing my business’ continues to be a barrier to Private Fostering notifications being made. Parents are often not in a position to make the notification easily and Private Foster carers are sometimes reluctant to open questions up about a child’s status. Schools admissions, receptionists in schools, health settings and the police are particularly well placed and identify most of the Private Fostering arrangements.

What do we plan to do next?
We need to continue to promote Private Fostering as a safeguarding issue along with concerns about child trafficking and child exploitation so that parents, Private Foster Carers and local communities understand why complying with the law is important.

We need to continue to engage more Private Foster carers and parents to promote permanence for children, so that they can feel secure and understand the arrangements they are in, how long they will continue and who is responsible for key decisions affecting their lives.

We need to improve our tracking of the progress of privately fostered children in terms of their school achievement, health and development and welfare.
Safeguarding children who go missing from home and care
Henrietta Quartano, Head of Quality Improvement Service, RBG Children’s Services

What did we do?

The Missing Work Group has a direct link to the GSCB priority of addressing the challenges and risks to children from exploitation (including cyber bullying/ e-safety, sexual exploitation, going missing, trafficking and involvement with gangs). The group has good links with the CSE MASE to ensure that the work of the two groups is streamlined and effective.

The GSCB Missing Group evolved from the Missing Joint Commissioning Group and has been meeting regularly since April 2016. A key activity of the group is to review data to identify emerging themes and areas for further consideration. The group has reviewed recording processes between the Police and Children’s Social Care of children who go missing from home. The changes have resulted in greater data accuracy and will contribute to developing our local problem profile.

The increase in missing from home is likely to be linked to better recording and a greater awareness among parents about the risks to children when missing and the need to report to the Police. More boys are reported missing from home than girls. (41 boys, 31 girls) The age of the children who go missing is 13+ which is consistent with previous years. The vast majority of children go missing only once (55 out of 75).

What was the impact?

A key priority for the Missing Group is to understand what works in relation to reducing the risk of going missing and where there are areas that require further development. The Missing Group has completed multi-agency case audits on four young people who have gone missing from care and from home. Each agency reviewed their case records and completed a brief report and then collectively the Missing Group discussed these and identified themes and learning. The key messages are:

- Have a clear understanding of a young person’s history and use this to inform interventions.
- Agencies need to undertake work with the family while the child is missing – not wait for return
- Need to have a whole family systemic approach – pay attention to siblings
- Be aware of the impact of unresolved trauma
- It is a challenge when YP or families will not engage with support services
- Be aware of the corrosive impact of neglect
- Relationship based practice helps – need to take time to build these up

Findings from our multi-agency audits have been disseminated to improve practice and outcomes for young people.

The over-representation of young people from a Black/mixed background who go missing both from care and home has been noted by the group. The story behind these figures appears to be that this was likely to be gang related and noted that young Black African males are specifically targeted by a local gang. We acknowledged that this group are really difficult to engage. We heard that where we have targeted the younger siblings of this cohort – before they become gang involved and go missing – this has had a positive impact. The group are working towards developing a clearer understanding of which cohorts of children may be at greater future risk of going missing and to become exploited with a view to exploring whether information and preventative work could be more targeted. This will be supported by an assessment tool.

**What we plan to do next?**

- The group has identified a number of tools that are used across services in relation to working with missing children. We plan to collate these and review them with a view to producing a GSCB fact sheet next year around missing.
- We will repeat our multi-agency case audits and focus on a cohort of young people who have stopped going missing to examine what changed their behaviour
- We need to improve information sharing from other local authorities about young people who are looked after that they place within Royal Greenwich so that we can better understand vulnerabilities and risks that they may present to inform our local profile
What did we do?

I am delighted to have joined the Royal Borough of Greenwich in September 2016, soon after the publication of the Ofsted inspection that judged Children’s Services in Greenwich to be good across all domains. Greenwich puts children at the heart of everything it does and this is reflected in the Ofsted report.

The high expectations for children mean that 94% of schools in Greenwich are judged by Ofsted as good or outstanding. Good universal provision such as schools, early years’ settings, children’s centres, youth centres, libraries, and health services provide the foundation for children to thrive, learn and develop. Effective universal provision is also essential to support safeguarding and emotional well-being and ensure that all children no matter what their background achieve well in life.

Critically for children and young people to thrive they need good parenting and family support. Some families need more support than others. Children’s Services aim to provide support for these families so their children achieve positive outcomes. Poor school attendance or behaviour difficulties often indicate the need for additional help. Children with special education needs and disabilities are more vulnerable to bullying, exploitation, abuse and neglect. Some children and families require more specialist intervention by our children’s social care and youth offending services because they are at risk of harm in or outside the family, or their behaviour poses a risk to other. We have a special responsibility towards our looked after children and care leavers.

The Ofsted Inspection of services for children in need of help and protection, children looked after and care leavers (report published August 2016) confirmed that our children and families benefit from effective services and that we have continued to improve the quality and effectiveness of our services since previous Ofsted inspections. There is always more to do and we are never complacent about our ambitions for children.

In partnership across all children’s services and provision, we have developed a new Children and Young People’s Plan 2017 – 2020. The Plan consolidates that which is working well, sets our vision, priorities and the performance framework organised across our fundamentals: safe and secure, prevention, strong foundations and recognises that resilience and good mental health is a factor that needs attention across all our fundamentals. The CYP Plan also identifies our values and principles, described as the building blocks of success; namely that children are at the heart of everything we do, work is family and outcome focused and we value our collaborative partnerships.

We continue to be innovative in how we develop our services and focus on how we can learn and improve. The successful bid to develop our pilot South East London Teaching Partnership has led to increased opportunities for social workers and leaders to develop and improve their practice. We are part of a successful bid to develop and extend out Pause work with women who have had children taken from their care. We have developed proposals for working in an innovative way with children in families where earlier intervention has not achieved sustained change.

During the year we have strengthened our corporate parenting arrangements. Our children and young people have developed the Promise (which replaces the Pledge to our looked after children and care leavers) and we now have a Corporate Parenting Board...
chaired by the Cabinet member and a member of our Children in Care Council.

We continue to be strongly committed to quality assuring our services and looking at the impact they have in improving children’s lives. In addition to our well embedded quality assurance programmes in children’s social care and the youth offending service, we carried out a deep dive in our early help services. The findings have informed our plans for strengthening our early help and targeted support for children and families.

We have continued to improve the way we listen and engage with children, young people and their families so that they are influencing and shaping services and provision. Our Local Offer for children with special educational needs and disabilities fully complies with statutory duty and is representative of children’s young people's and parents’ views.

What was the impact?

Early help continues to be effective in preventing problems from escalating and requiring a referral to children’s social care. Only 11% of children who get early help go on to be referred to children’s social care and 87% of children ‘stepped down’ from children’s social care to a Team Around the Child remain below the threshold for children’s social care. 75% of children have sustained this change for 12-24 months.

The consultation line and advice offered by Children’s Services combined with a good understanding of thresholds has led to 95% of children who are referred to children’s social care going on to have a social work led assessment. Our re-referral rate to children’s social care at 13.1% is better than last year, London and National averages. 87.7% of child and family assessments were completed in a timely way. The Ofsted inspectors and our own monthly case audit programme found that most assessments were of good quality.

The rate of children with child protection plans has slightly increased though fewer children have a repeat plan compared to last year, London and National averages.

There has continued to be a sustainable reduction in the numbers of looked after children, even though we have had an increase in children subject to care proceedings. Our performance on the timely completion of care proceedings and positive outcomes secured is good.

What we plan to do next?

There is more to do to strengthen arrangements for providing targeted early intervention for children and families on the edge of children’s social care. Our current early help offer is not always able to secure timely sustained change for children living in families particularly where there are multi-generational long term patterns of neglect associated with domestic violence, parental substance misuse and ill health.

Whilst we have been effective in helping teenage children who are being groomed whose own behaviour places them and others at risk of harm (for example through strengthening arrangements for responding to Harmful Sexual Behaviour) we know that sexual exploitation, exploitation by gangs and through radicalisation continues to be a largely hidden problem. Strengthening our work with boys and men is a theme of our new Children and Young People Plan and we are looking to be innovative in how we identify and respond to boys earlier in childhood.

Our looked after children, children in need and children with SEN and disability do relatively well in terms of educational outcomes that can transform children’s lives. However, there is more to do to close the gap between our more vulnerable children and all children.
Royal Borough of Greenwich Adults and Older People’s Services

GSCB Executive Board Member: Simon Pearce, Director of RBG Adults and Older People’s Services

Adults and Older People’s Services (AOPS) provide social work and care management assessments and support adult service users in the borough, many of whom are parents, or have childcare responsibilities.

The Safeguarding Adults Team liaise with Children’s Services in the identification of children at risk, particularly in regards to domestic violence and substance misuse by adult service users.

