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As the Independent Chair of the Greenwich Safeguarding Children Board (GSCB) I am pleased to present the annual report for the period April 2015 to March 2016 which sets out the GSCB’s accomplishments during the last year and intentions for further progress in the future. 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 co-ordinating 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, education 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 report reflects the work that the board has undertaken during 2015-2016. The last year has been a significant one for all those agencies who contribute to keeping children safe in Royal Greenwich. There have been important changes in personnel across agencies. All public sector agencies have been confronted with great resource challenges. However to be effective there needs to be a clear commitment of senior managers to the Board’s work and a willingness to be open and challenge one another. We are also awaiting the outcome of a national review of LSCBs which may significantly alter the partnership arrangements as we know them.

To conclude, I would like to thank the Board staff, especially the Board Business Manager, for their continued support to 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 safe in Royal Greenwich. Their work is not always recognised or understood by the children and the families with which they work, but it is highly valued by the Board.

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.

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. The work has examined progress on cases where young people have been at risk of child sexual exploitation (CSE). Additional audit work has focussed on domestic violence and abuse, neglect and FGM over the last year. More details of the outcomes of these audits can be found in the main body of the report.

In addition to its audit work, the Board identifies ways to improve practice through its reviews of individual cases, including Serious Case Reviews (SCR). The Board published two SCRs this year though these had been completed in 2014. Both SCRs had been delayed due to external process, a criminal trial and a coroner’s inquest. The learning from these cases is discussed in more detail in the following pages, but the way in which professionals from different backgrounds work together and share information is a continual focus of reviews both locally and nationally. Please see Appendix 4 for more information on key learning from these two SCRs.

The board has also reviewed its processes for undertaking section 11 audits in the last 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 effectively safeguard children. It will give the board the opportunity to understand how well frontline staff understand safeguarding across the partnership. Unfortunately due to timing of this report, the outcomes of this new S11 process will not be available to report on, but is intended to inform the report in future years.

Following a development session in January 2016, proposals have been developed for a new meeting structure with a new Monitoring and Challenge group, which will report directly to the Executive Board. This will introduce greater capacity for challenge and scrutiny of safeguarding issues across the partnership.

The Board has worked on developing and confirming its dataset over the last year to ensure we have the right information and data to measure activity but more importantly identify where there are areas of concern about performance or practice in individual agencies. The data has enabled the board to focus on areas of multi-agency practice and the impact on safeguarding children.

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, data or through SCRs 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), multi-agency training and the impact on frontline staff practice, private fostering and the effectiveness of more permanence arrangements for children, and allegations against professionals.

A permanent appointment was made to the Business Manager of the Board confirming the acting up arrangements that had been put in place. The Board is looking to appoint to the vacant post that this leaves for a QA/
Training Development Officer. Unfortunately the Designated Doctor resigned in January 2016 and this post is in the process of being recruited to again.

**Progress against 2015-2016 Priorities**

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 have taken 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 provided 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. When deciding priorities the Board recognised that the areas identified would require a two year work plan.

**Safeguarding and promoting the rights of the child in relation to the following vulnerable groups of children and young people:**

**Address the challenges and risk to children from sexual exploitation, going missing, trafficking and involvement in gangs.**

The learning from national Serious Case Reviews concerned with CSE has informed the development of multi-agency arrangements to tackle CSE in Royal Greenwich.

There are revised procedures and processes for handling individual children’s cases. We have promoted the use of a new CSE risk assessment tool, developing awareness about how children come to be exploited and sexually abused whether by peers or adults. Arrangements to monitor and track individual cases has improved and informed the planning, interventions and impact evaluation in reducing the risk of CSE to individual children. From the Metropolitan Police London wide CSE data we know that we have a higher than average crime and disruption/ intervention level of activity in our local area showing that perpetrators have been identified and been dealt with effectively.

Through audits/ questionnaires we know that practitioners are more confident working with CSE where there is a child being exploited and abused by an adult and taking appropriate action. The MsUnderstood peer on peer research and training has enabled practitioners and schools to develop their confidence in dealing with these issues. The second phase of Operation Makesafe revised campaign will focus on raising awareness in communities and schools about CSE. The use of Chelsea’s Choice in schools will support this process to raise awareness with young people of the risks of exploitation. The links with going missing are clearly known and recognised across the partnership and there is good information sharing. There has been a considerable amount of work focusing on young people at risk of CSE and missing in the last year. This is covered in more detail in two separate sections of this report and evidences the intervention by agencies to make children and young people safer.

The vulnerability of young people involved in gangs is managed effectively and there is a risk management panel processes to manage risk. The Youth Offending Service (YOS) inspection commented positively on the integrated nature of the work with children’s social care in this area of work.

A local strategy for dealing with trafficking of children and young people has been developed. Action has been taken to raise awareness of trafficking and how to report concerns. It has also been recognised that more work with the Adults Safeguarding board around Trafficking and Modern Slavery is needed and this is planned for next year.

The Board recognises there is more still to do in this area and has kept this as a priority area for 2016-2017. Because children and young people have told us about bullying and exploitation on the internet, and the links with grooming, the Board has decided that we will include cyber bullying/ e-safety as a priority area for next year.
Abuse and exploitation linked to faith, culture or belief including Female Genital Mutilation (FGM), witchcraft, physical chastisement and radicalisation – Work with partners and communities to promote the safeguarding of children.

The GSCB training package includes safeguarding children across culture and faith, including responding to FGM and witchcraft or belief in spirit possession. We have run briefing sessions on Prevent and radicalisation to frontline staff and schools. Information on FGM and forced marriage has been produced and distributed to help school staff identify and report concerns. The information pack was sent to all schools before the summer holiday together with a letter from the Independent Chair, reminding schools of the need to be vigilant.

Following the introduction of mandatory reporting, all regulated health professionals have been informed of their duty to report to the police any girl under 18 years who suffered FGM or if they see signs of FGM. Training has been provided to all health care professionals in order to be competent in recognising FGM and identifying women and girls at risk of FGM. Health care professionals know to report suspected FGM to MASH (Multi-agency safeguarding hub) by triggering the usual safeguarding procedures. There is mandatory recording of FGM in the health record and this data is being routinely collected. However, there has been a poor level of statutory reporting of FGM since its introduction. A local pathway for disseminating information regarding FGM has been established. The health group will continue to influence and monitor the effectiveness of the partnership’s response to FGM and it is recognised more needs to be done to ensure an effective response in this area, especially for young women.

Schools have worked closely with police on a preventative project which aims to reduce the incidence of cases where harm occurs through the use of physical chastisement by parents. The school-parent agreement has been updated to include information about physical chastisement, the legal framework and the expectations of parents. The plan is to introduce the revised agreements in the new academic year. The Board also supported a local voluntary organisation to organise a conference which aimed to bring together professionals and parents to discuss the issue of physical chastisement and how to promote positive parenting. It is anticipated that this work will help reduce the numbers of situations when statutory agencies need to become involved in families, with a subsequent reduction of numbers of situations of police needing to use their powers to remove children for inappropriate physical chastisement.

Royal Greenwich has an established CHANNEL panel to deal with radicalisation but in addition a supplementary process has been put in place to develop 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 delivery of staff training/ awareness raising around radicalisation in the form of Home Office designed programmes have been offered, prioritising schools and particularly to Heads, Deputy Heads and Dedicated Safeguarding Leads. The remainder of teaching staff in the borough have been encouraged to use an online self-training package. There have also been a number of projects established to tackle radicalisation lead by the PREVENT Co-ordinator using Home Office funding. 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 highlights the dangers of being drawn into extremism; workshops to explore the dangers associated with travelling to conflict zones and grooming/ radicalisation.

The Board recognises there is more still to do in this area and has kept this as a priority for 2016-2017, though the board has decided not to focus on witchcraft as a priority as there have been no cases of suspected witchcraft in the local area in the last year.

Children living out of borough – Ensure high quality support, experiences and
outcomes for Looked After Children placed at a distance from the borough.

We recognise that placing children out of borough can be challenging in terms of safeguarding and promoting their welfare. Children’s Services have published for other local authorities who are placing children in Royal Greenwich, information about services, support and where to get information about local gangs, CSE and crime profile. When placing our looked after children in other local authorities, information is requested about the locality so any relevant risk factors such as those associated with gangs and CSE activity are known and can be managed. Children’s Services have mapped the location of all looked after children placements by local authority area and routinely report on where children are placed. Most children are placed in or relatively close to Royal Greenwich but some children are purposefully placed some distance to reduce the risk of harm to them and others.

There are sound arrangements in place for responding to children who go missing from care, including arrangements with other local authorities who have children placed in Royal Greenwich. There is scrutiny of actions taken to find children, learn from what they say and what is known about the ‘push and pull’ factors that lead them to go missing and to prevent this happening again. Teenage boys who go missing more than once are likely to be affected by gangs and teenage girls who go missing more than once are more likely to be affected by CSE. See section on missing children for more information.

There is a continuing focus to increase the number and proportion of children in Royal Greenwich fostering placements, so that looked after children are placed closer to their schools, family, friends and communities. At the end of March 2016 there were 151 children in Royal Greenwich foster placements compared to 137 a year ago.

The Board has decided to sharpen the focus of this priority area for next year by changing this to: ‘Children not living with their parents – including Looked After Children and Privately Fostered – by ensuring high quality support, experiences and outcomes’, as this includes children who live away from their families including young people who sofa surf, are privately fostered or in other arrangements, including children who are looked after.

**Deliberate self-harm – Monitor the response to, and children at risk of self-harm and the services provided to them.**

Coinciding with Self-harm Awareness Day (1st March), the Board launched a campaign to help young people, parents, carers and professionals understand what deliberate self-harm is and how to get support. The development of the campaign was informed by findings from a local SCR (Child T) as well as the views expressed by over 4000 children who participated in the SHEU survey. Local young people were involved in the planning of the campaign and they came up with the campaign strapline: *No one should hurt you, so why hurt yourself?*

The topic of the campaign was also voted for by children, young people, parents and other members of the community during the Great Get Together event. As part of this campaign an information and advice hub was developed, hosted on the GSCB website. This provides links to relevant resources aimed at children and young people; parents and carers; professionals and volunteers.

The GSCB Self-Harm Protocol will be launched later this year. School nurses now have a clear process and pathway for responding to cases of self-harm. In addition to this work CAMHS have delivered a programme to support school nurses in their response to the general emotional needs of young people.

This will be a topic for multi-agency audit in 2016-2017 to understand the impact of intervention on reducing deliberate self-harm.

The Board recognises that there is more that can be done to respond to deliberate self-harm amongst young people and also recognises the increase in suicides within this group of vulnerable young people and has therefore added this as a priority area for the next year.

**Neglect – Ensure that the issues of neglect receives due prominence in**
assessments, prevention and intervention work alongside issues of adult mental health, domestic violence and substance misuse.

The Board is very aware from its audits and case reviews that the early identification of neglect when parenting deteriorates is a critical issue for safeguarding children. Children living with the ‘toxic trio’ often experience significant emotional and physical neglect. This in turn significantly impairs the child’s health and development, leads to poor progress at school and limited life chances. There has been a great deal of work completed in this area of work and the report expands on the developments in more detail.

A local Neglect Strategy has now been endorsed by the GSCB. The multi-agency protocol and practice guidance for working with children living in families affected by the ‘toxic trio’ has been finalised and promoted. This was linked to using the guidance on ‘disguised compliance’ to support child-centred multi-agency practice that focuses on parents changing their parenting behaviour.

Best practice guidance will also be developed for health care professionals to identify children affected by neglect and how best to manage the risk, including the use of an accredited tool to screen for neglect in order to put in place early support or if required to refer concerns.

We recognise there is more to do especially in providing early help to more children and parents to prevent the escalation of concerns. We have therefore agreed that this area will remain a priority for next year and we have added a further focus of parents with learning difficulties to this area.

Violence against women and girls (VAWG) – Monitor the implementation and impact of the VAWG strategy, including domestic violence, on children and young people.

There has been a significant increase in the number of Domestic Violence and Abuse (DV&A) offences reported and DV&A features in around 60% of children with a Child Protection Plan, so it remains a key safeguarding issue for the partnership. This is a shared priority area with the Safer Greenwich Partnership.

The Violence Against Women and Girls (VAWG) and Domestic Violence & Abuse strategies have been implemented this year as well as the development and commissioning of several services and initiatives to address DV&A. The GSCB has undertaken a deep dive audit on DV&A this year, looking at how effectively agencies respond to and deal with DV&A. This is dealt with in more detail in the report.

To improve responses to domestic abuse a Specialist Health Visitor for domestic violence and abuse was appointed at the beginning of the year, April 2015. From April 2016 information from police about domestic violence notifications will be shared with schools as a pilot. The information would enable schools to provide early help and support to children who may have witnessed domestic abuse.

It has been agreed that the Board will continue to monitor the DV&A developments through the neglect priority rather than a separate priority area.

The GSCB has decided to add an additional priority for next year – sexual abuse and sexually harmful behaviours.

The Board is aware of the low numbers of children subject of a Child Protection Plan for sexual abuse both in Royal Greenwich and nationally. We are aware of the research undertaken earlier this year about the identification and intervention of intra-familial sexual abuse. Much has been done to raise awareness of child sexual exploitation but often sexual abuse is reliant on disclosures by children. However, there are often concerns about a child’s behaviour, often of a sexualised nature, which practitioners are not responding to, as likely to be indicative of sexual abuse or exposed to inappropriate adult behaviour.

The Board therefore has identified this as an area of focus for the next year.

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 2015-2016.
- Reports on the statutory functions of the GSCB including private fostering, allegations against professionals, missing 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, current GSCB structure and membership.
GSCB Strategic Priorities 2016-2017

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 2016-2017.

The priorities were informed by:

- Feed-back received from GSCB members during the Development session in January 2016.
- GSCB quality assurance activity and analysis of performance data.
- Views of frontline 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.

Safeguarding children and young people is a key overarching priority for all partners working together in Royal Greenwich. The GSCB brings together senior leaders to promote partnership working and co-operation, 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 2016-2017

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

4. 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.

5. 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.