This year the Adult Social Care Services continued to work closely with Children’s Social Care to improve outcomes for children and families.

The Adults Principal Social Worker (PSW) is an active member of the GSCB Audit workgroup and has participated in various deep dive audits.

The audits are either single or multi-agency. Most recent involvement has been to undertake audits on Adult social care / Adult Services involvement in the following:

- Multi-Agency Audit – Child Sexual Abuse deep dive
- Multi-agency audit on interfamilial child sexual abuse

There are closer ties between the SAB and GSCB Learning & Development sub-groups as there are nominated reps from each Directorate to attend those sub-group meetings.

There has been dedicated work undertaken between the two parts of the Council to work on transition to adulthood with a joint protocol being agreed and now publicly available.
Lewisham and Greenwich NHS Trust
GSCB Executive Board Member: Jo Peck, Associate Director of Nursing

What did we do?

Lewisham and Greenwich NHS Trust (LGT) provide a range of acute health care services at Queen Elizabeth Hospital (QEH) Woolwich in the Royal Borough of Greenwich. LGT also delivers the Family Nurse Partnership (FNP) programme within the borough.

How have we made a difference for children?

Learning from Care Quality Commission (CQC) Children Looked After and Safeguarding Inspection (CLAS) in November 2016 and Serious Case Reviews (SCRs) has resulted in a review of the Maternity Safeguarding Pathway (MSP). This will ensure that unborn babies, children and their families who could benefit from early support are identified as soon as possible. All women booking for antenatal care are routinely asked about Female Genital Mutilation (FGM), Domestic Abuse (DA), mental health support and who will be involved in the new baby’s life. The Trust is part of the early adopter FGM Risk Indicator System (RIS) to ensure an electronic flag is automatically generated for children living in homes where FGM is a factor.

The Safeguarding Team contribute to the Multi-Agency Safeguarding Hub (MASH) through information sharing to support multi-agency risk assessment and decision making to safeguard children.

LGT joined the GSCB Multiagency Sexual Exploitation (MASE) group in 2016-17. This strengthened the LGT contribution to the identification of young people at risk of Child Sexual Exploitation (CSE). Learning from the multiagency audit on CSE resulted in ‘hands on’ training sessions on how to ask difficult questions, professional curiosity and the use of the CSE Toolkit to help staff identify concerns. Information on CSE was shared with staff through CSE posters, handbooks and the Safeguarding Team quarterly newsletter.

Help to support children and their families to be aware of possible CSE warning signs was achieved through the Spotting the Signs of CSE guidance and the NSPCC PANTS campaign.

The Safeguarding Children Policy is being reviewed to reflect updated guidance on Modern Slavery, Radicalisation and the Mental Capacity Act.

The Trust’s Managing Allegations against those involved with Children, Domestic Abuse policy and Therapeutic Holding Policy have been reviewed and updated.

Weekly safeguarding training is offered to help staff know what to do if they are worried about a child. Training is updated annually and has focused on CSE, Gang involvement, self-harm, neglect and learning from SCRs.

The Trust Intranet site was reconfigured in December 2016 with a specific Safeguarding Children page. This page also gives links to the GSCB web page, national and local guidance such as FGM, DA and CSE. The Safeguarding Team produces a quarterly newsletter on current topics.

The electronic record keeping system continues to be rolled out across the Trust as part of the Information Technology (IT) Strategy. This will provide better evidence of the child’s journey through LGT services. The Safeguarding Team became part of agile working, through the use of the community mobility strategy in 2017. This has enabled improved and ‘live time’ information sharing within the multi-disciplinary forums.

All children subject to a child protection plan are flagged on the system and routine notification of attendance is shared with allocated social workers. The ‘go live’ of the Child Protection Information Sharing System (CPIS) for Greenwich is due in April 2017.

Referrals to children’s social care are now sent via secure email which has resulted in more timely information sharing. Outcomes of referrals are routinely monitored in the weekly safeguarding meetings.
The Safeguarding Team reviews Emergency Department attendances using a Red Amber Green (RAG) system. This supports timely information sharing with partner agencies.

Safeguarding Supervision is available via reflective learning forums held quarterly.

An Independent Domestic Abuse Advocate and Learning Disabilities Nurse are available at the hospital to help with domestic abuse and learning disability support.

**Evidence for and evaluation of effectiveness**

The number of early help assessments and referrals made to and accepted by children’s social care has increased, highlighting that staff are identifying children and young people who could benefit from early help or who are at risk of significant harm.

The Trust revised its governance structure in 2016 to have a Safeguarding Assurance Group and Safeguarding committee which is chaired by a Non-Executive to provide objectivity and rigour.

The meetings monitor, review and escalate the Safeguarding Risk Register, Strategic and Operational Action Plans and Annual audit programme.

There is good Trust representation at LSCB meetings and contribution to quality assurance framework.

Training continues to reinforce and raise awareness of current safeguarding issues.

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

The Friends and Family test has been introduced across all of the CYP areas and feedback is monitored and shared with staff

Safeguarding and Parents notice boards are within key clinical areas

All areas have posters advising children and young people they can be seen alone if they wish to speak with a member of staff

A leaflet explaining child protection processes has been developed

A Children’s Complaint Leaflet is available across sites

Multi language posters on DA have been developed by maternity services

The use of interpreting services via telephone or face to face is available

**What have we learned?**

- All Emergency Department attendances are reviewed by the Safeguarding Team to support early identification of need.
- Reviewing and strengthening of information sharing pathways continues to keep children in mind.

**What do we need to do better?**

- Improve children’s engagement and feedback
- Support staff with Early Help identification
- Extend safeguarding supervision availability

**Examples of effective practice**

The Safeguarding Team has embraced agile working to share timely, ‘live’ information to support risk assessment and action planning.

Discharge documentation for GPs now contains specific safeguarding concerns questions to support information sharing.
NHS Greenwich Clinical Commissioning Group  
GSCB Executive Board Member: Yvonne Leese, Director of Quality and Integrated Governance

What did we do?

NHS Greenwich Clinical Commissioning Group (GCCG) is responsible for the commissioning of acute hospital, community, mental health, Out of Hours and Urgent Care Centre Services for Greenwich residents. It is also responsible for the commissioning arrangements for the health of Greenwich’s Looked-after Children.

The CCG is strongly committed to safeguarding children and young people living in Greenwich and this is integral to its commissioning decisions and contract management. In 2016/17 the CCG aligned its safeguarding children work plan to the annual priorities of the Greenwich Safeguarding Children Board.

The CCG has a statutory responsibility to ensure health agencies are providing safe and effective services to all children in the borough. Therefore the CCG has developed an assurance framework and a safeguarding children work plan which integrates all actions and recommendations from various single agency and multi-agency audits, serious case reviews and Care Quality Commission inspections. This ensures that progress on the implementation of action plans is effectively monitored and improvements in practice across the area can be evidenced.

The CCG regularly seeks assurances from healthcare providers around agreed priorities and safeguarding key performance indicators. This is undertaken through planned safeguarding meetings and quality visits. In this way the CCG obtains assurance that health providers are providing safe and effective services to children.

The safeguarding children team has continued to drive improvements in the quality of primary care safeguarding children services by ensuring advice and support is readily available to primary care practitioners through a CCG dedicated telephone line. In addition the designated professional has continued to carry out a number of monthly face-to-face safeguarding children support visits to local GP practices. The designated safeguarding professional also uses these opportunities to reinforce key safeguarding children messages and to improve practice engagement and awareness of local safeguarding children processes.

The Care Quality Commission (CQC) conducted an inspection of health services for Safeguarding and Looked after Children in Greenwich in October 2016. The inspection explored the effectiveness of health services in relation to safeguarding and Looked after Children in Greenwich. This identified many areas of good practice and made some recommendations for improvement in certain services.

What was the impact?

In 2016/17 the CCG maintained good oversight of the safeguarding children performance of health providers in Greenwich and ensured compliance with statutory requirements. This was achieved through attending the various providers’ safeguarding committees and challenging performance which does not meet the agreed targets as indicated by the safeguarding dashboards. The team also carried out monthly assurance visits to providers, identifying areas of concern and those requiring improvement.

The CCG worked closely with the community services provider to improve the health outcomes for Looked after Children. The Designated Nurse for Looked after Children is now attending the CCG Joint (Children and Adults) Safeguarding Group to provide bi-monthly assurance on the health of Looked after Children. This has contributed to improved outcomes for this vulnerable group of children as emerging issues are identified and actions agreed to address them. GPs are also invited to contribute to young people’s health assessments. This has been a positive first step as GPs hold significant health information about these young people. There remains work...
in progress to increase current uptake further in 2017/18.