6. Promote awareness of and address the issues relating to intra-familial sexual abuse and sexually harmful behaviours.
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 2015-2016

<table>
<thead>
<tr>
<th>Category</th>
<th>Number/Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children living in Royal Greenwich</td>
<td>64,676</td>
</tr>
<tr>
<td>90% of children who received Early Help were not subsequently referred to Children's Social Care</td>
<td></td>
</tr>
<tr>
<td>Number of Children's Social Care referrals</td>
<td>3271</td>
</tr>
<tr>
<td>Percentage of re-referral to Children's Social Care</td>
<td>15.4%</td>
</tr>
<tr>
<td>Percentage of MARAC cases where a child is known to be involved</td>
<td>64%</td>
</tr>
<tr>
<td>Children and Family Assessments completed within 45 days</td>
<td>79.6%</td>
</tr>
<tr>
<td>Children subject to a child protection plan</td>
<td>272</td>
</tr>
<tr>
<td>Average number of days a child has a CP Plan</td>
<td>354</td>
</tr>
<tr>
<td>Children had a second or subsequent CP Plan</td>
<td>16.3%</td>
</tr>
<tr>
<td>Percentage of Review Child Protection Conferences were held within timescale</td>
<td>100%</td>
</tr>
<tr>
<td>Number of Serious Case Reviews published by the GSCB</td>
<td>2</td>
</tr>
<tr>
<td>Children missing for more than 24 hours from home or care during the year</td>
<td>197</td>
</tr>
<tr>
<td>Number of Looked After Children (as at end of March 2016)</td>
<td>518</td>
</tr>
<tr>
<td>Practitioners attended a GSCB multi-agency training event in 2015/16</td>
<td>3000</td>
</tr>
<tr>
<td>Percentage of 16-18 year olds in education, training or employment</td>
<td>85%</td>
</tr>
</tbody>
</table>
GSCB Work Groups
Quality and Effectiveness of Arrangements and Practice

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

What did we do? Why?

The Quality Assurance (QA) Group supports the GSCB in monitoring and evaluating how effective all the agencies in Royal Greenwich are in safeguarding and promoting the welfare of children. The group uses the GSCB quality assurance framework to guide its activities. The group reviews performance information and gets behind the figures to the practice issues and evaluates the difference made for children through a range of quality assurance activities including multi-agency case audits, a deep dive audit into a specific issue, reviewing the learning from single agency audits and conducting on-line surveys of practitioners. What underpins all this activity is seeking 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. The group is clear that their activity needs to result in action to improve practice and the outcomes for children. A multi-agency action plan is drawn up after each activity which is robustly monitored, reviewed and signed off by the group when complete.

During the year a deep dive audit into the effectiveness of work in relation to Domestic Violence and Abuse (DV&A) was undertaken. In Royal Greenwich there has been a significant increase in the number of DV&A offences reported and DV&A features in around 60% of children with a Child Protection Plan so it is a key safeguarding issue for the partnership. The deep dive included; a multi-agency case audit of cases where DV&A is the issue of concern, including cases which received an early help response, a Child in Need response and a number of children who were subject to a Child Protection Plan; a focus group with service users who had experienced DV&A; an electronic survey of practitioners working with children, families and adults.

The following areas were found to be working well:

- Good levels of confidence around knowledge, recognition and response.
- Good understanding of thresholds in relation to DV&A.
- Clear understanding of how DV&A impacts on children.
- Most professionals are confident in talking to survivors of DV&A.

Areas that need improvement:

- Practitioners need to be more confident in talking to children and perpetrators of DV&A.
- More practitioners need to routinely ask questions about DV&A.
- More training is needed that supports transfer of learning into practice.

The QA Group is leading implementation of the resulting action plan.

Practitioner surveys provide an opportunity to hear directly from frontline practitioners. The QA Group carried out a survey of practitioners from across the partnership (including voluntary organisations, schools and GP practices) in relation to Female Genital Mutilation (FGM). The results show high awareness of the issue but less understanding among professionals of specific procedures and policies in relation to FGM. Reporting levels are very low and agencies did not have robust ways of recording FGM concerns indicating that FGM remains a hidden problem. These results are reflective of the picture across London and nationally. The QA Group is breaking down these results further to identify where awareness raising and training is most needed and will look more closely at recording practice to see where improvements are needed. A review of findings from single agency audits considered single agency quality assurance activity from children’s social care and local NHS trusts. The children’s social care report included analysis from the peer audit programme.
which showed that multi-agency work is assessed as positive and working well in most cases. The NHS report was to ascertain if the learning from the Serious Case Review (SCR) concerning Child T had been embedded into practice and to provide assurance to the GSCB that young people who attend the Emergency Department with Deliberate Self-Harm (DSH) are examined fully. It concluded that further training regarding DSH needs to be considered along with the implementation of a specific DSH pathway.

The QA Group has taken the lead in interrogating data from the GSCB’s performance information framework to identify trends and patterns in performance. During 2015-2016 the GSCB Executive agreed that performance data will now be reviewed in the Business Group and reported to the Executive bi-annually.

Over the last year the group has continued to ensure that actions resulting from quality assurance activity are being progressed:

- multi-agency improvement plan for tackling exploitation whose implementation is monitored by the CSE MASE Strategic Group
- child trafficking task and finish group led to an improvement plan implemented by GSCB Work Groups and monitored by the Business Group
- Neglect Strategy in response to a deep dive carried out last year. A fact sheet for practitioners on working with neglect was produced and disseminated across the network
- escalation policy where there is disagreement in relation to safeguarding decisions was reviewed by the group as a part of the Parental Mental Illness multi-agency audit action plan.

How have we made a difference for children?

Quality assurance activity provides evidence to the GSCB on the multi-agency response to safeguarding children in Royal Greenwich. Using this evidence we identify the strengths and areas for development across the partnership. The action plans that we develop and monitor are improving understanding and practice. For example the deep dive audit into DV&A, including the survey of practitioners, identified some professional confidence issues in talking directly to children about DV&A. As a result, tools have been identified and disseminated to practitioners to support them in talking directly to children about this sensitive issue.

Views of parents, carers, children and young people

As part of the deep dive into DV&A we spoke with service users who confirmed the areas for improvement from the multi-agency audit and practitioner survey.

The voice of children is captured through the practitioner recordings of what they say.

What do we need to do better?

The QA Group will review the way we conduct multi-agency and deep dive audits. We want greater involvement from frontline practitioners so that they can contribute to our understanding of complex issues and have a greater sense of ownership in relation to any learning and actions.

The QA Group would like to hear directly from children and young people and plans to explore different ways of doing this.
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? Why?

We identified learning and development priorities through a thorough needs assessment which included feedback from frontline practitioners, training impact evaluations, section 11 reviews and recommendations from local Serious Case Reviews and multi-agency audits. We also drew on Working Together to Safeguard Children, Ofsted thematic review of Child Sexual Exploitation and independent inquiries. We provided a comprehensive programme of multi-agency safeguarding training to support GSCB and Children and Young People Plan priorities.

Training included:
- safeguarding children across culture and faith
- responding to FGM
- working with young people who self-harm
- working with child sexual exploitation
- understanding the toxic trio;
and briefings on:
- prevent
- supporting families who have no recourse to public funds
- safeguarding children awareness sessions for colleagues who work with adults.

This year, 80 events reached more than 3000 attendees.

We have focused on the continuous improvement of our training:
- We increased our pool of trainers providing greater resilience to the programme
- All training is informed by delegates’ feedback and the core courses have been reviewed and revised
- We have continued to use a range of delivery methods, including courses, briefings, bite-size lunchtime sessions and e-learning.

How have we made a difference for children?

We know our training has an impact for those who work with children and families in Royal Greenwich. This is shown in participant feedback and through the evaluation process we have adopted for priority courses.

The evaluation of the child sexual exploitation training showed a substantial improvement in delegates’ knowledge and confidence before and after the course, which was supported by follow up phone interviews. The participant observer offered further evidence that the course achieved its aims and objectives.

Working with CSE pre and post course questionnaires

The GSCB Annual Conference Working together to keep young people safe provided participants with the opportunity to gain a more in-depth understanding of current key issues affecting young people: sexual exploitation, radicalisation, gangs and self-harm. It was attended by over 150 delegates.
from across the partnership and featured a performance of AlterEgo Theatre Company’s innovative applied theatre production ‘Chelsea’s Choice’, which was described by participants as powerful, thought-provoking and impactful. Dr Carlene Firmin, MBE, Head of the MsUnderstood Partnership and Senior Research Fellow, University of Bedfordshire spoke on peer to peer exploitation and Andrew O’Sullivan, Senior Assistant Director, Royal Greenwich Children’s Services spoke on local arrangements for tackling exploitation of children. The key note presentations were well received by delegates who found them informative and useful for their work.

Of the delegates who provided feedback, 78% rated the conference as extremely or very valuable in relation to their professional development and 80% rated it as good or excellent.

The most valuable things learnt by colleagues were:

- Better awareness of the scale of peer-on-peer exploitation and how it takes place.
- Improved understanding the different types of exploitation, the links between them and the signs to look for.
- Improved understanding of what can make young people vulnerable.
- Improved understanding of the importance of prevention of extremism and what to do and how to respond.

**What have we learned?**

Participant feedback and evaluation of training is used to improve training and to ensure equality and diversity issues are well managed. Overall, our 2016 learning needs analysis shows that the 2015-2016 training programme continues to meets the needs of practitioners and volunteers from partner agencies. Demand for courses from agencies means we will run more sessions on CSE, supporting families with nil recourse to public funds and tackling neglect. Additional training will be developed on good quality assessment, disguised compliance and difficult conversations and to build on Prevent training, focusing on safeguarding.

Evaluation indicates that bringing in the voice of the child through case studies and films continues to be effective and stays with participants beyond the training session. We’ve learnt that whilst external trainers are very effective, having Royal Greenwich practitioners develop training brings local context and knowledge which gives a sense of immediacy and supports the application of learning in practice.

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

We will continue to find ways to understand the impact of learning and development on practice, including:

- seeking managers’ feedback on the impact of training on practice
- understanding the impact of online training.

We will also seek to identify any gaps in the training programme for those agencies where there is low representation and undertake audits of single agency training.

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**Example of effective practice: Service user involvement in providing training**

A service user is involved in co-delivering training on parental substance misuse. She attends part of this course to talk about:

- her experience of struggling with substance misuse, domestic abuse and mental ill-health;
- the impact on her as a parent and the effect on her children;
- what helped and how professionals can support children and families.

Course attendees get the chance to hear a very powerful message from someone directly affected by these issues. The feedback from participants is very positive. They value this approach which provides a window into the life experiences of children and parents.
Child Death Overview Panel

Chaired by: Nikesh Parekh, Public Health Medical Associate

What did we do? Why?

Working Together to Safeguard Children (2015) provides the most recent framework for reviewing all child deaths at a local level. This process has been a statutory duty since April 2008 and it 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 2-3 monthly basis by a multi-disciplinary 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 2015-2016 will be available later this year.

How have we made a difference for children?

There were 4 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. None of these cases progressed to a Serious Case Review (SCR).

CDOP reviewed 20 child deaths this year, and these were categorised as follows:

<table>
<thead>
<tr>
<th>Category of Death</th>
<th>Number of Cases (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliberately inflicted injury, abuse or neglect</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Malignancy</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Acute medical or surgical condition</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Chronic medical condition</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Chromosomal, genetic and congenital anomalies</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>Perinatal/ neo-natal event</td>
<td>12 (60%)</td>
</tr>
<tr>
<td>Infection</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Sudden unexpected, unexplained death</td>
<td>1 (5%)</td>
</tr>
</tbody>
</table>

Not all of these deaths took place in the 2015-2016 financial year, but there was a delay in cases being brought for CDOP review due to pending investigations. Cases are only reviewed once all necessary information has been received and no further significant enquiries are pending.

Potentially modifiable factors were identified in four of these 20 cases (20%).

One of the SCRs was published by the GSCB this year on the case of a child death caused by deliberately inflicted injury.

What have we learned?

Robust referral mechanisms for smoking cessation support for pregnant women identified as smoking at their midwifery booking is critical given that smoking is a major risk factor for premature birth and complications.
There is significant room to improve uptake of the Pertussis immunisation amongst pregnant women in Royal Greenwich. The delivery of this immunisation programme is currently under review.

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. This raises awareness amongst key agencies and professionals of local concerns and recommendations, and the value and importance of engaging with the child death review process.

What do we need to do better?

Identify how CDOP should sensitively and efficiently retrieve relevant information on cases of child death occurring abroad where the children are registered residents of the borough. There is on-going consultation about this issue across London CDOPs.

Example of effective practice

Royal Greenwich CDOP has developed links with CDOPs in neighbouring boroughs. This has contributed to:

- increased collaboration between CDOPs in South-East London,
- improved analysis of cases to explore patterns and trends in child deaths in the region,
- more effective sharing of learning and resources.
Case Review Function: Serious Case Reviews

Serious Case Review Work Group Chaired by: Andrew O’Sullivan, Interim Chair (until September 2015); Simon Pearce, Director of Adult and Older People’s Services, Royal Borough of Greenwich

What did we do? Why?

The SCR Work Group has lead responsibility to consider cases that meet the criteria for a Serious Case Review as set out in Chapter 4 of Working Together to Safeguard Children (2015) and make recommendations to the independent chair of the Greenwich Safeguarding Children Board. The Work Group also has responsibility for looking at learning from multi-agency and single agency actions plans formulated following a Serious Case Review. The Work Group also considers the learning from Serious Case Reviews undertaken in other areas. The group met four times during the year. There is strong multi-agency representation at the group, with partners from schools, police, children’s social care, Oxleas, the Designated Doctor and Greenwich CCG.

The GSCB Work Group had oversight of two Serious Case Reviews that were commissioned in 2013-2014 (Child S and Child T). The Work Group Chair contacted the agencies involved in the reviews to confirm that the actions had been implemented as planned. The last GSCB Annual report set out the learning and improvements made as a result of the two reviews whose publication was delayed by other formal processes. The Child S review was published in January 2016 and the Child T review was published following the conclusion of the inquest in February 2016. The Coroner found that there had not been failings by the agencies involved with Child T leading up to her death that had caused or contributed to the suicide.

The Work Group considered serious incident notifications together with the findings and recommendations of a serious incident report completed by Greenwich Clinical Commissioning Group together with NHS England. None of these cases met the criteria for a Serious Case Review and there have been no new Serious Case Reviews in Royal
Greenwich in 2015-2016.

The Group also considered the Serious Case Reviews published by other local areas during the year. These included a case where a child from another authority attended a Greenwich school. The learning from two Serious Case Reviews concerned with child sexual exploitation has informed the development of multi-agency arrangements to tackle child sexual exploitation. Consideration of Serious Case Reviews about neglect informed the development of the GSCB multi-agency Neglect Strategy. The Group looked into the issue of co-sleeping and how health professionals provide guidance to parents.

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

Agencies and the professionals working in them are more aware of how to identify and respond to children who self-harm. There is guidance and there are improved processes in place to support professionals to make decisions and work with self-harm, especially in school settings. The re-commissioned Child & Adolescent Mental Health Service has extended its service to cover the times when children are most likely to present at hospital.

The Group has contributed to the development of a Neglect Strategy starting to shape how practitioners think about and respond to neglect whatever the age of the child. This has improved the response to teenagers who are neglected and at risk of exploitation.