Some concerns were flagged about delays in seeing children for their child protection medical reviews by the community paediatric team. Greenwich CCG has worked closely with the named doctor for safeguarding to improve the timeliness of reviews. In 2016/17, this was monitored through a quarterly safeguarding dashboard to capture on-going improvements to performance. The performance for Quarter 4 was 100% as all accepted referrals were seen within a day which is the gold standard.

The Designated Safeguarding Children professional facilitated training and the dissemination of the learning within the CCG and primary care from the two serious case reviews published in 2016. The implementation of actions from both published serious case reviews were monitored at internal assurance meetings.

As mentioned earlier a CQC inspection of Greenwich Safeguarding and Looked after Children services took place in October 2016. The inspection highlighted several areas of good practice across the health economy with some recommendations for improvement for certain health organisations. The improvement plan is taken forward by the individual health organisation concerned but is monitored by the CCG.

The CCG Safeguarding team in collaboration with the Communication and Engagement team carried out public-facing, awareness-raising campaigns on Child Sexual Exploitation and Female Genital Mutilation in June and Self-harm Awareness in October 2016. The team spoke to over 580 adults and young people in total at both events and also distributed accompanying leaflets.

The safeguarding support visits to a small number of GP practices each month have resulted in improvements in both GP engagement and their understanding of safeguarding children processes in Greenwich.

What we plan to do next?

- Seek assurance from the whole of primary care and our smaller providers
- Monitor action plans from the last CQC inspection of Safeguarding and Looked after Children
- Recruit to any safeguarding vacancies
- Plan and carry out public-facing awareness-raising sessions on two GSCB priorities for 2017/18.

Example of good practice

CCG had a market stall at the Great Get Together Event (June 2016) and used this opportunity to disseminate information and raise awareness of CSE and FGM

Comment from a mother at the June event:

“This [FGM] should not have happened to me but I am glad you are speaking to parents and young people about it.”
Oxleas NHS Foundation Trust
GSCB Executive Board Member: Stephen Whitmore, Executive Director of Children and Young People’s Directorate

What did we do?

Oxleas NHS Foundation Trust delivers a wide range of health services to the Royal Borough of Greenwich. This includes Adult Mental Health and Learning disability Services; Older Peoples’ Mental Health Services, Forensic and Prison Services; Adult Community Services; Children and Young Peoples services comprising CAMHS, health visiting and school nursing now known as Public Health Nursing 0 -19 years’ service and Children’s Specialist Services.

Oxleas vision and the challenge for safeguarding children remain unchanged, that is to ensure safeguarding and promoting the welfare of children is embedded across every directorate and in every aspect of the work of the Trust. Children and young people are considered in all interactions with service users and their carers and that the welfare of children is the paramount consideration of all staff across the trust, and guides their work.

Oxleas compliance with Safeguarding Children Training was excellent over the year. In September 2016 Oxleas Mandatory Training Policy was revised to reflect new updating standards this resulted in an anticipated but brief drop in compliance for Level 1 training in Quarter 2.

Oxleas Training Compliance at 3rd April 2017 (for green compliance is set at 80%)

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Oxleas in-house Level 3 face to face training is updated annually. This year the update was influenced by the findings from the GSCB Section 11 Audit (2016) which had innovatively taken the form of an online survey. The survey found that we needed to raise awareness of the GSCB Escalation Policy and that a small number of practitioners were not confident in raising a ‘professional challenge’. As well as the GSCB Escalation Policy the update included Oxleas ‘Whistle blowing’ Policy and information about the Local Authority Designated Officer role (LADO). Practitioners are reminded and encouraged to contact the Safeguarding Team if they require support or advice when raising a challenge, in addition supported challenge is an integral part of safeguarding supervision.

The network of Greenwich Safeguarding Champions acts as an additional safeguarding resource to their colleagues in Oxleas. The Annual Champions Event was held in June 2016. The Event helps to maintain and develop safeguarding knowledge across all services. This year the Greenwich Borough Gangs Link Officer gave a talk on ‘Understanding Gangs and Youth Violence’ which was well received. Other presentations included Abuse Linked to Faith, The Refugee Child and Radicalisation; the latter being presented by a member of Oxleas Adult Safeguarding Team.

Oxleas continues to promote a ‘Think Family’ approach in adult mental health services. To this end the findings from the CQC Report ‘Not seen not heard’ (July 2017) were disseminated through the Safeguarding Governance pathways with a focus on finding the hidden child, understanding the effect and impact of family situations on a child.

Information sharing between Oxleas adult mental health service and health visitors and midwives has been facilitated by the introduction of an editable letter on RiO. The letter is completed with consent when a client has a child under 5 or is pregnant. The use of the letter will be audited in the coming year.

What was the impact?

This year Oxleas made 71 referrals to Greenwich Children’s Social Care (MASH). Referrals are routinely checked by the Safeguarding Team for quality and to ensure the thresholds are being appropriately applied.
Feedback is provided to the referring practitioner for making a good referral as well as when improvement is required. As would be expected the majority of referrals come from Oxleas Children’s Services.

THINK FAMILY practice – supports a holistic assessment of children and their families and helps identify children at risk. The needs of children should be routinely considered and addressed when working with adult clients and all relevant information recorded so that timely and necessary interventions can take place.

What we plan to do next?
This year Oxleas will launch and embed the new Safeguarding Children forms for those working in adult and children’s services. The forms have been developed on RiO (Oxleas electronic record system) and will support practitioners in their safeguarding practice as well as providing an improved safeguarding children dataset.

We will continue to raise awareness of neglect and vulnerable groups of children which include those at risk of CSE and FGM; focusing on promoting practitioner confidence and not just awareness. This will include for example providing more information on the impact of FGM and specialist services available to child and adult victims or promoting the use of tools to help the identification and analysis of neglect cases.

Example of effective practice

In October 2016 the Care Quality Commission (CQC) undertook a Children Looked After and Safeguarding (CLAS) Review in Greenwich. This year examples of effective practice have been taken from the final CQC Report which was published in December 2016.

Re: Health visitors and adult mental health services -
“In health visiting we saw some effective joint working and information sharing with other agencies, such as adult mental health services, specialist midwives and GPs, to assess and address risks to children”.

Re: Contraceptive and Sexual Health (CASH) services
“A robust risk assessment tool is routinely used at all contacts with young people under the age of 16 who access the sexual health service and for any 16 to 18 year olds for whom there are any concerns. The tool incorporates questions to prompt practitioners to consider the risk of child sexual exploitation and questions are also routinely asked about alcohol and substance misuse, as well as mental health issues. When safeguarding concerns are identified, the tool includes a flowchart guiding staff on the actions they must take”.

Re: CAMHS
“We saw and heard case examples of vulnerable children being effectively supported by a co-ordinated multi-agency approach. The provision of a substance misuse worker based in the CAMHS adolescent team facilitates close co-operative working between the CAMHS practitioners, Addaction, the youth offending team (YOT) and the gangs lead worker”.

Metropolitan Police Service – Child Abuse Investigation Team
GSCB Executive Board Member: Fiona Martin, Acting Detective Chief Inspector, Child Abuse Investigation Team

What did we do?
The Child Abuse Investigation Command is part of the Sexual Offences, Exploitation and Child Abuse Command (SOECA) of the Metropolitan Police. Within SOECA the Child Abuse Investigation Teams (CAIT) remain as separate units. The Greenwich/Bexley team is run by DI David Williams. The primary objective of CAIT is to make London a safer place for children. The teams aim to achieve this through preventing and detecting reported crimes against children and there is a CAIT officer on duty 24/7. We investigate sexual abuse, physical abuse, neglect and emotional abuse of children within the family setting or where the perpetrator is abusing their position of trust. We also deal with adult victims who have been abused during their childhood. In addition to criminal investigations CAIT investigate Sudden Unexplained Death in Infancy, under what is known as Project Indigo.

CAIT continues to work closely with partner agencies, predominately children’s social care, on a daily basis to protect and keep children safe. We achieve our aim by having manager to manager discussions with social care on all referrals received into the unit. We deploy officers to undertake joint visits with Social Workers; we conduct risk assessments and take actions to safeguard children. This includes the use of police protection and arrest of offenders where appropriate.

What was the impact?
We place Safeguarding and victim care at the centre of our investigations, provide 24/7 experts in the field, and continually review crimes and risk profiles to ensure optimal responses for vulnerable children. Our approach to Total Victim Care within the Metropolitan Police Service (MPS) ensures monitoring on all crimes, to ensure that victims, parents and/or guardians are updated on a regular basis and have a good understanding of how the investigation is progressing at all stages.

DI Williams has worked closely with the GSCB Schools Group to implement a Parental Chastisement Agreement Project where the parents are fully sighted on the illegality of physical Chastisement, this has seen a reduction in the number of low level physical abuse investigation by CAIT.

We have learnt that focusing on children through the investigation and subsequent court cases leads to a more positive outcome for the child, the young witness initiative at court has seen an increase in effective trials as the matter is brought to court in a more timely fashion.

We are also working with the Child House Project which aims to provide a single point of care for a child victim of sexual assault. It is anticipated that these will be a better environment to speak to the child, and obtain evidence of offences. The police experience should be less impactful on the child and will enable more support and recovery for that child.

The Regional Historic Investigation Team (RHIT) that was implemented on the South has now rolled out across the MPS to enable effective investigation of complex non recent offences without drawing resources from the regional CAITs.

The MPS is responded to the HMIC report and continues to strive to improve. As a result of audits we have identified examples of good practices as well as areas for learning. These are currently being shared Met wide.
On a local level the Greenwich team continues to work with Children Social Care to safeguard children and provide positive outcomes. There have been a number of excellent outcomes for victims at court.

**What we plan to do next?**

The MPS is moving towards a more holistic approach to Safeguarding by locating CAITs with the Sapphire and CSUs. The outcome is intended to enable a joined up response to safeguarding issues.
Greenwich Police are committed to safeguarding children and young people. Our ambition is to provide better outcomes for the most vulnerable people in our communities by keeping them safe from harm. The delivery of Safeguarding is considered a core component of policing but inevitably it crosses over into other areas of activity.

The Violent Organised Crime Unit (VOCU)
The VOCU’s remit includes safeguarding young people being recruited into gangs, who go on to be missing from home or care and young people becoming victims of gang-related violence or intimidation. The VOCU works closely with the Greenwich Police Missing Persons Unit (MPU) to identify missing children suspected of gang involvement, to ensure that they are fully debriefed. The VOCU chair the monthly Serious Youth Violence (SYV) Panel meeting, working with partner agencies, to support young people who have become involved in gangs, identifying potential gang risks to any siblings and providing support options to Parents and Carers. The SYV panel has proved critical in developing effective, sustainable working relationships to minimise harm to young people, ensuring relevant information is shared quickly and with those who need it.

Multi-Agency Safeguarding Hub (MASH)
MASH and Youth Offending Service – police officers within the MASH team work in partnership with children social care, health, housing and the MPS Child Abuse Investigation Team, delivering proven early intervention. The MASH allows fast information sharing between agencies to enhance the safety of children and where absolutely necessary, children being removed from unsafe environments. As areas of learning are identified, including through Serious Case Reviews, these are shared throughout the MASH, to frontline officers and within the community.

The Team continues to deliver joint training to all frontline officers relating to the areas of Child Sexual Exploitation, deliberate self-harm and neglect. Engagement has also taken place with Project MOSAIC, passing on the learning to the wider community and harder to reach groups, to enhance knowledge on the services available. The MASH play an important role in identifying and triaging risk to vulnerable children and young people.

The Police MASH team has continued to deliver front line training throughout 2016, with officers across Greenwich borough, benefitting from both group and one to one inputs. Each of the response teams, local policing teams and schools officers has a single point of contact (SPOC), to enable MASH to resolve any issues quickly, or to cascade learning points if required.

Between 1st January 2016 and the 31st Dec 2016 the police MASH team dealt with 14,709 child notifications and Merlin reports; an increase of 11% on the previous year’s figure. Allocated (open) cases accounted for an increase of 15% on reports sent to Children’s Social Care (CSC) in comparison to 2015’s figures.

As well as the responsibility for processing the large volumes of Merlin reports that highlight when a child or young person has come to the notice of police; the police MASH team also work closely with their co-located partner agencies (Children’s Services, Health & Education) as well as those that visit and or sit remotely including probation, housing, YOS/YOTS etc. They engage in the ‘MASH’ process which sees all partners identify those cases where there is believed to be a risk to vulnerable children, families where there is not enough information known about them. Police provide detailed research for these complex cases, and then they participate in bi-weekly meetings (minimum) to identify the best pathway to support/protect those most at risk. In 2016 the police also dealt with 276 of these cases with their partner agencies. The drive for 2016/2017 is to examine more cases to try...
and identify and support a greater number of vulnerable children within Greenwich; this is currently on target.

Youth Offending Service (YOS police)

YOS are also within close proximity to the MASH, forming a strong partnership working between YOS police and social care ensuring safeguarding concerns are shared through the MASH and protective/support plans created quickly.

Identifying and addressing CSE

Over the past year significant work has taken place regarding Child Sexual Exploitation (CSE) and Human Trafficking within the Borough; a dedicated CSE team has been established, clear reporting pathways identified and a structure for referrals developed to assist partners. Greenwich Police and RBG also have a much stronger relationship with the Metropolitan Police’s centrally based Sexual Exploitation Team who have delivered training to every Schools officer in the Borough to assist in identifying young people who may be subjected to CSE. Greenwich Police have developed a training package for Borough Officers. Reporting pathways for officers to make referrals were developed with the MASH team. Both strategic level and operational level CSE multi-agency meetings were set up. As a result of the systems that have been put in place, a number of child safeguarding investigations have taken place with early intervention to prevent and educate those at risk of CSE.

Working within schools

We have dedicated Safer Schools Officers, who regularly interact with pupils through school youth council meetings and surgeries to listen to student concerns, identify and address issues within the school and local environment. They also conduct presentations / deliver talks at assemblies to inform young people of police initiatives, crime awareness and safety, including the promotion of Voluntary Police Cadets (VPC) and Junior Cadets programmes within secondary schools. These VPC’s are encouraged and attend local community events to promote positive police activities and listen to community concerns. They have also this year supported events organised by local agencies, such as Charlton Athletic Community Trust (CACT) to engage young people in crime deterrent initiatives.

What was the impact?

The MASH was highlighted by the Ofsted report in 2016 as being good at partnership working, and in doing so adding value to the process of safeguarding children and vulnerable young people. The impact of working closely with partners is clearly evident, with the Section 11 audit highlighting the positive attitude officers have towards both the MASH and other police departments that work with partners to promote safeguarding. The amount of confidence officers and staff had in highlighting or escalating concerns was 100% and the audit was completed by a far greater number of respondents compared to the 2015 survey. The learning identified has translated into a number of trafficking investigations, which have arisen from missing episodes involving young people.

What we plan to do next?

Greenwich Police intend to continue to promote child (and adult) safeguarding; this will include continued training sessions, and fully supporting the GCSB in their campaign to highlight neglect in all its forms. The MASH team have distributed the links to the Neglect campaign for June 2017, including a pan borough email to advise all staff of the action week, and posters have been displayed to support this. Greenwich Police intend to continue to support social workers, managers and partners with appropriate fast and slow time research, and to review all Merlin reports as swiftly as possible, to ensure that CSC can review and act to safeguard children. The MASH will continue to work closely with partners to deliver effective safeguarding training sessions to a wide variety of professionals who have safeguarding responsibilities.
Example of effective practice

In Oct 2016 police MASH identified that a mother who had been of previous interest to CSC was pregnant, and that this was apparently unknown to them and health colleagues. Police identified during extensive research that the mother was also known for child cruelty, and that she was also wanted on warrant. Furthermore, they identified that due to the risk already identified the siblings of this child were already under Special Guardianship Orders (SGO’s) and in the care of their Aunt. The MASH police spoke directly with their co-located partners to discuss the known risks. The relevant information was recorded and cascaded to health visitors, hospitals etc. The actions of police within MASH ensured that an unknown pregnancy was brought to light to both CSC and other MASH partners; the safety of the unborn child was now able to be given the appropriate consideration, and allow CSC to deliver an effective intervention and to manage the risk going forward.
Probation – National Probation Services
GSCB Executive Board Member: Deirdre Bryant, Head of NPS Greenwich

What did we do?
The National Probation Service is a statutory criminal justice service that supervises high-risk offenders released into the community.

The NPS was set up on 1 June 2014, along with 21 community rehabilitation companies (CRCs) that manage low and medium risk offenders. We work in partnership with the CRCs, with the courts, police and with private and voluntary sector partners in order to manage offenders safely and effectively.

NPS is responsible for:

- preparing pre-sentence reports for courts, to help them select the most appropriate sentence
- managing approved premises for offenders with a residence requirement on their sentence
- assessing offenders in prison to prepare them for release on licence to the community, when they will come under our supervision
- helping all offenders serving sentences in the community to meet the requirements ordered by the courts
- communicating with and prioritising the wellbeing of victims of serious sexual and violent offences, when the offender has received a prison sentence of 12 months or more, or is detained as a mental health patient

NPS priority is to protect the public by the effective rehabilitation of high risk offenders, by tackling the causes of offending and enabling offenders to turn their lives around.

The NPS was incorporated in a wider organisation which is now named HM Probation and Prison Service (HMPPS) in April 2017 which replaced the National Offender Management Service (NOMS). HMPPS is about people: reforming those sentenced by the courts; keeping the public safe; and giving their staff – working across probation, prison and headquarters – the tools and support they need to do this.