The Group has contributed to improving local arrangements and practice in responding to children at risk of child sexual exploitation and abuse.

**What have we learned?**

Self-harm is a growing problem and we need to continue to strengthen local arrangements and build capability in the workforce to identify and respond effectively to this problem. The GSCB Business Group considered a presentation on how we can improve our response to suicide prevention.

We understand better the link between neglect earlier in childhood and children subsequently being at risk of exploitation whether this is sexual exploitation and abuse or exploitation by gangs or extremist ideologues.

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

We want to be more systematic in identifying learning from Serious Case Reviews and communicating this to the GSCB Learning & Development and Quality Assurance Groups so that we ‘close the loop’ to inform improvement actions and which have an impact for children. We are considering how we can carry out more in depth reviews of individual cases where there is multi-agency learning but no Serious Case Review, and also consider cases where there is good multi-agency practice and learn from this.

We considered the second report of the panel of independent experts on Serious Case Reviews and learning from what methodology is most effective in drawing key learning and driving improvement when we undertake Serious Case Reviews. The future of SCRs is subject to current consultation by Government. The Group will consider changes arising from this review in terms of local learning and improvement from looking at individual children’s cases.
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? Why?**

The co-presence of domestic violence and abuse, parental substance misuse and parental mental ill health, the ‘toxic trio’ of factors, increases the risk of significant harm to children. Children living with the ‘toxic trio’ often experience significant emotional and physical neglect. This in turn significantly impairs the child’s health and development, leads to poor progress at school and limited life chances.

The Group has developed a local Neglect Strategy which has been endorsed by the GSCB Executive. The Group has finalised and promoted the use of the multi-agency protocol and practice guidance for working with children living in families affected by the ‘toxic trio’. This was linked to using the guidance on ‘disguised compliance’ to support child-centred multi-agency practice that focuses on parents changing their parenting behaviour.

The Parental Substance Misuse Co-ordinator plays a key role in linking parents with children’s centres and works with Early Help Practice Managers. While there is strong evidence of the overall impact of early help, it was difficult to get a clear picture of how effective early help is in tackling emerging mental ill health.

The feedback on the Neglect Strategy has been positive and has provided a shared framework for thinking about and working with neglect both in terms of building resilience, prevention and protection.

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

The work of the Group has raised the profile of the ‘toxic trio’ across the professional network and the protocol and guidance have informed practitioners on common pitfalls in practice and ways in which help and interventions can be best co-ordinated within a timescale that meets children’s needs. There is evidence that practitioners and supervisors have benefited from the work the Group has done around protocols and promoting practice tools. There is more robust practice and effective multi-agency work to achieve timely change for children at risk of significant harm because of the ‘toxic trio’ and the strengthening families approach and practice focus on parenting behavioural change having a positive impact for children is evidenced in case audits.

The number of children with repeat Child Protection Plans where the Plan ended in the last 2 years is lower now than in previous years, though the percentage of children with a Child Protection Plan for a second or subsequent time has increased this year. The rate of children with Child Protection Plans is the same as last year. The number of care proceedings issued was broadly the same as the previous year.

**What have we learned?**

The Group has reviewed the findings and recommendations from multi-agency quality assurance deep dive and audits. The Group has also considered the fact that most children are identified as being at risk of the ‘toxic trio’ as a result of domestic incidents responded to by the police. Referrals from adult mental health services, primary health and other adult services are relatively low. Where there is early help provided this is most effective for pre-school children and their parents.

The hospital based maternity services and pre-birth support and assessment team continue to be effective in identifying pregnant women affected by the ‘toxic trio.’
The local Pause pilot is working with women who have had one child removed from their care. The analysis undertaken for the Pause work found that between 2009-2015 there were 60 women who had 168 children removed from their care. 67% of the mothers in this cohort had experienced domestic violence, 38% had experienced a range of chronic mental health issues, 30% have issues with drugs and 23% have issues with alcohol. Significantly 25% of the women who had two or more children removed had a diagnosed learning disability and 20% were care leavers. Of the 55 women who have had one child removed, 19% had a learning disability and 24% were care leavers.

The reported rate of early help assessments/team around the child activity and referrals to children’s social care from primary health services and adult mental health services are relatively low. Frequently, it is a significant episode coming to the attention of school or police which triggers an intervention for children and their parents.

Analysis of re-referrals to children’s social care indicates that children affected by the ‘toxic trio’ are over-represented and where a lead professional and team around the child arrangement is not operating and in place before the child’s case is closed by a Social Worker, there is an increased likelihood of changes made not being sustained by the parent. Adult services play a key role in sustaining changes in parenting and identifying in a timely way when children’s needs are not being met. An area for practice development is how to keep the focus on the child making the expected progress in terms of their health, education and wider development, taking a less episodic approach that relies on whether or not the child is the subject of an incident of concern.

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

We will review referrals from primary health and adult mental health services and, if necessary, we will work across agencies to improve pathways so that the impact of the ‘toxic trio’ is tackled before children are affected.

When we step down cases which have involved ‘toxic trio’ concerns, we will make sure that lead professional and team around the child arrangements are in place before children’s Social Workers end their work with the child and family to sustain positive changes made.

We will support practitioners through developing practice guidance and tools to help them focus on the child’s right to safe, reasonable parenting and helping parents change their parenting behaviour within a timescale that meets the child’s needs. In particular we will look at how we can remain focused on whether the child is making the expected progress and intervene early when the progress in parenting is starting to slip.

We will work with adult services to raise the profile of a ‘think family, think child’ approach.

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**Example of effective practice**

Effective joint working between adult drug and alcohol services and Children’s Services is supported by a Parental Substance Misuse Co-ordinator who provides advice and makes sure that the pathways to support are effective and that all practitioners are focussed on the safety and welfare of the child.
Communication and Engagement

Chaired by: Jack Joslin (until December 2015); Roy Gopaul, Development Officer, Greenwich Action for Voluntary Services

What did we do? Why?

The Work Group has continued to give high priority to make information about safeguarding more accessible to the public as well as workers across our partner agencies. We ensured that the GSCB website was reviewed on a regular basis during 2015-2016 and that important safeguarding documents were disseminated across the partnership, such as new editions of the London Child Protection Procedures, updated Protocol for Assessment and Threshold Guidance 2015 and revised guidance on CSE. As a result, the GSCB now has a comprehensive website which includes up-to-date information, guidance and training for professionals and the public. Over 2015-2016 there have been over 24200 page views by 9262 users.

GSCB awareness campaigns

During this reporting year the Work Group planned and launched three awareness campaigns focused on various safeguarding issues.

The Work Group put together key information on FGM and forced marriage to help school staff identify and report concerns. The information pack was sent to all schools before the summer holiday together with a letter from the GSCB Independent Chair. The campaign was also highlighted in the schools’ bulletin.

On Safer Internet Day (9th February) the Group re-launched its e-safety campaign. The campaign 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. It gave parents the information and support they needed in order to have conversations with their children about how to stay safe online and provided practitioners with e-safety resources, tools and materials that they can use in supporting children to learn about how to stay safe online.

Members of the GSCB provided e-safety training to professionals and one of the GSCB Lay Members was supported to deliver training to parents.

In support of Self-harm Awareness Day (1st March), the Work Group launched a campaign to help young people, parents, carers and professionals understand what self-harm is and how to get support. The event aimed to reduce stigma surrounding self-harm and let those affected by this issue know that there is help available, that they can access a range of resources online or contact local and national agencies to receive the support they need so they do not suffer in silence. The topic of the campaign was voted by children, young people, parents and other members of the community during the Great Get Together event.

The development of the campaign was 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. Local young people were involved in the planning and they came up with the campaign strapline: No one should hurt you, so why hurt yourself?

As part of this campaign the Group developed an information and advice hub, hosted on the GSCB website. This provides links to relevant resources aimed at children and young people; parents and carers; professionals and volunteers.

Reaching children and young people

GSCB understands the importance of listening to 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.

We consulted extensively and engaged with young people during community events and while planning our campaigns.
The Group has continued to work with Participation People, the Greenwich Young People’s Council (GYPC) and the Children in Care Council (CiCC). Both Groups met the GSCB Independent Chair. These meetings focused on: What does it mean to feel safe? What are the main areas that we need to keep young people safe from? Whose job is it to keep us safe? What do you think is the most important safeguarding concern? A young person who is also a Safeguarding Champion will join the work group early in 2016-2017.

Engaging with the Community and Voluntary Sector

We have continued to build on the strong partnership between the GSCB and voluntary sector, in particular with Greenwich Action for Voluntary Service (GAVS). This has enabled the Group to engage with the sector to promote GSCB campaigns and safeguarding messages within the community. GAVS CYP Newsletter for the sector carried regular updates on safeguarding issues. GAVS has also made effective use of its CYP Forum, BME Forum and Youth Crime Forum to engage community groups in the borough around some of the key GSCB safeguarding issues; for example, child trafficking, FGM, CSE and gangs. We supported a local voluntary organisation to organise a conference which aimed to bring together professionals and parents to discuss the issue of physical chastisement and how to promote positive parenting.

How have we made a difference for children?

By making information widely available and accessible to the community at large, including professionals, we have contributed to a better understanding of safeguarding in the borough. Our work in engaging with children and young people has ensured that they remain at the centre of our decision-making process and that children and young people’s views and experiences continue to inform and influence what we think, say and do.

What we have learned?

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 have also learnt that we need to adapt the information that we produce in order to reach different audiences.

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.

Example of effective practice: Engaging with children, young people and the community

The GSCB stall at Royal Greenwich Great Get Together event provided safeguarding information to members of the community. The day was a great success and a good opportunity to communicate key safeguarding messages to the community. Over 150 children, young people and parents/ carers visited the GSCB stall. They were all asked to vote the topic of the next GSCB public campaign and let us know on what safeguarding issues they would like to receive more information about. The majority of participants voted self-harm as the topic of the campaign and this, together with some of the stories shared by parents/ carers confirm this as a significant issue nationally and locally.
Tackling Child Sexual Exploitation

CSE MASE: Co-Chaired by Andrew O’Sullivan, Senior Assistant Director, RBG Children’s Services; Mike Balcombe, DCI, Greenwich Police

What did we do? Why?
The Director of Children’s Services, Borough Commander and Chair of the GSCB asked a multi-agency CSE task and finish group to review current multi-agency arrangements and practice relating to preventing and tackling child sexual exploitation. A key recommendation from this Group was to change the function and terms of reference of the CSE MASE Strategic Group which first met in its new form in September 2015. It reports to the GSCB Business Group.

The Group implemented recommendations from the task and finish group including revised procedures and processes for handling children’s cases, promoting the use of a new CSE risk assessment tool, developing awareness about how children come to be exploited and sexually abused, whether by peers or adults, developing resources for schools to promote positive safe relationships and use of the internet. We have developed our understanding of the links between sexual exploitation and other forms of exploitation and on understanding the effectiveness of work undertaken to reduce the risk of harm where children are likely or known to be in situations where they are exploited, such as children who go missing.

The Group is also leading on monitoring the implementation and impact of the multi-agency tackling exploitation plan and whether we are achieving the ambitions set out in our refreshed Child Sexual Exploitation Strategy that was developed by the CSE task and finish group.

We have contributed to the London Safeguarding Children Board’s review of CSE procedures and guidance and most of our newly developed local procedures have been adopted across London.

How have we made a difference for children?
The new CSE risk assessment tool has been rolled out to all practitioners in universal, targeted and specialist services. Children’s Social Workers have used it to review the level and type of risk to children previously presented to CSE MAP meetings and where there are current concerns about grooming and abuse. This has promoted the message that the threshold for responding to CSE has to be low as it is largely a deliberately hidden problem and is likely to require investigation before being evidenced.

The revised procedures and arrangements for handling children’s cases where CSE is a concern or known risk are now integrated into assessment, team around the child, child in need, child protection and child looked after processes. This has improved practitioners’ professional judgements. Decisions to strengthen protective factors and reduce risk are made by those who know the children best and routinely chair planning meetings for children. There are clear arrangements for reviewing the risk level and impact of actions to safeguard the child irrespective of whether they are a child in need, subject to a Child Protection Plan or a care plan. Cases for all 94 children who were previously identified as being at risk of CSE have been reviewed to determine whether there is a continued risk of CSE and if so the level of that risk. Positively this has confirmed the picture from previous Annual reports that for most children the level of risk is reduced in a timely way and eventually eliminated. An improvement challenge is to achieve positive change for all children so they do not continue to be exploited and abused as adults.

What we have learned?
We have considered the profile of children, perpetrators and location using profile information that brings together all known risk factors around the child. We have also used
‘hot spot’ maps showing a number of risk factors including crimes by locality. We know that most victims are teenage girls aged 14 or 15 with a White UK background. A significant proportion of the girls experienced neglect earlier in their childhood and have difficulties in attending and making progress at school. It is either through other teenagers or on-line that they meet older young men who opportunistically groom them for abuse by other people. We have confirmed a strong link between teenage girls going missing more than once and a risk of CSE.

We know there is further work to do on analysing the profile of victims, perpetrators and locations. The new CSE monitoring form will assist in providing information on this. A key development will be to bring in analysts who can integrate information from other agencies with what we know from the Children’s Services and police Merlin reports.

From the Metropolitan Police London wide data we know that we have a higher than average crime and disruption/intervention level of activity in our local area than other areas. Detection and bringing to justice numbers across London are small.

We have learnt that practitioners are more confident about identifying and working with CSE where there is a child being exploited and abused by an adult but not where there is peer on peer abuse where the victim talks about the groomer as ‘my boyfriend’ or being part of a group of ‘friends’. The findings of the MsUnderstood peer on peer research and training have enabled practitioners to develop their knowledge, confidence and skill in this area of work. We looked at the Children’s Society research about some of the challenges around appropriate responses to 16 and 17 year old teenagers.

We have considered a report back from the Greenwich Action for Voluntary Services (GAVS) about what local communities know and think about CSE and other forms of exploitation and abuse to children. This found that for most local communities there was little understanding of what CSE was and how to recognise problems early. In some communities it was a ‘no go area’ unlike for example, understanding the risk of gangs and their exploitation of children. This informed our work on redesigning our awareness raising campaign through the Operation Makesafe initiative which will be rolled out later in 2016.

Children’s Services have taken part in a second peer review of arrangements around CSE with the Tri-Boroughs and Southwark. This process supports our learning and improvement activity.

We have also looked at learning from Serious Case Reviews undertaken by other LSCBs including the Oxfordshire (March 2015) review. This has helped us shape some of the key messages for our prevention work around understanding early warning signs that exploitation is happening, understanding consent issues and how posting images on-line can be a pathway to exploitation and abuse. We have also looked at material on promoting self-esteem, confidence and positive intimate relationships within schools. We have sought feed-back from pupils that these are the right areas to focus on as we design or validate tailored material for pupils according to their age and understanding.