Priorities include:

- Better use of resources in HM Prisons and NPS to enhance public protection
- Reduction in crime to reduce prison numbers
- Better use of resources to create efficiency
- Embrace change and new ways of working for better service delivery
- Building of new prisons – Ease overcrowding
- Better interventions in prison – reduce offending
- Drug Strategy to reduce drug dependency
- Training and Development of prisoners – jobs on release
- Better Personality Disorder pathway Strategy for women offenders (NHS England)
**Greenwich Action for Voluntary Service (GAVS)**  
**GSCB Executive Board Member: Roy Gopaul, GAVS Development Officer**

**What did we do?**

**Representation and Engagement**

GAVS continued to represent the voluntary sector on the GSCB Executive Board, its associated working groups and Task and Finish Groups. These have included membership of the Learning and Development Group; Audit Group; Chairs Group; FGM Task and Finish Group and Communication and Engagement Group which GAVS also chaired until March 2017.

Aside from contributing directly to the work of the GSCB at Board meetings and Group meetings, GAVS ensured that key messages from the GSCB were disseminated to community groups to ensure that children in the borough are better safeguarded and supported.

Throughout the year, we used GAVS CYP Forum and the CYP E-bulletin to disseminate a range of safeguarding information. These included the Neglect Strategy, GSCB Safeguarding Escalation Policy; and GSCB planned campaigns on Self-harm, Internet Safety and the GSCB Annual Conference. We also promoted multi-agency training and Me-learning in the sector to ensure that the sector took full advantage of both of these learning opportunities. The Director of Children Services and Assistant Director of Commissioning attended the CYP Forum to consult with GAVS members on the CYP Plan 2017-20.

Representation has ensured on-going engagement of the voluntary sector on safeguarding children and young people in the borough and has ensured a consistent flow of information to the sector, as well as shared knowledge across a range of safeguarding issues.

**Safeguarding and the voluntary, community and faith sectors in Royal Greenwich**

Voluntary and community organisations and the faith sector provide many services to children and young people in Royal Greenwich. GAVS recognises that all organisations that work with children need to have appropriate safeguarding arrangements in place. In 2016/17, GAVS revised its safeguarding policy for the voluntary sector to ensure that it remained up-to-date with the GSCB’s key concerns on risks and challenges faced by children and young people, for example on issues around FGM, Forced Marriage and Child Sexual Exploitation.

We carried out 8 single agency evening and weekend safeguarding training events for organisations unable to attend multi-agency training provided by the GSCB. We thus trained a total of sixty staff and volunteers, including training for Islamic teachers and faith/community leaders at the Woolwich Mosque.

As a member of the GSCB Audit Group, GAVS undertook case audits in the voluntary sector on High Risk Teenagers, and Child Sexual Exploitation to help improve multi-agency practice. We also helped implement the GSCB Section 11 Audit.

**Gangs and CSE Project**

GAVS Gangs and CSE Project ended in March 2017. Funded by Children’s Social Care, the aim of the project was to raise awareness of gangs/CSE-related issues in the voluntary sector. A total of 22 groups received in-depth training on recognising signs of gangs/CSE involvement, risk assessments and referral pathways for young people at risk. We also ran a Youth Crime Forum during the
period of the project to provide an opportunity for these groups to discuss and learn about the wider context of crime in the borough and to share knowledge.

The end of project evaluation showed that over 80% of participants had developed their confidence in recognising and assessing risks with respect to gangs/CSE. As part of GAVS work, we will continue to work with all groups in the community to raise awareness of these issues through our E-bulletins and CYP Forum.

What was the impact?
The voluntary sector working with children and young people are generally better informed about the key priorities for children and young people. Safeguarding training for groups at weekends and evenings has ensured that all groups are better equipped to deliver services that are safe and appropriate for children and young people.

GAVS also held workshops at the CYP Forum on neglect, early help and social media. We believe that these workshops significantly improved the knowledge and ability in the sector to deal with related issues and safeguard children and young people in the borough.

What have we learned?
The voluntary sector is a hugely diverse sector differing widely in size and role. Therefore, there is no “one size fits all” in the approach to safeguarding in the sector. The level and nature of any particular approach should be determined by, and proportionate to, the size and services delivered by groups.

Our local child population as well as the risks and challenges are constantly changing. There have been newer communities over the past few years. This has meant a need for the sector to adapt to these needs. These include the impact of social media and how to keep young people safe, child trafficking and child sexual exploitation, amongst others.

What do we need to do better?
GSCB Section 11 audit has shown that we need to tailor safeguarding training according to the needs of staff and volunteers working in the sector. This means reviewing and adapting the GSCB training material. More work also needs to be done with groups to ensure that they develop services to meet priorities for local children, young people and their parents, working closely with our statutory partners.

Example of effective practice
Recently, GAVS delivered safeguarding training to one of the faith groups in the borough. Following the session an opportunity was given to the participants to raise/discuss any issues of particular interest to their community. They highlighted FGM and requested for a more in-depth session on the issue. Both men and women present expressed an interest in becoming “champions” to prevent this form of harm. GAVS is committed to working with the group to help raise awareness of this issue within the community.
Housing Services
GSCB Executive Board Member: John O’Malley, Head of RBG Community Housing Services

What did we do?
The Housing Service aims to provide good quality, well maintained homes for its tenants, and through the management of the Housing Register allocates social housing to those in need, including vulnerable families. Advice, support and statutory assessment services are provided by the Housing Options and Support Service (HOSS) for households who are at risk of homelessness, which includes families, young people and victims of domestic violence. The Housing Service provides advice and support services to residents and through the Landlord Accreditation Scheme it seeks to improve standards in the private rented sector.

Families and Young People at Risk of Homelessness
The Housing Service has an excellent track record in the prevention of homelessness for families and young people, through the provision of advice and casework support. We were the first local authority to achieve the ‘Gold Standard’ in recognition of the quality of our homelessness services. Despite the increasingly challenging housing environment, especially with the lack of affordable private sector accommodation, the HOSS continues to achieve excellent outcomes for families and young people.

Through working in partnership with other services and agencies, and focusing on prevention through the provision of specialist advice and support, the Housing Options & Support Service has:
- Prevented 1759 households from becoming homeless in 2016/2017
- Ensured that Greenwich has lower levels of families in temporary accommodation and accepted homeless households than the majority of London boroughs.
- Ensured that no families with children stayed longer than six weeks in shared temporary accommodation (the average stay was four weeks in 2016/17)

Appropriate Housing & Support for Families & Young People
The Allocations Service and the HOSS Families and Young People’s Team provide support and rehousing services to families and young people in housing need. Despite the housing demands, which includes over 16,500 households on the Housing Register, we continue to prioritise those families and vulnerable young people that are most in need, so that in 2016/2017:
- 235 families in severe overcrowding were rehoused into suitable accommodation.
- 404 accepted homeless households were rehoused into suitable accommodation.

The Housing Service has remained a key partner in the development and management of integrated services for young people at The Point. Our ‘1st Base Housing Options and Support Service’ includes a social worker working alongside housing staff to complete Housing Act and Children’s Act assessments of young people’s needs. Ofsted’s 2016 inspection of services for children in need of help and protection, looked after children and care leavers, cited The Point as ‘good practice’, providing ‘an excellent range of multi-agency services to support young people in crisis and young people who present as homeless’.

Clear pathways and protocols with housing associations and support providers, ensure that supported housing and floating support services are targeted appropriately to meet needs. In 2016/2017, on the basis of these protocols, 82 young people, including care leavers and other vulnerable households in supported housing schemes were rehoused into suitable properties.

Overall, the Housing Service manages a budget of just over 2M for the commissioning of housing support services for young people, victims of domestic violence, ex-offenders and those with substance misuse problems. In commissioning services, the Housing Service
requires that providers have in place robust policies and procedures to address the safeguarding needs of clients. The Housing Service Supporting People Commissioning Officer carries out regular monitoring and reviews of the services and has set up reporting requirements, including for incidents, which ensure that the providers meet best practice standards for safeguarding.

**Proactive Early Help and Child Protection**

There are established service pathways and joint working in place to ensure early help is offered to prevent homelessness and provide support for families, young people and children. The safeguarding needs of vulnerable groups are recognised with specialist Housing Service teams for families, young people, mental health, substance misuse and domestic violence. There is a Housing Case Review Panel of senior managers, which considers cases of urgent housing need and determines whether a rehousing priority should be awarded, where there are safeguarding concerns or risks associated with domestic violence. In addition, Housing Service staff participate in the MASH and the Assistant Director is a member of the MASH Strategy Group.

**Supporting Families affected by the Welfare Reforms**

The specialist Welfare Reform Team co-ordinates the provision of advice and support for families affected by the welfare reforms. The WRT have proactively identified and contacted families offering advice and support including on: housing and employment options; budgeting; assistance with childcare. Since April 2013, 637 Council tenants have been moved to smaller accommodation through rehousing or mutual exchanges.