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

Building resilience:

- in our local communities by raising awareness about CSE and how it can be prevented and tackled.
- with children through delivering tailored sessions on positive relationships, staying safe on-line and understanding consent issues.

Targeted prevention work with children identified at risk through grooming, their associates, where they are going and what they are doing on-line.

Improving effectiveness of interventions to protect children in a timely way including where there is peer on peer abuse.
Example of effective practice

Anna (not her real name) came into care at the age of 12 following a very troubled and chaotic childhood. Her Social Worker was persistent and, in the face of challenging behaviour, built up a good relationship with Anna. The foster placement broke down due to increasing concerns about CSE and she was placed out of borough in a residential unit but continued to attend the same school. This was very important because school was a safe place for Anna. She had come to trust staff and feel part of school life. The Social Worker and Independent Reviewing Officer were also consistent people in her life.

Professionals worked well together and were honest with Anna about the reasons why decisions affecting her life were made. They also listened carefully to Anna’s views. Plans were put in place to deal with her challenging behaviour and build her self-esteem and confidence. As time went on Anna started to dress more appropriately; the episodes of her going missing reduced; her behaviour became calmer and far less volatile and the concerns about CSE decreased.

Last year Anna decided she was ready to move back to foster carers and worked hard to convince the professionals that she was ready for this. Anna did really well on returning to their care. Her self-esteem has increased and she talks positively about herself and understands the risk that she placed herself in in the past. She says “you all stayed with me or came back to talk to me.”

CHILD SEXUAL EXPLOITATION
Spot it- Report it
Keeping Children Safe in Health

**Health Safeguarding Work Group:** Chaired by Dr Derek Abel, Lead GP for Safeguarding Children

**What did we do? Why?**

The Work Group met quarterly during 2015-2016, with good representation across agencies and services including:

- Designated Nurse for Safeguarding Greenwich CCG
- Named Doctor for Safeguarding Greenwich CCG
- Oxleas Foundation NHS Trust; Universal and CAMHS services
- Royal Borough of Greenwich GSCB, Public Health and MASH,
- Family-Nurse Partnership
- Lewisham & Greenwich NHS Trust, Acute, Maternity and Family Nurse Partnership
- London Ambulance Service
- Early Help Practice Manager

Our work streams reflect GSCB priorities.

**Female Genital Mutilation**

Training has been provided to all health care professionals to improve competence in recognising FGM and identifying women and girls at risk of FGM.

All regulated health professionals have been informed of their duty to report to the police any girl under 18 years who suffered FGM or if they see signs of FGM. Health care professionals know to report suspected FGM to MASH by triggering the usual safeguarding procedures.

There is mandatory recording of FGM in the health record and data are now being collated. A local pathway for disseminating information has been established. The group will continue to lead the partnership’s response to FGM.

**Neglect**

The Group has considered recent findings from research into neglect and the key role that health professionals play in tackling it.

The Group has mapped arrangements in health agencies to enable staff to identify and respond to neglect. The Group is currently developing best practice for health care professionals to identify children affected by neglect and manage the risk. This will involve an accredited tool to screen, put in place early help or, if necessary, refer to social care.

**Private Fostering**

Locally agreed guidance, defining private fostering and what needs to happen when it is identified, has been distributed to health care staff.

**Voice of the Child**

The Work Group continually looks for examples of good practice. It is becoming routine practice to record the views of children in the health care record.

**Learning from Serious Case Reviews**

A named professionals group has been established to look at lessons learnt from Serious Case Reviews and to disseminate learning through respective organisations.

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

During the next year the main area of focus will be self-harm. The self-harm guidance will focus on:

- Ensuring health care professionals are confident in recognising and assessing self-harm.
- Confident in knowing their own responsibilities when self-harm is identified and which other agencies they need to liaise with.
- How to liaise with other agencies.
- How to record self-harm in the health care records.

The Health Safeguarding Work Group will also address some of the causes of perinatal illness and death in Royal Greenwich, focusing on smoking in pregnancy, influenza and whooping cough immunisation of pregnant women.
Keeping Children Safe in Schools

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

What did we do? Why?

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.

This year, the Work Group developed and implemented a borough-wide Child Protection Record Transfer Protocol and database, in response to the Greenwich Serious Case Review (SCR) for Child T. Each school now has a named person responsible for passing on and receiving child protection records via the Pupil Transfer Information Form. Crucially, they are responsible for acknowledging receipt of the records, for ensuring that they are then disseminated and read by the appropriate person(s) in their setting.

In response to a SCR published by another LSCB, concerning a child from another authority who attended a Royal Greenwich school, the Work Group developed an Out of Hours/Holiday safeguarding contacts database.

The GSCB Model Safeguarding Policy and Safeguarding Audit for schools have been updated in light of new legislation, learning and recommendations.

We worked with Police CAIT (Child Abuse Investigation Team) on a preventative project to reduce the incidence of physical chastisement by parents. Work Group members reviewed school-parent agreements to include clear information about physical chastisement, the legal framework and the expectations of parents. Revised agreements will be introduced in the new academic year.

The Group worked with Early Help to develop a pathway for schools to receive information from MASH about children who come to the attention of police but do not reach the statutory threshold for social care. The information would support schools to provide early help. The process will be tested from April 2016.

The Work Group received presentations: MsUnderstood on their research in the borough about peer on peer exploitation and the role of schools, Prevent and radicalisation, recent research on neglect and how schools can tackle this issue.

How have we made a difference for children?

We ensured that children are better protected and receive the right support because:

- Relevant staff in schools have the information they need to provide appropriate support to vulnerable children, including children subject to a Child Protection Plan or looked after children.
- Schools have the right safeguarding arrangements in place.
- There is improved information sharing between schools and other agencies at all times including school holidays and out-of-hours.
- Early help is promoted in all schools.
- Schools will work together with parents to promote principles of positive parenting and prevent the use of physical chastisement.

What have we learned?

- Schools play an essential role in providing effective early help which prevents needs escalating. We know more about how improvements in information-sharing can help schools to intervene early.
- An increasing amount of time is spent within schools, Children’s Services and Police CAIT dealing with disclosures from children alleging physical chastisement from their parents or carers.
- How safe young people in Royal Greenwich feel in our schools and how they feel schools can be made safer (with specific regards to peer on peer exploitation).
What do we need to do better?
These issues will be addressed by the Work Group this year, alongside other work relating to the GSCB priorities for the year. We will also ensure that good practice guidance is disseminated to all staff at all levels in schools.

Example of good practice: Pupil transfers

As well as using the Pupil Transfer Information Form for transferring child protection records within RBG, schools have followed the protocol for out of borough transfers. Colleagues from other parts of the country have acknowledged receipt in line with our protocol. Other local authorities have sought our agreement to adopt the protocol as a model of good practice because they have found it effective and useful.
GSCB Statutory Functions
Allegations Against Staff
Henrietta Quartano, Head of Quality Improvement Service, RBG Children’s Services

What did we do? Why?
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 Designated Officers who offer advice and manage the investigation of allegations against people that work with children.

We have continued to:

- Investigate all allegations that reach a LADO threshold relating to staff working or volunteering in Royal Greenwich including in relation to their private lives.
- 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
- Provide training and consultation to ensure that the LADO role is well understood across the children’s workforce
- Maintain a data base to identify trends and any learning needs
- Disseminate learning across the partnership arising from LADO investigations

Our focus this year:

- To continue to improve the timeliness of our response to LADO allegations
- To improve our response to allegations against staff by increasing the number of people undertaking the Designated Officer role.

How have we made a difference for children?
The number of LADO referrals has been very consistent for the last 5 years ranging from 70-79. In 2015-2016 there have been 56 contacts which met the threshold for a LADO investigation. This is a decrease on previous years.

In addition there were 41 consultations with the LADO which did not meet the threshold for an investigation. This is an increase on the previous year when there were 31 consultations.

We need to understand why there has been a drop in the number of referrals. GSCB surveys tell us that there is a good understanding of thresholds in relation to safeguarding children and we plan to examine the findings from the Section 11 survey, which asks specifically about allegations against staff. If there are learning needs identified these will be addressed in 2016-2017.

We monitor closely allegations made by children who are Looked After by Royal Greenwich. Some of these children will be placed outside of Royal Greenwich and therefore other LADOs will have the responsibility for any investigation. However the Royal Greenwich Designated Officers work closely with the child’s Social Worker and other Designated Officers to ensure a timely and robust response for our children.

What have we learned?
Table 1 shows LADO contacts by agency excluding the consultations.

![Table 1 LADO referrals By Agency](image-url)

Table 1 shows LADO contacts by agency excluding the consultations.
The largest number of referrals relates to staff working within education and this is to be expected given the number of children who attend schools in the borough.

Table 2 shows the professional role of the individuals where LADO referrals were made.

It is positive to note an increase in referrals from Early Years settings as there had been a decrease in the previous year.

Table 3 shows the contacts with the LADO that did not meet the threshold for an investigation.

Training has been undertaken with schools by the School’s Safeguarding Officer through inset days and with the school Designated Officers. The ratio of consultations to referrals has changed from previous years demonstrating an increased understanding of the thresholds within education.

Table 4 shows the nature of the concerns and those that reached a threshold for an investigation and is consistent with previous years.

Table 5 shows the outcome of contacts with the LADO.

Example of effective practice
Following a change in statutory guidance the Designated Officer has worked in collaboration with Royal Greenwich human resources officers and colleagues in schools to ensure that all staff working with young children in our schools are aware of their duty to inform their employers of any information past or emerging that may have an impact on their suitability to work with children.
Effectiveness of early help

Rachel Egan, Interim Assistant Director, Early Help, RBG Children’s Services.

What did we do? Why?

We have established an Early Help Partnership, bringing together agencies across the whole early help system to increase confidence of practitioners in providing early help as a single agency and in leading where children need co-ordinated early help.

We revised the Early Help Guidance to include ‘tools of the trade’ to support effective early help based on good quality Early Help Assessments.

Although we can see that early help is effective in preventing problems escalating, our ability to measure impact for children of specific interventions is under developed. In response, we have used a series of Early Help Problem Solving Forums to develop a methodology to demonstrate the impact of Early Help for children and parents to understand the impact at population, service and child level.

We have commissioned a management information system for Early Help (goes live on 1st April 2016) to improve data sharing and our ability to track the progress of children and parents following an Early Help Assessment. To increase the visibility of early help provided by single agencies we will also monitor Early Help Connections which result in signposting, advice and take up of services.

How have we made a difference for children?

Early help is effective in preventing problems from escalating and requiring a referral to children’s social care. Only 10% of children who get early help go on to be referred.

Early Help continues to reach children living in the most deprived areas of the borough and through the work of Children’s Centres and, with our focus on the first 1001 days, we reached 250 additional children under 5. Early Help is particularly effective for children in this age range with just 6.3% of children referred to Children’s Centres via MASH requiring subsequent referral to children’s social care.

Referrals to the primary Fair Access Panel (FAP) increased by 27% this year (from 339 to 431). Referrals to secondary FAP were fairly steady (up from 464 to 467). Around three in ten secondary FAP referrals and half of primary FAP referrals came from out of borough schools or for children out of school. For children referred to FAP “at risk of permanent exclusion”, permanent exclusion was avoided in all cases for primary age children and in 96% of cases for secondary. FAP has been successful in supporting education stability, with 88% of primary children and 86% of secondary children remaining at the same school.

What have we learned?

We know that where early help is timely and supported by a good quality Early Help Assessment and robust Team Around the Child arrangements it is effective in preventing needs escalating and the need for step up to children’s social care.

Over the year fewer children aged 11-13 and 14-18 are reported as getting early help though repeat referrals where early help was the outcome of the previous referral were zero.

Step down was effective for the majority of children with 95% remaining below the threshold for children’s social care. Scrutiny of our ‘step down’ arrangements identified a greater likelihood of re-referral where a lead professional and Team Around the Child are not in place and the parent is not engaged in an agreed plan. We have reviewed and revised our ‘step down’ process to ensure ‘step down’ is well planned for every child as this is key to sustained change.

The quality of work undertaken across the system is not yet consistent and the effectiveness of preventing step up varies...
between agencies. Where practice is strongest, only 3.9% of children require a referral to children’s social care; this is what we want to achieve for children across the whole system of early help.

The new Early Help Practice Manager role and their links to the MASH has improved capacity to provide children and parents with the right early help. Their role is critical to improving step down (see above).

Early help is less effective for children who are White British. Girls are more likely to require a referral to children’s social care, with children aged 5-9 the most likely to step up to CPP and those aged 1 to 4 to become looked after.

What do we need to do better?

- Strengthen ‘step down’ from children’s social care to early help.
- Understand how effective early help is in sustaining change in children’s lives.
- Ensure that our understanding of impact is understood across the partnership.
- Understand how effective early help is in tackling emerging mental ill health. Early Help Assessments and Team Around the Child reporting is low from some adult services where we know parental mental health to be significant.
- Use Troubled Families Outcomes Framework to raise awareness of the positive impact of parents’ behaviour on change for children.

Example of effective practice: Families 1st

Melanie is 48, her daughters Kayley and Jennifer are 15 and 8. Melanie’s mental health problems and debts were having a negative impact on parenting and family life, the girls were often late to school and Kayley was becoming overwhelmed by the caring responsibilities she was undertaking.

Melanie was supported through Families 1st to go back to her GP regarding mental health needs and to stop smoking which helped her mobility and breathing difficulties. Working in partnership with Meridian Money Service, Melanie paid her creditors at a more affordable rate which has eased stress.

Kayley and Jennifer are both now getting support from the Young Carers Service with activities away from the home for the girls to give them both a break. Kayley feels much happier; the school have put in great support for her including counselling, a job in the school library, access to computers to do homework and a time out card to escape from lessons when things get overwhelming. She now feels more able to tell her mother when she feels she is relying on her too much. The girls’ attendance at school is now good and they are both feeling happy again.

Melanie says: “Families 1st were very understanding, honest and very helpful through my and my family’s situation. I think they do a great job.”
What did we do? Why?

‘Corporate parenting’ means having the same ambition for our children in care as we have for our own children.

We work with partner agencies, foster carers and parents to provide the love, care, support and opportunities that enable children and young people to be happy, healthy and fulfil their ambitions.

Most children in our care are living in good or outstanding placements. Our own, local children’s home has been judged outstanding. Where there are adverse inspection findings for any placement we work with Ofsted inspectors and the provider to be assured that the child is safe and their needs are met.