**What have we learned?**

The Housing Service has well established policies and procedures including for rehousing and homelessness, which would identify safeguarding concerns and identify actions to address them. There are strong areas of preventative work and a good understanding of safeguarding arrangements across the Housing Service (HOSS have introduced compulsory training for all staff regarding children’s safeguarding). The Homelessness Strategy 2014-2019 sets out key Safeguarding objectives and actions which have been included in our other key plans and strategies.

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

We recognise that there is continuing need for bespoke Children and Adult safeguarding training, for non-specialist staff such as plumbers and electricians as these staff are more likely to be having regular contact with our tenants in their homes but would not normally get involved in safeguarding issues. Through the ‘Keeping Children and Adults safe’ Steering Group, housing staff have worked with the safeguarding teams to tailor an appropriate course to make operatives and managers aware of the safeguarding signs to look for and the process of reporting any concerns. Currently the course is being rolled-out to staff within the Asset Management division and will be extended to other officers within the directorate. Procedures within the HOSS around children’s safeguarding have been reviewed and updated as a result of lessons learnt from SCR’s in 2016/17.

**Example of effective practice**

The Housing Service has achieved the Gold Standard in recognition of the quality of its homelessness services. A key feature of the successful practice is the partnership working, which takes place at The Point one stop shop for young people; where dedicated housing advice and support is provided alongside the services provided by Children’s Services, health and community agencies. In addition, the Housing Service in partnership with the Her Centre provides the Sanctuary Scheme, through which enhanced security measures are installed, so that victims of domestic violence can live more safely in their homes.
Community Safety
GSCB Executive Board Member: Ray Seabrook, Assistant Director, RBG Community Safety

What did we do?
The Greenwich Safer Communities Team works with partners to reduce crime and promote safety in Royal Greenwich. Part of this work includes having oversight and co-ordination of:

- the implementation of the Violence Against Women and Girls (VAWG) and Domestic Violence & Abuse strategies and the development or commissioning of several services and initiatives.
- the Domestic Violence MARAC (Multi-Agency Risk Assessment Conference) which is a panel that manages high risk domestic violence cases.
- work with young people involved in gang activity and serious youth violence
- carrying forward the PREVENT agenda in the Royal Borough which includes work to reduce children and young people’s risk of radicalisation.

VAWG, including Domestic Violence
The Safer Communities Team has improved the safety and well-being of victims/survivors and their children by:

- Commissioning a police Domestic Violence Intervention Team (DVIT) to reduce DV reoffending rates by targeting high risk couples. They pursue and prosecute the perpetrators and support victims to separate from their partner and to pursue criminal proceedings.
- Commissioning an early intervention helpline managed by Housing for Women. This provided victims with vital information and advice about domestic violence and abuse and the support services available locally. This has been backed up by a locally run website: http://www.gdva.org.uk/
- Continuing to run a domestic violence campaign that aims to tackle attitudes towards DVA, to improve reporting and to inform those involved in DVA about how to obtain help.

Community Safety has chaired the VAWG Strategic Partnership. It has convened and supported the Multi-Agency Risk Assessment Conference (MARAC). This prioritises the safeguarding of children and young people and involves Children Services Social Care when a MARAC referral is received concerning a family where children are present. The information provided can help assess whether a child or a young person is at risk. MARAC continues to convene fortnightly and has been successful in keeping victims and their children safe. There is a lower number of Domestic homicides in RBG compared to similar local authorities; we undertook our first Domestic Homicide Review in 2016/17 and have learnt a great deal from this tragic incident.

Community Safety has lost funding for the DV Perpetrator Programme, although there were already concerns that the programme was not having the impact we were seeking. There is a significant challenge in finding a programme which changes the behaviour of DV perpetrators effectively. There are particular difficulties in working with those who are the most serious and persistent offenders because they are usually poorly motivated to engage and change.

Gangs and Serious Youth Violence
The Safer Communities Team has a Gangs Link Worker who is able to provide advice and guidance to staff and partner agencies on gang-related issues. This ensures specialist input to ensure appropriate risk assessments and partnership action plans are put in place to safeguard young people from gang related violence and crime.

The Safer Communities Team has commissioned the St Giles Trust to intervene early with young people who are at risk of...
becoming involved in gangs and SYV and to provide pathways out of violence and gangs for young people wanting to make a break with the past. A Gangs and Serious Youth Violence Training Programme, developed by the Safer Communities Team in partnership with St Giles Trust and the Metropolitan police, has been delivered to staff during 2016/17 to improve their knowledge and understanding of gangs in Greenwich borough and highlight the interventions and services that are available.

In the previous year (2016-17) we have continued to fund Growing Against Violence (GAV) which is a positive life skills schools programme to support early intervention and preventative work to stop young people being involved in criminal and gang activity. Sessions are age specific and delivered across year groups from Year 6 to Year 10 and are offered to all schools in the borough, including the Pupil Referral Units and alternative education providers. In 2016-17 the GAV programme has delivered its workshops to 2,650 pupils. Since delivery began in Greenwich in 2013, the GAV programme has delivered its workshops to over 13,000 pupils from 25 primary schools, 13 secondary schools and 6 alternative education providers. Of students who completed and returned feedback forms the feedback is very positive with the vast majority reporting that they enjoyed the session they received, they know more about risks and can make safer decisions.

PREVENT

A Home Office funded PREVENT Coordinator is based within the Safer Communities Team. His role is to have an oversight of all Prevent cases and counter-terrorist issues in the borough and to take forward initiatives promoted by the Home Office.

Sections 36 to 41 of the Counter Terrorism & Securities Act 2015 sets out the duty on Local Authorities and partners to provide support for people vulnerable to being drawn into Terrorism. The CHANNEL Panel is the multi-agency delivery mechanism that meets this duty and has been running in Greenwich since 2011. The panel is chaired by the Royal Greenwich Safer Communities Manager and coordinated by the PREVENT Coordinator and seeks to manage the risk to any child, young person or adult for whom sufficient concern around radicalisation, extremism or terrorism has been identified. The role of members of CHANNEL is to develop a support plan or intervention for individuals accepted on to it or to consider alternative provisions such as Health or Social Care.

In addition the Greenwich CHANNEL panel has established a supplementary process that puts in place plans or interventions for individuals who have been referred to the PREVENT co-ordinator because of professional concerns regarding radicalisation, but where the CHANNEL criteria are not met.

The Safer Communities Team coordinates the delivery of staff training in the form of Home Office designed programmes, namely Workshop Raising Awareness of Prevent (WRAP) training sessions. The delivery of training has been prioritised for schools and particularly to Heads, Deputy Heads and Designated Safeguarding leads. The remainder of teaching staff on the borough have been encouraged to use an online self-training package. There is also a twice monthly ‘walk in’ WRAP session at the Woolwich Centre.

The Safer Communities Team has established a number of projects using Home Office funding. These have been, or are currently being, commissioned by the PREVENT Coordinator. These have included a project based around football, a female Somali Engagement Officer to build communication with mothers, an interactive DVD for delivery in schools and youth hubs that highlight the dangers of being drawn in to extremism and provide workshops to explore the dangers associated with travelling to conflict zones and grooming/ radicalisation.

In 2016/17 the Safer Communities Team received Home Office funding to pilot the UK’s first Prevent/Gangs crossover project. Known
locally as the Somali Youth Support Project and staffed by experienced caseworkers from St Giles Trust, the project seeks to engage and support the Somali youth away from the dangers of gang violence, radicalisation and travel to conflict zones and into employment, education and training. In March 2017 the project was independently reviewed and deemed to be a successful ‘proof of concept’ and something the Home Office would seek to replicate in other Boroughs. Sophie Linden, Deputy Mayor for Policing and Crime, has since visited and met with project staff. Home Office funding has been agreed to continue to fund the project for 2017/18.
What did we do?

Harinder is an experienced Lay member of the GSCB and sits on the Communication & Engagement Work Group and the Monitoring and Challenge Work Group, having joined the board in 2014.

Her background in Education includes teaching primary school children, training teachers and colleagues and as Headteacher for over 30 years. Currently, she works with the Greenwich based charity “MOSAC”, which offers support and services to non-abusing parents and their children as an Advocate and Help-Line Volunteer and occasionally still finds time to work at Cancer Research.

As a long standing resident of the Royal Borough of Greenwich, I have a passion and commitment to making an active contribution to the safeguarding of children within our borough and wider community.

How have we made a difference to Children and Young People?

I believe that my unique knowledge base and independence has enabled me to make valuable contributions to the strategic work of the Executive, Communication & Engagement Work Group and the Monitoring and Challenge Work Group, through discussion, exploration and where appropriate challenge.

I am active in the reviewing role of the Board meetings and reports of the Work Groups as well as more recently at the Monitoring and Challenge Work Group.