Most children are placed in or relatively close to Royal Greenwich but some children are purposefully placed some distance away to reduce the risk of harm to them and others. The Personalised Commissioning Team, children’s social care and Youth Offending Service work closely together to make the right placement choice when young people are placed where there are concerns about them being affected by gangs and there are risks to themselves or others.

We recognise that placing children out of borough can present challenges in safeguarding and promoting their welfare. We seek from other local authorities information about the locality where we are placing children so we are aware of any relevant risk factors such as those associated with gangs and CSE activity. We have published for other local authorities placing children in Royal Greenwich information about our services and where to get information about our local gangs, CSE and crime profile.

There are sound arrangements for responding to children who go missing from care, including arrangements with other local authorities who have their children placed in Royal Greenwich. We have commissioned an independent service to provide a return from missing interview offer to all children who have gone missing. There is close scrutiny by senior leaders of actions taken to find children, learn from what they say and what we know about the ‘push and pull’ factors that lead to them going missing and to prevent this happening again. We know that most teenage boys who go missing are affected by gangs and that most teenage girls who go missing are likely to be affected by CSE.

We have been implementing our Placement Sufficiency Strategy so that more looked after children live locally with Royal Greenwich foster carers who provide a good quality service where our children do well. Our involvement in the Mockingbird Project is improving placement stability for teenagers who have benefited from an extended fostering network. Evaluation will be completed in 2016 by the University of Loughborough.

Every looked after child has an Independent Reviewing Officer (IRO) who, in most cases, will remain allocated to them throughout their time in care. The IRO provides challenge to the Local Authority where plans are not progressing in a timely way; ensures the voice of the child is heard; ensures that their parents are involved as appropriate and ensure the safeguarding needs of looked after children are addressed. They support children in making complaints and refer to Advocates and Independent Visitors where needed.

We have developed our Children in Care Council (CiCC) to include a Care Leavers Forum and Junior Children in Care Council, all of whom have been busy contributing to our understanding of their experience in care and how we can improve it.

The work of the Corporate Parenting Impact Groups and the Care Leaver Hub ensures strong partnerships which promote the best interests of children in our care, for whom the Council’s Scrutiny Committee provide a challenge and monitoring role. To support the transition of children into adulthood, we have been involved with The Belongings Project with the Care Leavers Foundation. This has
focused on care leavers and has driven improvements in participation, supporting independent living skills and engagement in education, employment or training.

**How have we made a difference to children?**

Most children who become looked after do so because there is no other way of safeguarding and promoting their welfare. Court proceedings are shorter and more children are securing permanence quicker. Fewer children are becoming looked after children, 239 children became looked after children during the year ending 31st March 2016 compared to 275 children the previous year. Our performance on adoption continues to improve, 22 children were adopted during the year compared to 17 children the previous year.

Placement stability continues to be relatively good for most of our children. Our outstanding children’s home has had a positive impact for those who have called it home.

Good education improves children’s life chances and attendance at school is an important protective factor for the child. Our Virtual School has achieved a step change through its work with schools and social work teams. For 92% of our children, Personal Education Plans were reviewed in timescales and the quality of these plans is leading to effective action to help children do well. Most of our children (88%) attend a good or outstanding school. Children’s achievement and attendance at school are consistently better than the national average for looked after children. For the last two years, none of our children has been excluded permanently from school (in Royal Greenwich or other areas) making our performance the best in the country. Care leavers (aged 19-21) in higher education remains above national and London averages at 10.5% although, at 16+, too many of our looked after children and care leavers are not in education, employment or training which increases their vulnerability.

The emotional health and well-being of our looked after children population is relatively good and there is access to services for children who self-harm. The specific vulnerabilities of disabled children are recognised in placement plans and by practitioners working with the children. We are currently reviewing our work with disabled children.

Where teenagers enter the care system late in childhood they may have a pattern of behaviour that increases the risk of exploitation and harm. Our own case audits and the inspection of services for young people who offend commended the commitment of our practitioners and leaders to making a positive difference with this cohort of looked after children and in most cases risk levels are reduced and children make progress. Our work around tackling exploitation whatever form it takes has helped us to understand the importance of practice focussing on improving self-esteem, addressing trauma and building positive relationships with peers and adults.

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

- Continue to increase the number and of children living in Royal Greenwich fostering placements.
- Improve placement stability for children with emotional and behavioural difficulties whose placements become fragile when they reach adolescence and for teenagers entering the care system late in childhood.
- Improve outcomes for children who enter the care system late in childhood with entrenched patterns of behaviour that places themselves and sometimes others at risk of harm.
- Engage more young people post 16 in education, training and employment.
Example of good practice

Our children’s home provides a home to five children at any one time but many more children and young people keep in touch and benefit from outreach support. There is strong leadership and well-motivated experienced practitioners provide high quality nurturing care that raises aspiration and enables children to do well. The impact for children is excellent and children talk very positively about their home and the difference it has made for them.
Private Fostering
Winsome Collins, Quality Improvement Leader, RBG Children’s Services

What did we do? Why?
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. An adult providing private fostering may be an extended family member, a friend of the child’s family or someone who is previously unknown to the child. 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 is a Designated Monitoring Officer in RBG Children’s Services who has a lead responsibility for assuring private fostering arrangements and that the child is being safeguarded. This is achieved by:

- promoting awareness of the law relating to private fostering so that private fostering arrangements are recognised and notified;
- visiting the private foster carer where the child lives, speaking with the child, talking to the parent, where possible;
- undertaking reasonable checks as to the suitability of the arrangement.

The Social Worker will also assess whether the child is a ‘child in need’. A child in need is defined as a disabled child or one whose health or development will be impaired without support and services. Advice is provided where needed to parents and private foster carers.

During the year there have been between 15 and 25 children privately fostered in Royal Greenwich at any time, because of

- children coming from abroad to live with extended family or a family friend or where the parents’ immigration status is an issue;
- relationship breakdown between parents;
- parent being in prison.

For the majority of the children and young people private fostering is a short-term plan but, increasingly, these arrangements have become longer term. Consideration is given to ensuring stability for these children through a more permanent and legal framework.

During the year all children were visited at a frequency that meets regulations.

How have we made a difference for children?
The needs of privately fostered children are assessed by practitioners with expertise in fostering leading to support provided as appropriate. The link between private fostering and child trafficking is understood. Confirming the child’s identity and the parent’s agreement to the arrangement are key safeguarding checks. Social Workers take an open enquiring approach to who the parent is, whether there is evidence of their agreement to the arrangement and what the child says about them. Our rigorous approach means we identify children in private fostering arrangements who are in need of protection or are children in need of children’s social care services. As a result of these checks one suspected case of child trafficking was identified.

There remains a proactive approach regarding achieving permanence for children and during the year 4 children were made the subject of Special Guardianship or Child Arrangement Orders. Once the Orders are made the children cease to be privately fostered. This is a good outcome for the children who were under the age of 11 years as it provides stability, a sense of belonging and gives the carers parental responsibility.

The improvement actions from 2014-2015 have been achieved. The first was to raise professionals’ awareness so that referrals are made to children’s social care where there are reasonable grounds to think that there is a private fostering arrangement. There has been an increase in referrals especially from carers. This year 5 carers have made direct
contact to inform us that they were privately fostering. This is a significant improvement on previous years and demonstrates an increased awareness of their duties and their understanding.

During the year there was a Private Fostering Fortnight during which Social Workers visited Health Centres, GP surgeries, Leisure Centres, Children’s Centres and community centres throughout the borough. There were stalls in The Woolwich Centre and the Woolwich Library staffed by Social Workers. The leaflets and posters are promoted at every opportunity, including at community events. Posters are displayed outside the Town Hall and in the Woolwich Library. In addition there is a continuous programme of briefings for targeted staff in universal services.

What have we learned?
We know from research and local information that there is significant under identification of children in private fostering arrangements, this is the case across the UK. We will continue to improve awareness around private fostering.

We can identify children in need of protection through applying the private fostering regulations.

Outcomes for children are improving through securing permanence through the Courts.

What do we need to do better?
Increase the number of referrals from health services by targeting health professionals to ensure that they have a good understanding of the issues and their responsibilities.

Continue to incorporate awareness of private fostering into other GSCB communication campaigns.
What did we do? Why?

Children who go missing are a recognised priority in the Children and Young People Plan (2014-2017) as well as a priority of the GSCB. They also feature in Children’s Services Thematic Improvement Plan to tackle exploitation of young people.

Children who go missing are at increased risk of being drawn into gangs, crime and being sexually exploited. Children go missing for a number of reasons; some will be running away from something, known as push factors; others will be running to something, known as pull factors. The majority of young people who go missing are teenagers which can be a confusing and challenging time for many young people, their parents and professionals working with them. Most children only go missing from home once. It is essential for the multi-agency network to work closely together and alongside families on individual cases to reduce the risk. However there is also a need to consider the missing young people on a strategic level.

In 2015-2016 the Missing Joint Commissioning Group has continued to meet quarterly. The Missing Group ensures that:

- There is a multi-agency focus on children who go missing;
- Our responses to missing children are quality assured by analysing data and sharing learning;
- An understanding is developed of the local factors.
- There is effective information sharing between different organisations with differing roles who respond to children who go missing, children who get drawn into gang activity and children who are at risk of sexual exploitation.

The Missing Group is revising their terms of reference and membership to focus more on strategic oversight of the issues and less on individual cases. This is in part because we are reassured that the response to individual children is sufficiently robust. The Missing Group will become a sub-group of the Greenwich Safeguarding Children Board. The missing data is being reviewed on a weekly basis by the Chair of the Group to ensure a more timely challenge when needed.

How have we made a difference for children?

Fewer children went missing from home compared to last year. Although more children went missing from care for more than 24 hours, the number of times they went missing was about half the level of the previous year. In most cases where children have been persistently missing from home and become looked after children the incidence of them going missing reduces and ends.

When children have been missing, whether from home or a care setting, a return interview is always offered to them. This interview looks at reasons why they went missing, explores the risks with them and thinks about ways to avoid the risk of going missing in the future. Over the last year we have analysed information from these meetings to inform our practice. We have commissioned a service to deliver all our return interviews to provide greater independence and consistency. More children took part in a return from missing interview this year than the previous year. Analysis of the return interviews completed when children go missing from home has shown us that there were some common themes around both push and pull factors. Parents have been positive about the interview; they felt that the young person better understood their concerns and they were now more open in their communication. Young people were also positive about the interview and described how it helped them better understand the concerns of their parents.
The GSCB has adopted the London Safeguarding Board Protocol in relation to children who go missing. Having a London-wide agreed response will result in a response which is co-ordinated, consistent and clear with partner agencies who overlap boundaries and where children go missing in neighbouring boroughs. This is particularly important as children who are missing will often not remain in their original local authority while missing.

**What have we learned?**

Table 1 shows the number of children who have been missing from their homes in Royal Greenwich in the last 5 years.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Children Missing From Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12</td>
<td>22</td>
</tr>
<tr>
<td>2012/13</td>
<td>54</td>
</tr>
<tr>
<td>2013/14</td>
<td>85</td>
</tr>
<tr>
<td>2014/15</td>
<td>44</td>
</tr>
<tr>
<td>2015/16</td>
<td>46</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 time only</td>
<td>4%</td>
</tr>
<tr>
<td>2 to 3 times</td>
<td>20%</td>
</tr>
<tr>
<td>4 to 7 times</td>
<td>76%</td>
</tr>
</tbody>
</table>

This table shows us that the number of children who go missing has been similar in 3 out of the previous 5 years. More boys than girls were reported as missing from home in the last year.

During the year 133 children went missing from home (188 children the previous year). Table 2 shows the number of times that children have gone missing from home.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Times Missing From Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12</td>
<td>2</td>
</tr>
<tr>
<td>2012/13</td>
<td>2</td>
</tr>
<tr>
<td>2013/14</td>
<td>5</td>
</tr>
<tr>
<td>2014/15</td>
<td>10</td>
</tr>
<tr>
<td>2015/16</td>
<td>15</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 time only</td>
<td>5%</td>
</tr>
<tr>
<td>2 to 3 times</td>
<td>3%</td>
</tr>
<tr>
<td>4 to 7 times</td>
<td>90%</td>
</tr>
<tr>
<td>8 to 10 times</td>
<td>2%</td>
</tr>
</tbody>
</table>

From this we can see that the majority of children only go missing once. For the small cohort of children who go missing more than once from home there are often concerns about gang affiliation for boys and sexual exploitation for girls.

During the year 58 RBG looked after children went missing from their placement for more than 24 hours (compared to 33 children last year). Table 3 shows the number of times looked after children go missing.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Times Looked After Children Missing From Place</th>
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</thead>
<tbody>
<tr>
<td>2011/12</td>
<td>1</td>
</tr>
<tr>
<td>2012/13</td>
<td>1</td>
</tr>
<tr>
<td>2013/14</td>
<td>2</td>
</tr>
<tr>
<td>2014/15</td>
<td>3</td>
</tr>
<tr>
<td>2015/16</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>1 time only</td>
<td>5%</td>
</tr>
<tr>
<td>2 to 3 times</td>
<td>3%</td>
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<tr>
<td>4 to 7 times</td>
<td>90%</td>
</tr>
<tr>
<td>8 to 10 times</td>
<td>2%</td>
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</table>

The majority of young people (82%) only go missing one or two times. However we have a small cohort of children who go missing more frequently. Again for these young people gang affiliation is a feature. Some have families who are not working well with the local authority which destabilises the placement. For others going missing was already an established problem before becoming looked after.

We have continued to build on the model of the ‘persistent practitioner’ and seizing windows of opportunity with young people around missing and other forms of exploitation. Case audits and talking to young people have shown us that what will work in reducing risk is for a practitioner to build up a trusting relationship with a young person, to stick with them however many times the young person might reject their advice and to be there when the young person is ready to listen and begin to make small steps towards change.

A challenge for us locally has been the links between gangs and going missing. A number of young people who are missing for extended periods are associated with gangs who harbour them. There are effective working relationships between children’s social care, Youth Offending Services and the Police to try and locate children. Preventative work is
being undertaken with younger siblings of these young people to support them in making safer choices for themselves.

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

- We need to build up a better local problem profile drawing on all available data including information on children placed in Royal Greenwich by other local authorities. This will enable us to target services more effectively.
- Services should be focussed around the child and it is important that where young people have a number of different risk factors there is a well co-ordinated response and young people do not feel overwhelmed by the numbers of professionals involved.
- We need to extend our focus to include children who go missing from education.
Safeguarding disabled children
Joan Lightfoot, Head of Integrated Support for Disabled Children, RBG Children’s Services

Disabled children are some of the most vulnerable that we work with. We are determined though not to limit their opportunities, to realise their ambitions and fulfil their potential. The reforms of the Children and Families Act, the Care Act 2014 and the SEND Code of Practice support this through person-centred work with children, focussing on their aspirations, involving them and their parents in planning for the future.

We continue to involve disabled children and their parent in commissioning services. They were involved in the re-commissioning of the Speech and Language service and short breaks services. The Disabled Children’s Board supports this work.

We have focussed on Preparing for Adulthood and held a partnership event in October to gain wider engagement in improving the lives of disabled young people and collaboration between services for children and services for adults.

We have continued to develop our short breaks offer through our commissioned providers. Having a break from caring, whilst knowing their children are safe and happy is important for families and can help relieve tensions. We have been able to increase the number of activities available, especially for children and young people with the most complex disabilities.

We are reviewing care packages systematically to ensure that the support provided is meeting current needs. As a result we have completed more children and family assessments than in previous years.

The Children with Disabilities Team (CWDT) has strengthened links with special schools and health partners to share information to identify concerns at an early stage.

We have continued an on-going programme of safeguarding disabled children training for staff at Willow Dene and Charlton Park Academy. We have also trained foster carers to increase their understanding of safeguarding disabled children.

Our new SEND Key Working Team provides ‘hands on’ support for families with a child (0-18) with complex needs. This Team provides early help for families and support for Social Workers in understanding how to interact and communicate with children who have little verbal communication.

We have trained school SENCOs and provided guidance for them in considering the social needs of children when preparing profiles for Education, Health and Care (EHC) Plans.

One of our priorities is to prevent the need for residential schooling which results in children being cared for outside of their community. We have worked with the small number of families whose needs have not been met by the usual support available. An in depth person-centred approach has enriched our assessments and improved planning for these children.

How have we made a difference for children?

By gathering the voice of the disabled child, support plans are being shaped by their views directly rather than only by the parent’s wants and needs. This means more children are having the opportunities to do the things they enjoy and learn the skills they are interested in.

Improved information sharing with our partners means we are responding in a more timely way so children are getting the help or service they need, when they need it.

What have we learned?

Parents identified a lack of suitably trained personal assistants to provide support for children. We are considering how to develop the market for qualified and experienced carers.
Whilst most parents feel that they have been able to have their voice heard in developing EHC Plans, many feel that the process could be better co-ordinated. The assessments are not always capturing all of the children's needs in a way that would improve overall outcomes.

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

At the end of the year we commenced a review of social care services for disabled children. This has not yet concluded but we anticipate that it will highlight the following areas for improvement:

- Transition from Children’s to Adults and Older People’s Services so that parents and young people know what to expect well before their 18th birthday.
- Collaborative planning for children through the EHC planning process including a greater focus on how the child’s social needs impact on their educational outcomes.
- Joint working with CAMHS to support families with children and young people with challenging needs, and develop the pool of skilled carers.
- Clarify and strengthen the respective roles of mainstream Social Workers and the Children with Disabilities Team.
- Ensure safeguarding disabled children is everyone’s business.
Making a Difference to Children & Young People in Royal Greenwich – Partner Agencies
Royal Borough of Greenwich Children’s Services
GSCB Executive Board Member: Gillian Palmer, Director of RBG Children’s Services

What did we do? Why?

The over-arching aim of Royal Greenwich Children’s Services is to improve outcomes for every child in Royal Greenwich, safeguarding and promoting their welfare by building their resilience, preventing problems from becoming entrenched and intervening swiftly and decisively to protect children when we need to. Children’s Services support children and their parents through universal, targeted and specialist services, some directly provided and some commissioned. These services discharge our statutory responsibilities. The Youth Offending Service (an integral part of Children’s Services) provides targeted intervention to divert children and young people from offending as well as fulfilling statutory partnership functions for young people who offend.

To meet the partnership’s ambitions in our Children and Young People Plan 2014-2017, this year we have continued to focus firmly on improving practice and the effectiveness of our interventions in changing children’s lives.

We have developed our local model for social work practice and being an early adopter for the social work teaching partnership has provided new opportunities for collaboration with colleagues in adult services, other local authorities and Goldsmiths University for our Social Workers to teach, learn, reflect on and improve practice. We are integrating the Chief Social Worker’s Knowledge and Skills Statements into our workforce recruitment and development activity including supervision. Our Principal Children & Families Social Worker provides professional leadership in developing direct face-to-face work with children and parents and sharing good practice across the service. Focussing on the difference for children our practice makes in improving outcomes for children is now a core part of the way we work. Improvements in our practice and performance are evidenced in the findings from quality assurance activity, performance reports and in the inspection of services for young people who offend.

We are making good progress in recruiting permanent Social Workers led by permanent leaders. Our use of agency Social Workers is below 10% for the first time in many years and we have one interim leader in children’s social care. Overall workloads are reasonable. We are working on more time being spent on face to face work with children and their parents.

Our Quality Assurance Framework (case auditing, structured observations of practice, performance analysis and team performance reviews) provides windows into our practice and its impact for children, enabling us to identify and disseminate effective practice and informs improvement actions. Increasingly, we support professional development through coaching from Professional Educators, opportunities to lead and develop the service by participating in Task & Finish Groups and learning visits to learn from other areas. We recognise the importance of informal learning within teams, across different parts of the service and promote learning from case reviews. We continue to provide good quality
practice placements and experience for students, many of whom join us as Newly Qualified Social Workers who receive support through our new Assessed & Supported Year in Employment (ASYE) programme. We are very proud of our care leavers who have joined the service as apprentices, working in “the family firm”.

We have worked to strengthen the voice of children and young people in shaping services by the way we engage children in everyday, direct work and in assessments, plans and decision-making that affects them. We value feed-back from parents and carers about how we can work more effectively with them to achieve change for children. Each month we do a telephone survey of service users’ views about our service. We held our first Care Leavers event and through the Belongings Project have improved the engagement of care leavers in how we develop and improve our services.

Our Multi-Agency Safeguarding Hub (MASH) arrangements have been strengthened by a dedicated Education Officer who provides strong links to schools, the behaviour and attendance service, school admissions and other school facing services. The new Early Help Practice Manager role and their links to the MASH has improved capacity which will help us improve step down from children’s social care to a Team Around the Child.

We have continued to promote the local offer for disabled children and implement the changes in how we assess and plan for disabled children with a strong emphasis on to enabling parity with their peers. Education, Health and Care Plans are helping us put children’s achievements, ambitions and capabilities at the centre of the Plan.

We have focussed this year on young carers and have worked with colleagues in adult services to develop a better understanding of the needs of our young carers, put in place a strategy and improvement plan that gets the balance right between children’s rights and welfare, and what they do to help with the emotional or practical care of someone in their household.

**Youth Offending Service in Children’s Services**

We were delighted that the inspection of our services for young people who offend found that our youth offending service has achieved a step change and is performing well within a strong partnership of services that place the young person and the safety of children and the wider public at the centre of what they do. Our focus on working as a partnership at all levels to tackle gang related offending including sexual exploitation and abuse, serious violent offences and drug related crime was judged to be sound and having impact for children.

The Youth Offending Service is building on its Restorative Justice work to use restorative approaches to conflict resolution. The response to young people whose behaviour is sexually harmful has been strengthened. A key practice development has been to learn from others about how underlying trauma driving offending behaviour has to be identified and addressed.

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

![Image](image-url)

*“Greenwich is a great place to grow up.”*  
We want every child, living in a great borough in a great capital city, to be able to take full advantage of the opportunities available. Some children will need more support and, for them, every day matters and every action counts.

Early help is effective in preventing problems escalating and requiring a referral to children’s social care. Over the year more children have been supported through early help and just 10% have needed to be referred to social care. There is a greater likelihood of re-
referral where a lead professional and Team Around the Child arrangement are not in place prior to step-down and the parent is not engaged in an agreed plan.

Thresholds are well understood overall although the fit between the referrer’s concerns and threshold for children’s social care is much closer for referrals from schools than from other agencies. The rate of referrals to children’s social care increased by 9%. This has led to a 7% increase in the rate of children’s social care assessments. This represents an increase in referrals that did not meet the threshold for children’s social care assessment.

Timeliness of assessments has improved with 80% (74% last year) of assessments being completed within 45 working days. Differential performance between teams is pulling overall performance down and is being addressed. The rate of children with Child Protection Plans has reduced, the average duration of Child Protection Plans has reduced and the number of children with repeat Child Protection Plans where the previous Plan ended within 2 years has reduced. Fewer children became the subject of applications to the court and the average duration of care proceedings has reduced. Overall risk is being managed more effectively. We have been exploring whether too many children are subject of child protection enquiries as the rate has increased and is relatively high. There is a continuing downward trend in the number of looked after children (see section on Looked After Children).

What have we learned?

Improving the quality of social work practice is leading to more effective interventions and better management of risk.

For some cohorts of children it is more difficult to secure sustained change. This is either because of the difficulties in achieving sustained change in parenting behaviour or because of the embedded patterns of behaviour shown by young people who have already had experiences that have had an adverse impact on their health, development and on how they think, feel, handle relationships and behave.

What do we need to do better?

Breaking the cycle remains a real challenge. We will continue our focus on improving practice:

- More good, timely assessments leading to plans that are specific about what needs to change for the child within a timescale that meets the child’s needs.
- More and more effective direct work with children and their parents.
- Better planned and supported step down from social care which sustains change for children.
- Improving outcomes for specific cohorts of children including children who go missing more than once and are at risk of exploitation, children whose behaviour is sexually harmful, children who have been sexually abused, children who enter the care system late in childhood, trafficked children, children living with ‘the toxic trio’.

Example of effective practice: Impact Reviews

Impact Review, led by Safeguarding Group Leaders, help practitioners with the most complex and stuck cases. Cases are presented by Social Workers and their Team Leaders who have a forum to discuss their views about the case, what needs to change for the child and how that might be best achieved. The meeting provides reflective space to look at whether all aspects of the child’s needs, parenting capacity and wider family, environment and community factors have been considered. The approach is systemic in looking at the whole world around the child. The social work team is enabled to learn by considering the effectiveness of previous interventions and the type of further work with the family. As a platform to improve practice, the aim of these reviews is to think collectively about how we can break the cycle of neglect, ensure consistency of thresholds and evaluate interventions.
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 to 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.

Making a Difference to Children and Young People in Royal Greenwich

Following the successful MARAC workshop, where 40 staff members attended, we continue to promote and ensure staff from Adults Services attends training on supporting children and their families to raise their awareness and enhance their professional development and skills.

Raising awareness of domestic abuse and its effect on adults with additional needs and children continues to be a priority. In 2015 we held 13 multi-agency workshops across the borough, led by the Safeguarding Team, on the MARAC process to raise the profile of domestic abuse and the impact on children – 160 staff from a variety of agencies including AOPS, health, education and housing attended.

AOPS advocates that all organisations, which employ staff or volunteers to work with children or vulnerable adults, should adopt a consistent and thorough process of safer recruitment. A multi-agency safer recruitment and safer organisations toolkit has been implemented with input from the GSCB and the voluntary sector.

Continued improvements for Children with disabilities

The transitions team has been successful in improving the experience of disabled children, their families and their carers during the transition from children’s services to adult’s services. The team has provided better understandings of the transition pathway and families report they have found it beneficial to have a central point of contact for advice and support.

The Community Learning Disability Team (CLDT) offers assessments and support to service users who are not eligible for assessed services but who are vulnerable and in need of support as parents. The Team commissions Advocacy in Greenwich to undertake work with parents who have learning difficulties or a learning disability.

We have developed new Good Practice Guidance for staff on assessing and supporting disabled parents.

Learning and Development

The MeLearning is very popular and well used resource and with the implementation of the Care Act 2014 and Children and Families Act 2014 we have jointly commissioned new courses. AOPS continues to encourage staff to attend multi-agency training regarding protecting children and young people. In 2015 we organised two events in partnership with the GSCB specifically on safeguarding children, early help, MASH and young carers. These were facilitated by trainers from the GSCB and staff from children’s social care and we had around 40 members of staff in attendance.

Supporting families with Nil Recourse to Public Funds

The Nil Recourse to Public Funds (NRPF) Team continues to play a key role in identifying children who may be in need or at risk. Their links with the Home Office and the use of the national NRPF Connect database helps increase the speed with which cases awaiting immigration decisions are resolved, leading to greater certainty for families. The database makes it possible to check if families are known to more than one borough, ensure
children are identified and linked into education and health. This prevents vulnerable children slipping through the net and has the potential to identify trafficking and abuse. An officer from the Home Office sits and works alongside the Team two days a week.

What we have learned and continue to develop

We need a better understanding of the needs of young carers (Care Act 2014 and the Children and Families Act 2014), assessments should have “the whole family approach”. We also need to ensure we are taking ‘take reasonable steps’ to identify young carers.

In respect of young carers, Section 1 of the Care Act 2014, alongside Section 96 and Section 97 of the Children and Families Act 2014, offers a joined up legal framework to identify young carers and parent carers and their support needs. Both Acts have a strong emphasis on outcomes and well-being.

The Care Act 2014 sets out five aims of co-operation between partners which are relevant to care and support, although it should be noted that the purposes of co-operation are not limited to these matters.

The five aims include:

- Promoting the well-being of adults needing care and support and of carers;
- Improving the quality of care and support for adults and support for carers (including the outcomes from such provision);
- Smoothing the transition from children’s to adult’s services;
- Protecting adults with care and support needs who are currently experiencing or at risk of abuse or neglect and identifying lessons to be learned from cases where adults with needs for care and support have experienced serious abuse or neglect.

Within transitions there continues to be a need for better understanding of the Mental Capacity Act and assessing capacity within Children’s Services to aid the transition process and ensure a resilient approach for young people reaching the age of 18.

Together the Children and Families Act 2014 and the Care Act 2014 create a new comprehensive legislative framework for transition, when a child turns 18 (MCA applies once a person turns 16). The care needs of the young person should be at the forefront of any support planning and requires a co-ordinated multi-agency approach. Assessments of care needs should include issues of safeguarding and risk. Care planning needs to ensure that the young adult’s safety is not put at risk through delays in providing the services they need to maintain their independence, well-being and choice.

Very few adult safeguarding referrals come via Children’s Service and there is a need for increased awareness, especially in light of the Care Act guidance and revised pan London guidance on adult safeguarding.

There are on-going discussions about how adult services and children’s service can complement each other by delivering joint safeguarding training, especially around ‘making safeguarding personal’ and transitional work.

There are good links between the Adults Safeguarding Board and the GSCB and agreements about shared areas of focus for future joint work.
Lewisham and Greenwich NHS Trust
GSCB Executive Board Member: Meredith Deane, Divisional General Manager, Children and Young People’s Services

What did we do? Why?

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 Royal Greenwich. The FNP is offered to all first time teenage mothers.

How have we made a difference for children?