I continue to raise the profile and awareness of the GSCB with the voluntary sector and in the community, whilst attending and promoting the training opportunities provided by the GSCB and its campaigns.

I regularly review the GSCB website and the online resources, particularly the section relating to “Parents and Carers” as well as the Board’s Newsletter, and give input to the campaigns as they arise, including this year’s Neglect campaign.

As a panel member for the Section 11 Audit, I have worked closely with colleagues and partners at reviewing our priorities and effectiveness, ensuring the safeguarding of children and young people in the Royal Borough of Greenwich.

Over three consecutive years I have attended and supported our community event “The Great Get Together”, a day aimed at promoting the work of the board and gathering community views. This gives us the opportunity to capture the views of parents, carers, children and young people on range of safeguarding issues that help to establish the priority for the next campaign.

As a trained “PitDA” (Parenting in the Digital Age) facilitator I have run a number of sessions in primary schools on “Authoritative parenting in the Digital Age” as part of the annual e-Safety week.

What have we learned?

My learning continues to grow through attendance at and contribution to the Executive Board Meetings, Communication & Engagement and Monitoring and Challenge Work Groups.

I have attended further safeguarding training during the year on; Commissioning services, e-Safety on-line, Observing & Assessing Neglect and Attending & Presenting at Child Protection Conferences and Core Group Meetings.

As a result of my participation at meetings throughout the year with individuals and teams i.e Annual Conference, Business Development Sessions and GAVS forums I have increased my knowledge and awareness of the wide range of issues affecting children and young people in the Royal Borough of Greenwich. I have an improved understanding of how
partnerships and organisations are working together to promote safeguarding of children and young people in the Statutory and Voluntary sectors in the borough.

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

I hope in the year to come to continue to improve my efficacy as a Member of the Board, to continue to promote the work of the GSCB within the community through various channels and to work towards helping the Board achieve its new priorities on Neglect through my developing knowledge base and strengthening networks with our partners in the Statutory and Voluntary Sectors.
Essential Information

Approval Process:

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This publication and other information is available on the Greenwich Safeguarding Children Board Website: www.greenwichsafeguardingchildren.org.uk

All enquiries regarding the Greenwich Safeguarding Children Board should be made to:

Greenwich Safeguarding Children Board
1st Floor, The Woolwich Centre
Wellington Street
Woolwich
SE18 6HQ

Phone: 020 8921 4477
Email: safeguardingchildren@royalgreenwich.gov.uk
Website: www.greenwichsafeguardingchildren.org.uk
Appendix 1 - GSCB Financial Information 2016-2017

The GSCB budget ended 2016/17 in a good position with an underspend of £40,949. This was mainly due to one vacancy within the GSCB between April and August and the income generated through the training programme. The cost of the current SCRs is not reflected in this year’s budget as most of the invoices were sent towards the end of the financial year and were processed against the 2017/18 budget.

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Appendix 2 - Agency Attendance at GSCB Executive Meeting

(Standard required is 75% attendance)
Appendix 3 - Attendance at GSCB training 2016-17

The majority of attendees (49%) were from the Children’s Services and the Third Sector (15%). Some parts of the health sector (L&G NHS Trust) and Police continue to be under represented (it should be noted though that health organisations and Police have their own single agency Safeguarding training).
Appendix 4 – Lessons from local SCRs

LEARNING FROM SERIOUS CASE REVIEWS – CHILD T – FEBRUARY 2016

What happened in this case?

Child T was a 15-year old girl who committed suicide by hanging at her school in June 2013. The Greenwich Safeguarding Children Board conducted a Serious Case Review which focussed on the last 2 years of her life. Child T came from a chaotic family characterised by domestic violence, neglect and frequent moves. She suffered sexual abuse from two older male siblings, beginning at a very young age and continuing for several years. Children’s Social Care was involved with the family over two decades and Child T and her siblings were made the subject of Child Protection Plans in both Royal Greenwich and Lewisham. At the age of 11, she went to live with her grandmother and an aunt. Her first years of secondary school were settled and she made progress in her studies and enjoyed school. In Year 10 she became increasingly distressed and unable to cope with her life and was beginning to tell some teachers about her previous abuse and about her growing level of self-harm. During Year 10, Child T was supported by the school’s pastoral and counselling services. At the time of her death she had just become an out-patient of the local Child and Adolescent Mental Health Service. Shortly before her death, Child T was physically attacked and verbally abused at home by her uncle. He was removed by police, and left the country.

At the inquest into her death the Coroner concluded that Child T had committed suicide. She found that there had not been any failings by the agencies involved with Child T leading up to her death that had caused or contributed in any way to the suicide and that she had been appropriately responded to and well supported by professionals working with her.

Key learning from the Serious Case Review:

- The level of self-harm in Royal Greenwich and nationally has risen significantly.
- Professionals are not uniformly well enough equipped to understand self-harming behaviour, meaning that their response may not be confident or consistent.
- A need for clear and consistent guidance for professionals, particularly secondary schools, regarding self-harm, how to respond and when to seek specialist help was identified.
- Child T was guarded and chose to share different pieces of information with different people so the whole picture was hard to see. This highlighted the importance of effective information sharing within a school setting.
- The children’s social care consultation line was not known about by some professionals.
- As Child T was doing well in school her troubled history had become hidden until closer to her death which meant that links with her self-harm and previous experiences may not have been made early enough.

What practitioners should do:

- Make sure that you are familiar with policies and practice guidance in relation to self-harm.
- If a young person tells you they are self-harming share this information with your Designated Safeguarding Lead.
- If you are not sure how to respond seek advice. Use the children’s social care consultation line.
- Where problems are complex with a number of different practitioners involved convene Team Around the Child meetings to share information.
- Make sure that you are familiar with children’s histories to ensure that they get the right type of support when problems emerge.
LEARNING FROM SERIOUS CASE REVIEWS – CHILD S – JANUARY 2016

What happened in this case?

Child S was born in January 2012. The child died aged thirteen months old in February 2013. Expert medical opinion found that physical abuse and injuries contributed to her death. The family had only been in the UK since mid-2011 having arrived from a war-torn area. Prior to the death of this child, there had been no concerns about the care she was given. The family were not known to any targeted or specialist services. The parents have been convicted of neglect. The trial took place at the end of 2014 and the parents were sentenced in January 2015; father received a custodial sentence and mother was given a suspended custodial sentence.

In March 2013, the Independent Chair of the Greenwich Safeguarding Children Board decided that a Serious Case Review was needed. The family had only been living in Royal Greenwich for a few weeks prior to the child’s death. Therefore, the findings and recommendations are also for wider consideration beyond Royal Greenwich across London and for the other areas in which the family lived. The SCR was published in January 2016.

Key learning from the Serious Case Review:

- It is unlikely that the death of this child could have been predicted.
- The family were mobile. They had lived in four different Local Authorities in a period of 18 months. This made them more vulnerable as they moved away from family and did not have community support.
- The need in the current high demand on housing to move families to other areas away from the host authority increases the likelihood that vulnerabilities may not be identified.
- The family registered with GPs but Child S was not referred onto health visiting services. This meant she did not have access to universal health care checks and support.
- As a result of experiences in her country of origin, mother has Post-Traumatic Stress symptoms. However services did not have as good an understanding of her needs because interpreters were not always used, particularly during her pregnancy and the early months of Child S’s life.
- A comprehensive action plan was drawn up and shared across all the Local Authorities and Health Authorities where Child S had lived. A summary of this action plan can be found on the Greenwich Safeguarding Children Board website.

What practitioners should do:

- When working with mobile families, from any agency, practitioners should take full histories and use these to inform assessments around vulnerability and need.
- Make sure that families who have recently moved into a new area know how to access support locally.
- It can be harder for families where English is not their first language to access support. Make sure you use interpreters where needed. Do not rely on family members to interpret.
Greenwich Safeguarding Children Board

Overview of: Principles, Scope and Functions, Governance, Accountability, Membership and Structure

Introduction
The Greenwich Safeguarding Children Board (GSCB) is the statutory inter-agency mechanism for agreeing how the different services and professional groups should cooperate to safeguard and promote the welfare of all children in Royal Greenwich and to hold each other to account, ensuring that safeguarding children remains high on each partner agency’s agenda (Children Act 2004). The Board has a lead role in monitoring and scrutinising those arrangements to ensure that they work effectively and result in better outcomes for children and driving improvement across the partnership.

Underlying Principles of the GSCB
The GSCB is a child centred partnership that is independent from all organisations. It provides system wide leadership and has responsibility for the scrutiny and challenge of safeguarding practices throughout agencies in the Royal Borough of Greenwich. The interests of children and young people and their journey throughout services will be central to the work and strategic decisions made by the Board. Throughout the work of the Board, the emphasis is on facilitating continuous learning with the aim of constantly improving practice so that children, young people and families are receiving effective services and support as early as possible.