Staff continue to work closely with the hospital based Pre-birth Social Care Team to safeguard unborn children. This ensures that risks to babies, other children within the family and vulnerable adults are identified and appropriate care and safeguarding pathways are put in place at the earliest point.

All first time teenage mothers are offered the FNP Programme. This preventative two year programme uses evidence based behaviour change methods to support first time young parents to adopt healthy lifestyles. FNP specialist nurses use an intensive structured home visiting programme to support young families to provide warm and nurturing parenting.

The Maternity Safeguarding Pathway has been updated to ensure that unborn babies, children and their families who could benefit from early support are identified as soon as possible.

Training has been delivered to high risk areas such as maternity services, sexual health and emergency department (ED) staff to raise awareness of Female Genital Mutilation (FGM) and new mandatory reporting requirements since October 2015. The Trust completes monthly data submission of identified FGM in line with national guidance. The Trust is the second London Trust to implement the national Child Protection Information Sharing (CP-IS) system. This system will ensure that children who are subject to a Child Protection Plan, are looked after or an unborn baby subject to a Plan will be highlighted using an alert. Maternity, ED, Children’s Outpatients, sexual health services and children’s in patient’s services across LGT will all be using the system. This system will ensure that mobile families moving across regions and borders will be highlighted to staff in unscheduled care settings.

Connect Care, a virtual patient record system went live in September 2015 and enables staff to view restricted aspects of patient records from Royal Greenwich GPs, Royal Greenwich adult and children’s social care, Oxleas mental health records and electronic record systems within LGT.

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

The Safeguarding Children Policy has been reviewed to reflect integration of safeguarding services in line with local and national guidance.

We offered a weekly safeguarding training programme focusing on key safeguarding issues such as Child Sexual Exploitation (CSE), FGM and domestic abuse in 2015-2016. The programme is updated regularly to reflect learning from research, national and local Serious Case Reviews (SCRs).

Annual combined Adult and Children Safeguarding newsletter distributed to all staff raised awareness of FGM, domestic abuse and CSE.

LGT Safeguarding meetings use a Learning and Improvement Framework to share good practice from Inspections and SCRs to benchmark LGT practice.

Referrals to children’s social care are sent via secure email which resulted in more timely information sharing. Outcomes of referrals are routinely monitored in weekly safeguarding meetings.

Safeguarding Supervision is available to all key case load holders including Midwives,
School Nurses, Health Visitors, allied Health Therapists and sexual health services.

Improvements in maternity services around routine enquiry regarding domestic abuse, FGM, mental health issues and vulnerabilities has improved early identification and early help for families using LGT services.

Evidence for and evaluation of effectiveness

The number of early help assessments and referrals to 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. This includes increased referrals for those who are at risk of FGM, domestic abuse and CSE.

The Trust has a strong governance structure, with a Safeguarding Operational Group, Safeguarding Assurance Group and the Adult and Children and Young People Safeguarding committee which is chaired by a Non-Executive to provide objectivity and rigour.

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

Children’s Safeguarding leads have been working with Greenwich CCG and Greenwich Public Health Teams to improve and develop domestic abuse services. An IDVA is in post on QEH site supporting those experiencing domestic abuse.

The Trust contributed to the Self-Harm Steering Group to improve understanding of self-harm and how best to support young people.

Views of parents/ carers/ children/ young people

Friends and Family test has been introduced across all of the CYP areas and feed-back 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 Children’s Complaint leaflet is available across sites.

Multi-language posters on domestic abuse have been developed by maternity services.

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

What have we learned?

- Maternity Safeguarding Pathway has been extended across three boroughs.
- Improved collaboration with Adult Safeguarding Team provides a stronger Safeguarding Assurance Framework across LGT.

What do we need to do better?

Improve children’s engagement and feed-back

- Extended domestic abuse services across all sites.
- Support staff with Early Help Assessments.

Example of effective practice

Improved links with Adult Safeguarding Team to provide a safeguarding assurance framework which:

Thinks Child, Thinks Family and Thinks Adult
NHS Greenwhich Clinical Commissioning Group
GSCB Executive Board Member: Diane Jones, Director of Integrated Governance

What do we do and Why?
NHS Greenwhich Clinical Commissioning Group (GCCG) is a membership organisation which brings together general practice to commission health services for children and families living in Royal Greenwhich. GCCG is responsible for commissioning hospital, community healthcare and mental health services for the Royal Greenwhich population, and although not directly responsible for commissioning GP practices and other primary care services, it has a duty to support improvements in the quality of primary medical care in the local area. GCCG is committed to safeguarding and promoting the welfare of all children and young people living in Royal Greenwhich. This remains at the heart of all its commissioning, planning and decision making and the GCCG has continued to work with all commissioned providers to ensure they understand their role in health and well-being of all children accessing their services. The GCCG has a statutory responsibility to ensure that all organisations from which it commissions services have systems in place that keep children safe.

How have we made a difference?
2015-2016 NHS GCCG successfully recruited to all designated safeguarding professionals roles for safeguarding children and looked after children on behalf of the local health system. They played an integral role in all parts of the commissioning cycle, ensuring that safeguarding children is firmly embedded within the wider duties of all provider organisations across the health system.

The GCCG currently funds two health professionals in the Multi-Agency Safeguarding Hub (MASH) and they contribute to multi-agency information sharing and analysis within the MASH, making it quicker to respond to children’s needs.

GCCG is a statutory partner of the Greenwich Safeguarding Children Board and its sub groups. The Director of Integrated Governance is a member of the Executive Board and Designated Nurse for Safeguarding Children contributes to the various subgroups work streams.

GCCG is represented on the Health and Well-Being Board by the Chief Officer
GCCG has worked with GSCB to ensure that all health recommendations from the published Serious Case Reviews were implemented and learning embedded in practice.

GCCG is represented on the Corporate Parenting Board by the Designated Nurse for Looked After Children. GCCG has ensured that looked after children, especially those placed out of the borough have their health assessments and this is monitored at contract meetings.

GCCG does not currently commission primary care but has a duty to support quality and improvement to the service, so therefore designated safeguarding professional’s co-ordinate and support the Level 3 safeguarding training delivered by the Named GP to local GPs and practice nurses.

GCCG have ensured that commissioned providers are meeting their responsibility through quarterly monitoring of safeguarding metrics and attendance at their safeguarding committees. These meetings provide safeguarding governance/ assurance and risks are reviewed. This also provides the GCCG the opportunity to challenge safeguarding children practice across the health economy.

NHS England (NHSE) carried out a safeguarding deep dive assurance of GCCG in order to obtain full and thorough view of children’s and adult’s safeguarding as part of GCCG assurance. The deep dive considered the well led component of assurance as well as the performance component, utilising the Safeguarding Accountability and Assurance Framework. GCCG was assured on all the domains except work force which has limited assurance. This report has been considered by the GSCB.
What do we need to do better?
GCCG will need to work with commissioned smaller providers and seek assurance from them around their Section 11 compliance.
GCCG to work with local GP practices to ensure they contribute to multi-agency audits throughout the year.

GCCG to seek assurance from NHSE with regards to the whole of primary care and their safeguarding processes.
Appoint to the Designated Doctor role.

Example of good practice

- GCCC has set up the Named and Designated safeguarding professional forum to provide opportunity for local safeguarding children professionals to network, share reflective learning and identify any safeguarding issues.
- The GCCC developed a safeguarding newsletter to disseminate information across the local health economy.
Oxleas NHS Foundation Trust
GSCB Executive Board Member: Stephen Whitmore, Executive Director of Children and Young People’s Directorate

What we did? Why?

Oxleas NHS Foundation Trust delivers a wide range of health services in the Royal Borough of Greenwich including mental health (adult and child), learning disability (adult), health visiting, school nursing, community paediatrics, paediatric therapies and other community based services for both children and adults.

This year Oxleas welcomed a new Director of Nursing and Executive Lead for Safeguarding, Jane Wells, a new Head of Safeguarding Children and a new Named Nurse for Greenwich. During this period of embedding new personnel we are pleased to report that there were no lapses in our contribution to the various GSCB sub groups, work streams and GSCB multi-agency training.

In May 2015 the role of the Oxleas MASH Health Professionals’ was reviewed. A rota system has now been instigated whereby the MASH Health Professionals and the Greenwich Safeguarding Specialists rotate in and out of the MASH. This has been well received by our multi-agency colleagues in the MASH who have developed closer working relationships and an understanding of the wider Safeguarding Team. The Greenwich Safeguarding Team now all have first-hand experience of working in the MASH and can give informed, expert advice to our frontline practitioners who may be seeking guidance on making a referral to children’s social care and need support in understanding or challenging the referral threshold.

The Oxleas Safeguarding Children Policy and Procedures were revised this year. The section on Managing Allegations against Staff was updated in the light of Working Together 2015 and other government guidance/recommendations; we have added sections on FGM, CSE and Radicalisation/Prevent. In addition we have strengthened the emphasis on the early identification of need and referral to Early Help and the use of the Royal Greenwich ‘Protocol for assessment and threshold guidance’ to determine if a referral to children’s social care is indicated.

How have we made a difference to children?

The Trust’s vision for safeguarding children as set out in Oxleas Safeguarding Children strategy is that safeguarding and promoting the welfare of children is embedded across every directorate and in every aspect of the Trust’s work.

We have worked very hard this year to raise awareness about FGM across all our Service Directorates. On 31st October 2015 the mandatory reporting duty for regulated professionals in health, social care and education came into force. In anticipation of this and the change in law and guidance we developed an FGM action plan at the beginning of the year. Some of our achievements as set out in the plan have been: an FGM information sharing protocol was agreed between health visiting and midwifery services; the health visiting service will now make enquiries about FGM at routine universal service contacts; the health visiting service will identify school age girls with a ‘family history of FGM’ to the school nursing service. The Oxleas Intranet has a FGM page with all the recent government and health guidance and links to the NHS Choices FGM website and Department of Health FGM resource package. We have incorporated FGM into our Level 3 in-house safeguarding training; practitioners can also access FGM e-learning through the Oxleas Learning Centre, we have identified groups of practitioners for whom this learning is essential.

We have paid particular attention to ensure that practitioners working in Adult Mental Health services are aware of their duty to record and respond to cases of FGM in women and know what they should do if they suspect a child of their client is at risk of FGM.
Oxleas CAMHS and school nursing service made a significant contribution to the development of the GSCB Self-Harm Protocols which will be launched later this year. The protocols have been developed in response to national and local concerns in relation to the incidence of self-harm amongst school age children in addition to the lessons learnt from the Serious Case Review Child T. School nurses now have a clear process and pathway for responding to cases of self-harm. In addition to this work CAMHS have delivered a programme to support school nurses in their response to the general emotional needs of young people.

The Trust-wide Oxleas Safeguarding Champions Forum was held in June 2015, it was attended by 37 Champions from Royal Greenwich who represented a range of adult and children’s services. The GSCB Business Manager gave a presentation on the work of the GSCB and the priorities for the coming year, a wide range of subjects were covered in some very thought provoking presentations which included: FGM, CSE, Prevent and Neglect. Our Greenwich Consultant Paediatrician gave some useful insight into the use of stress positions as a form of physical chastisement and the potential for harm to a child. This presentation was given to Royal Greenwich Social Workers at a lunch time learning session this December, it was very well received and repeat sessions will be arranged for the coming year.

Oxleas has shown consistent compliance to date with Safeguarding Children training. This shows compliance at January 2016 as

- Safeguarding Children Level 1 97.9%
- Safeguarding Children Level 2 94.3%
- Safeguarding Children Level 3 Core 90.7%
- Safeguarding Children Level 3 Specialist 92.5%

This year e-learning packages on FGM and CSE were added to the Oxleas Learning Centre.

In recognition that universal children’s services needed to improve responses to domestic abuse a Specialist Health Visitor for domestic violence and abuse was appointed at the beginning of the year, April 2015. Part of the remit of the post holder has been to develop a training programme targeting Health Visitor and School Nurse Teams. The programme included: understanding domestic abuse; assessing risk; safety planning; making a MARAC referral. It looked in some detail at the emotional and physical impact of domestic abuse on a child at differing stages of their development. Time was also given to developing the skills required to make enquiries about domestic abuse, a lack of confidence in asking difficult and sensitive questions and knowing how to respond can be a barrier to the identification of domestic abuse. To date 67 Royal Greenwich practitioners from school nursing and health visiting have undertaken the programme. The programme has been amended so that it can be used for Adult Mental Health services this coming year. It was recently piloted with the Adult Mental Health Champions and was well received.

**Example of engaging with children and young people**

In August 2015 Oxleas CAMHS launched its Headscape website. Headscape has been designed for young people, by other young people in Royal Greenwich to give them a trusted website to use for information, to check how they feel and even take a test to find out if they need help with their emotions.

Headscape is a ‘one stop’ source of self-help about a range of mental health issues for young people to browse at leisure. Uniquely, Headscape offers young people the opportunity to independently undertake a mental health screening questionnaire, which when completed, provides individually tailored advice and information. Depending on the results, the site can offer young people living in Royal Greenwich and Bexley the option to self-refer directly into their local CAMHS.
We piloted Headscape in Royal Greenwich with the support of School Nurses and two local schools. Although analysis is at an early stage, by December 2015, the site had received 7376 visits, with nearly 800 completions of the screening tools, resulting in 25 referrals.

What do we need to do better?
This year saw the merger of our 3 electronic record systems (known as RiO), the development of this new system is complex and on-going. A significant challenge for Oxleas this coming year is to ensure that this system supports safeguarding children practice in all its elements.

Example of effective practice
This year we have continued to expand our network of team-based Safeguarding Children Champions and now have 55 champions who promote safeguarding children practice within their teams in Royal Greenwich. We have also improved support to them in their role with the establishment of a Greenwich borough based forum which is in addition to a highly evaluated Annual Learning event.
What did we do? Why?

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 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. 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 we investigate Sudden Unexplained Death in Infancy, under what is known as Project Indigo.

The team responsible for Royal Greenwich is run by DI David Williams. CAIT works 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.

How have we made a difference for children?

We place 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.

The CAIT provides 24/7 cover throughout the MPS. Experts are on duty at all times that can provide an improved service and deal with incidents as they arise. With this approach we are able to provide the best response to all vulnerable children, at all times. In addition there is a daily meeting chaired by Senior Management Lead 7 days per week with senior manager leads responsible for CAIT’s in which all new allegations of crime are scrutinised to ensure correct action is taken and children safeguarded.

The Continuous Improvement Team review crimes on a daily basis, identifying children on a CP Plan, incidents that may be critical, or outstanding suspects that are identified as an enhanced risk. Any crime not managed in accordance with the victim charter is flagged to the unit Detective Inspector to ensure we continue to fulfil our commitment to victims of crime.