Arrangements for an effective GSCB
The effectiveness of the GSCB is characterised by:

- A clear commitment by all agencies to cooperate with each other and actively work to safeguard and promote the welfare of children
- Effective system wide leadership with senior managers in all agencies committed to the importance of safeguarding and promoting children’s welfare
- Clear lines of accountability
- Clear and effective communication links within the GSCB network and the wider strategic network
- A risk based approach, whereby the GSCB has oversight of risk factors and controls across the partnership, as well as in individual agencies, and holds partners to account for minimising risk.
- A professional culture of openness to challenge about agencies safeguarding arrangements
- A shared ‘learning culture’
- A commitment to partnership funding that adequately resources the work of the Board
- An agreed structure of work groups that enable the annual work plan to be progressed

Scope of the GSCB’s Role
The GSCB maintains strategic overview of how organisations work with children, young people and families to provide early help and safeguarding intervention when necessary. Board members in consultation with their agencies and organisations set and review strategic priorities, which are set out in an Annual Business Plan, thus driving the focus of safeguarding work throughout the Royal Borough.

Functions of the GSCB
Statutory guidance sets out the functions of the GSCB which include:

1. Develop local policies and procedures for how the different organisations will work together on safeguarding and promoting the welfare of children including those on:
   - action taken where there are concerns about the safety and welfare of a child, including thresholds for intervention
Greenwich Safeguarding Children Board links with Strategic Bodies, the Children and Young People Plan and the Joint Strategic Needs Assessment

The work of the GSCB will sit within the wider context of the Children’s Trust arrangements to improve outcomes for all children.

GSCB will link with the strategic partnerships working in the locality which includes the following:

- Children’s Services Strategic Partnership
- Children’s Trust Board
- Safer Greenwich Partnership (Youth Crime JCG, Alcohol and Substance
Misuse JCG and Violence against Women and Girls Partnership (including MARAC))

- Multi-Agency Public Protection Arrangements (MAPPA – a statutory operational arrangement led by police and probation)
- Health and Well-being Board
- Safeguarding Adults Board

The GSCB will contribute to and be consulted on the development of the Children and Young People Plan. The work plan of the GSCB will reflect the safeguarding priorities of the Children’s Plan. Similarly, the GSCB will both inform and draw on the Joint Strategic Needs Assessment (JSNA) and Health and Well-Being Strategy.

**Membership of the Greenwich Safeguarding Children Board Executive Partnership Board**

The Greenwich Safeguarding Children Board Executive Partnership consists of senior representatives from its member agencies as required by legislation.

This includes:

- GSCB Independent Chair
- RBG Children’s Services – Director of Children’s Services
- Lewisham and Greenwich NHS Trust – Divisional General Manager, Children’s Services
- Oxleas – Service Director of Children & YP Service
- GCCG – Director of Integrated Governance
- CAIT – Detective Inspector
- Borough Police – Detective Chief Inspector, Plumstead Police Station
- Probation
- Adult Services – Senior Assistant Director
- Voluntary Sector – GAVS Development Officer
- Lay Members
- Community Housing Services – Head of Community Services
- Community Safety – Head of Community Safety
- Youth Offending Services – Head of Service
- Head Teacher
- Lead Member for Children’s Services (Participant Observer)
- CAFCASS
- GSCB Manager

It is acknowledged that in order for GSCB to retain its strategic focus and be effective in its role the Board membership will be limited. However GSCB recognise that the network working with or in contact with children and their families in Royal Greenwich is vast and that engagement with the wider network will occur via the GSCB MAC Group, GSCB Work Groups and steering groups, representation on thematic groups and other Strategic Partnerships as well as through training sessions, the GSCB Annual Conference and via communication and publicity campaigns.

**Chair of the Greenwich Safeguarding Children Board**

In order to enable the GSCB to exercise its local challenge function effectively, the Chair of the GSCB is independent of local agencies and is appointed or removed following consultation with Board partners. The Chair supports the Board to operate with an independent voice and ensure that the Board is not subordinate to, nor subsumed within other local structures in a way that compromises it.

**Accountability**

The Director of Children’s Services will be held accountable for the effective working of the GSCB by the Chief Executive and challenged where appropriate by the Lead Member.

**Elected Members**

The Lead Member for Children’s Services will have a particular focus on how the Council discharges its responsibilities in relation to safeguarding and promoting the welfare of children. The lead member will attend GSCB
Executive meetings as a ‘participant observer’.

**Board Members**

A ‘Job Description’ for members is provided.

In order for Board Members to be effective in their role, it is the expectation that all Board members will have the authority to:

- Be accountable to the Board on behalf of their organisation/ agency
- Ensure arrangements for safeguarding and promoting the welfare of children are working effectively to bring about good outcomes for children, in accordance with S11 Children Act 2004 and statutory guidance
- Commit resources of their organisation to a policy or course of action
- Agree their organisation’s contribution to the Board’s annual budget
- Ensure commitment of staff and resources to ensure the effective function of the Board
- Implement changes to practice within their own organisation/ agency
- Ensure effective response to strategic and policy recommendations within their own organisation
- Contribute to and work within the framework established by the Greenwich Children and Young People Plan

**Structure of the GSCB**

The **GSCB Executive Partnership Board** holds a strategic overview of safeguarding activity across the Royal Borough. It is responsible for:

1. Independent monitoring, scrutiny, challenge and problem solving
2. Focusing on the impact and outcomes of Board activity to children and families
3. Maintaining oversight of risk via the local multi-agency performance framework
4. Holding partners to account through Quality Assurance Activity
5. Agreeing and reviewing strategic priorities
6. Monitoring implementation and effectiveness of local response to national policy and priorities.
7. Communicating messages to the network via its partners and Work Groups
8. Ensuring that the Board maintains focus on on-going learning and development

The GSCB Executive Partnership will meet a minimum of 4 times per year. The GSCB Independent Chair will call an extraordinary meeting should a particular need arise.

The **GSCB Chairs group** is the forum whereby the Work Group Chairs will:

1. Monitor GSCB Business Plan including Work Groups
2. Receive reports, undertake analysis, monitor action plans and approve work completed by the Work Groups, GSCB staff and/ or others on behalf of the GSCB.
3. Undertake scrutiny and challenge through the regular review of the Strategic Priorities Register.
4. Identify and address cross-cutting themes including:
   - Capacity
   - Ownership
   - Engaging children, young people and families
   - Diversity
   - Forward Planning
   - GSCB priorities
5. Identify development needs for the effective functioning of the LSCB
6. Set the Agenda for the GSCB Executive Partnership

**GSCB Work Groups** are chaired by Senior Professionals from the multi-agency partnership. Their role is to progress the work plan of the board, with an emphasis on the strategic priorities. They will report into the Chairs Group on a rolling basis. A report on the activity of the Work Groups will be presented to the Executive Partnership at least annually.

The GSCB work groups consist of:

- Serious Case Review
- CSE MASE
- Child Death Overview Panel
- Learning and Development
- Audit
- Communication and Engagement
- Toxic Trio
- Health
- Missing
- Schools
- Monitoring and Challenge

**Professional Support to the GSCB**

In order to meet the demands of the work plan the GSCB has a Board Manager and a Learning and Improvement Co-ordinator who oversee the Annual Business Plan. These staff members support Board Members and Work Group Chairs to progress the day-to-day work of the Board.
Appendix 6 - GSCB Structure Chart
Appendix 7 - Glossary

AOPS – Adults and Older People’s Services
CAIT – Child Abuse Investigation Team
CiCC – Children in Care Council
CIN – Child in Need
CPP – Child Protection Plan
CRC – Community Rehabilitation Company (Probation)
CSE – Child Sexual Exploitation
DV – Domestic Violence
EHA – Early Help Assessment
GCCG – Greenwich Clinical Commissioning Group
GSCB – Greenwich Safeguarding Children Board
LAC – Looked After Child
LADO – Local Authority Designated Officer
LGT – Lewisham and Greenwich NHS Trust
MAPPA – Multi-Agency Public Protection Arrangements
MARAC – Multi-Agency Risk Assessment Conference
MASH – Multi-Agency Safeguarding Hub
NPS – National Probation Service
QEH – Queen Elizabeth Hospital
SCR – Serious Case Review
SENCO – Special Educational Needs Co-ordinator
TAC – Team around the Child
TF – Troubled Families programme
Toxic Trio – The combination of parental mental illness, substance misuse and domestic violence. This are factors that feature in many serious case reviews.
UHL – University Hospital Lewisham
VAWG – Violence Against Women and Girls
VOCU – The Violent and Organised Crime Unit
YOS – Youth Offending Services
For more information on the work of the Greenwich Safeguarding Children Board visit:
www.greenwichsafeguardingchildren.org.uk