On a local level the Royal Greenwich team continues to work with children social care to safeguard children and provide positive outcomes. Two examples include the successful prosecution and sentencing of two perpetrators of abuse, a male who was sentenced to 18 years imprisonment for multiple counts of rape in May 2015 and a step-father who has recently received 12 years for multiple counts of rape against his step-daughter.

The DCI represents CAIT on the Board and the DI attends the GSCB Business Group. Members of CAIT attend different GSCB work groups and are involved in multi-agency audits as well as in the delivery of multi-agency safeguarding training.

What have we learned?

The Sexual Exploitation Team (SET) set up by SOECA in February 2014 has made a good start to addressing the increasing problem of
Child Sexual Exploitation and the difficulty in investigating this area of crime. These reactive/proactive teams are still recruiting and evolving to ensure the safety of those most at risk.

The Regional Historic Investigation Team (RHIT) that was implemented last year has seen some good results in complex investigations. Having a dedicated unit to deal with complex historic allegations within Royal Greenwich and across the South Region has enabled a growth of expertise in this area and enabled the CAIT to focus on current crimes. This model is now being implemented in the West Region.

The Independent Review into the Investigation and Prosecution of Rape in London by Dame Elish Angiolini DBE QC has been published. The Metropolitan Police Service has responded and all the recommendations are currently subject to multi-agency working groups looking at 3 main strands of CPS, Investigations and Havens. This is an area of work that is on-going.

We know that in Royal Greenwich the use of physical chastisement by parents/carers is a significant issue as this is reflected in the high number of cases that CAIT deal with. In order to address this we initiated a preventative project together with members of the GSCB Schools work group.

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

Over the past years high profile cases in the media have raised public awareness of child abuse. In turn the CAIT team has seen a particularly high increase in work load. Not only increase overall in each crime type, but a rise in historic allegations, which are often protracted and therefore require more resources. This has had an effect on officer availability to deal with day to day referrals.

The Senior Management Team have secured an increase in staff workforce across the command to address the rise in crime allegations and a series of recruitment campaigns are underway across the region to fill the positions. In addition, the South Region has implemented a Regional Historic Investigation Team to manage complex and historic allegations of crime across Royal Greenwich and the whole south regional boroughs to ensure consistency and allow CAITs to focus on the investigation of current allegations of child abuse.

**Crime Totals (April 2015 - 31 January 2016)**

Total offences reported for Royal Greenwich and Bexley has stayed steady from last financial year. Although there has been a 10% increase in the number of incidents that are reported to CAIT.

Rape allegations have increased by 31% (from 32 to 42).

Violence with injury offences have decreased by 13%.

Serious Sexual Offence has stayed level.

Child Cruelty has seen a very slight decrease.

**Sanction Detections** (where a person is charged, cautioned, issued with a summons, formal reprimand or final warning. Where the offence is taken into consideration by the courts, or a fixed penalty notice is issued in relation to a notifiable offence.)

Royal Greenwich and Bexley CAIT has seen an increase in the sanction detection rate and is currently the highest performing CAIT in the MPS.
What did we do? Why?

Greenwich Borough Police are committed to safeguarding children and young people throughout the Royal Borough as part of the Borough’s Senior Leadership Team structure as the Safeguarding Children Lead, within the Criminal Investigation Department.

How have we made a difference for children?

A focussed response regarding children involved in gangs – the Violent Organised Crime Unit (VOCU) work falls broadly into two categories: children being recruited into gangs who go on to be missing from home or care and children becoming victims of gang-related violence or intimidation. The VOCU also works closely with Greenwich Police’s Missing Persons Unit (MPU) to identify missing children suspected of gang involvement and ensure that they are fully debriefed. Over the past few years this work has significantly reduced the number of children who go missing through gang activity. This is now rarely seen on a daily basis where it was once a significant issue.

VOCU chair the monthly Serious Youth Violence Panel which incorporates a multitude of organisations who work with and support young people who have become involved in gangs, assessing potential gang risks to any siblings and providing support options to parents and carers. This panel has been 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.

Using their experience of the safeguarding issues associated with gang involvement, the VOCU has driven awareness both throughout organisations within the Borough, across London and nationally in holding a number of conferences with partners such as a County Gangs Summit with NHS Greenwich Clinical Commissioning Group.

This shared focus across the organisations within RBG to safeguard children involved in gangs and combating gangs overall enabled Greenwich Police to set up the Tackling Gangs Strategic Meeting with senior partners across the Borough coming together to discuss strategies to combat gangs. The police co-chair this meeting and lead on revising the Borough’s gang strategy.

Multi-Agency Safeguarding Hub (MASH) and Youth Offending Service – police officers within the MASH team now work closely with children social care, health, housing and the MPS Child Abuse Investigation Team, delivering proven early intervention. The MASH allows fast time 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.

Two MASH open days were held delivering training to outside agencies and internal partners; a multitude of agencies attended and were represented, with over 100 participants gaining a valuable insight into the practical working of the MASH team. Between February and December 2015 the MASH police team processed 13205 child notifications.

The Youth Offending Service (police) are also within close proximity to the MASH, forming a strong partnership working between YOS police and YOS Safeguarding and social care ensures 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 CSE within the Borough; a CSE workshop was delivered jointly with RBG in January 2014. Clear reporting pathways were identified and a structure for referrals developed to assist partners.

Greenwich Police Missing Persons Unit received training in CSE investigation and developed this into 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/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 VPCs 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.

**Project Mosaic** – working with the Faith Communities to enhance youth safety

This year the project has hosted a number of training evenings for faith leaders designed to increase their knowledge of youth safety issues on the borough including:

- **Child Safeguarding** – covering child protection and safeguarding responsibilities for those running youth groups. It also covered how the public sector bodies involved in Project Mosaic would respond to referrals made by faith leaders about a vulnerable child.

- **Violence against Women and Girls (VAWG)** – focusing on domestic violence and FGM and provided advice and guidance on these matters. The aim was to help faith leaders identify those in their community who may suffer from these issues, where to seek support and the police response to such issues.

- **Faith and Gangs** – a full day conference went into more depth on this topic and various faith leaders discussed their own experiences of intervening with members of their community to steer individuals away from such activity. Specialist police officers from the VOCU briefed delegates on the extent of gang activity in the borough so faith leaders are able to give an accurate and informed picture of events to their community.

Future events will focus on VAWG, including honour based violence and CSE. We are also working with partner agencies to host a Youth Question Time event which will give young people the opportunity to question senior figures around issues which are important to them.

**What have we learned?**

Partnership working is key to the success of the work that we do. Through communication and strengthening our existing working relationships with agencies and establishing new ones, we are able to safeguard children more effectively as information is shared.

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

We need to continue to build on our successes to date, continue to work cohesively with our safeguarding partners improving each other’s knowledge and continue jointly to educate the Royal Greenwich residents of the importance of safeguarding.
What did we do? Why?

The role of the new National Probation Service (NPS) came into existence on 1st June 2014 following a programme of reform. NPS responsibilities include the following:

- The Offender Rehabilitation Act 2014 came into force fully on 1st February 2015. This made a number of changes to the sentencing framework, most notably changing the law so that all offenders released from short prison sentences now receive 12 months of statutory supervision and assistance with their resettlement back in the community.
- NPS manages offenders who pose a high/very high risk of harm to the public many of whom are subject to Multi-Agency Public Protection Arrangements (MAPPA). NPS advises the Courts by preparing pre-sentence reports, determining allocation of cases between the Community Rehabilitation Companies (CRC) and NPS as well as manages Approved Premises, delivers victim liaison services and other bespoke interventions, for example sex offender treatment programmes.
- The NPS has a statutory duty to safeguard children and promote their well-being. At the first point of contact with an offender we explore their social and family circumstances. In line with the Service Delivery Model, there are instances where information requests can be made to children’s social care (CSC) departments as part of fulfilling our safeguarding statutory duty. Given our presence in the Courts, NPS is well placed to identify children that may be at risk and offenders who pose a direct risk of serious harm to them.

Partnership Arrangements

The NPS engages with a number of local partnership working arrangements and have agreed protocols relating to participation and information sharing. The NPS is also a key statutory partner with Local Safeguarding Children’s Boards. One of our key priorities as part of that board is to comply with Section 11 (Children Act 2004) which places duties on Probation to ensure our functions and any services that we contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. This includes appropriate vetting levels of all staff and on-going safeguarding training. We continue to remain committed to this agenda.

The NPS play an active role in contributing to the MARAC, MASH, MASE and the troubled families’ agenda. We remain committed to ensuring that staff are fully trained in managing domestic abuse cases and high risk domestic abuse perpetrators. A Probation Officer is seconded one day a week into the local MASH and a full time Probation Officer is seconded into the local YOS.

How have we made a difference for children?

The NPS does not work directly with children, but Probation staff do come into contact with children and families during the course of their work with offenders. Evidence indicates that outcomes for children of offenders are often not as good as those of their peers. Through our work with a parent/ carer to support
desistance from offending we are improving the life chances for their children. Probation Officers are encouraged to undertake more home visits and to get to know the family to embed the “think family” approach.

Any child safeguarding concerns are promptly followed up; Probation Officers can make valuable contributions to the effective assessment of a child’s needs. NPS can represent the statutory sector, given its regular contact with parents convicted of criminal offences.

**Next Steps**

The NPS remains committed to working with partnerships to improve outcomes for children, safer recruitment principles and the professional development of the workforce.

The HMIP inspection in 2014 reinforces areas of improvement, to undertake routine checks with CSC, incorporate actions into offenders’ sentence plans and be more proactive in assessing the likely impact on children of any change in an offender’s circumstances. This will be integral to NPS’s pan London Business Plan.

NPS’s current priorities both locally and nationally include delivering on-going training for practitioners and managers. To imbed effective quality assurance processes, implement a new audit tool and contribute to the development of the National Performance and Improvement framework on safeguarding children.

All performance and quality work surrounding safeguarding children continues to be via our senior leadership team meetings and performance and quality sub groups.
What did we do? Why?

Representation and Engagement

GAVS has remained fully engaged with the GSCB and continued to ensure that key messages from the GSCB are disseminated to community groups to ensure that children in Royal Greenwich are better supported and safeguarded. GAVS’ Development Officer for Children and Young People chairs the GSCB’s Communication and Engagement Work Group in addition to being a member of the Executive Board, Business Group, Learning and Development Work Group and the Quality Assurance Work Group. The voluntary sector is also represented on the Toxic Trio Work Group.

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 its capacity building role, GAVS has continued to support local groups to develop and update their safeguarding policies and procedures as well as their work practices. This has included ensuring that their paid and volunteer staff are aware of their responsibilities for safeguarding and promoting the welfare of children, how they should respond to child protection concerns and make a referral to local authority children’s social care or the police if necessary.

In partnership with Charlton Athletic Community Trust (CACT), GAVS has delivered a number of training sessions for voluntary groups and has continued to promote and encourage take-up of GSCB multi-agency training.

We have encouraged and supported voluntary organisations to participate in multi-agency audits, GSCB surveys and events. For the first time this year the voluntary sector also took part in the new Section 11 audit process developed by the GSCB. Voluntary organisations played a key role in supporting the GSCB’s campaigns on self-harm and e-safety by organising training sessions or disseminating information.

Gangs and CSE Project

GAVS is implementing the second phase of a Gangs/ CSE Project supported by children’s social care. Phase 1 completed in June 2015 consisted of a voluntary sector mapping exercise to find out how the issues were being dealt with in the sector. Following this work GAVS has worked with Community Safety and the Lead Professional for CSE from children’s social Care to develop training on “Understanding Exploitation of Young People” for targeted groups in the community, including faith groups. This training focused on all forms of exploitation. Work has also been undertaken to help groups with funding applications to further support for young people at risk and ensuring that safeguarding policies and procedures take into account issues related to gangs and CSE.

How have we made a difference for children?

The voluntary sector working with children and young people are better informed about key issues in safeguarding, although we need to ensure that information and training is being accessed by all workers in the sector, including volunteers. Our work with BME groups in particular has ensured that they are
aware of the particular issues impacting on children and young people from these communities and how to keep them safe.

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 risk inherent in the activities and roles of groups. Some roles often require little more than an introductory talk about what the role demands and what the organisation hopes to gain from it. Others may need more complex policies and procedures in place as well as on-going training to ensure a safe environment for children and young people.

What do we need to do better?

GAVS has committed to delivering training on behalf of the GSCB to voluntary organisations who struggle to access courses during the day or who experience difficulties accessing training proportionate to their roles. But we need to strive to continue to make sure that all organisations have access to information appropriate and relevant to their needs and will be working closely with GSCB and The Safe Network to develop best practice guidance for voluntary organisations and to deliver Safer Organisation training as part of our on-going support to the sector on safeguarding.

Example of effective practice

Young people attending one of the groups hosted by Charlton Athletic Community Trust reviewed the Trust’s Anti-Bullying Policy. This was an important process for CACT. This was done by the young people hosting a workshop to review the content and suggest revisions so it was relevant to young people. Members of CACT staff were present but the workshop was very much led by the young people. The workshop helped to update the content of the current policy and make it real to young people who it is aimed at.
Housing Services
GSCB Executive Board Member: John O’Malley, Head of RBG Community Housing Services

What did we do? Why?
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. Through the Housing Options & Support Service information, advice, support and statutory assessment services are provided for households who are at risk of homelessness, which includes families, young people and victims of domestic violence. Advice and support services are provided to residents in private sector housing and a Landlord Accreditation Scheme has been developed with the aim of improving standards in the sector.

How have we made a difference for children?
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 advice and casework support. We are the only local authority to have achieved 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 Housing Options & Support Service 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:

- Ensured that no families with children stay longer than 6 weeks in shared temporary accommodation.
- Ensured that Royal Greenwich has lower levels of families in temporary accommodation and accepted as homeless than in the majority of London boroughs.
- Prevented households from becoming homeless through casework support provided by the HOSS or funded partner agencies.

Appropriate Housing and Support for Families and Young People

Through our Allocations Service and the HOSS Families and Young People’s Team advice, assessment, support and rehousing services are provided for families in need. Despite the housing demands which includes over 16,000 households on the Housing Register, we continue to prioritise those families and vulnerable young people that are most in need, so that families in severe overcrowding were rehoused into suitable accommodation; families who were under occupying their properties were rehoused into suitable alternative 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. Since implementing joint assessments in an integrated service centre we have reduced the number of young people (16-17) approaching as homeless, and have ceased the use of temporary accommodation for this age group.

In order to address the housing and support needs of young people and other vulnerable groups, the Housing Service has established clear pathways with protocols with housing associations and support providers. These protocols ensure that supported housing and floating support services are targeted appropriately to meet needs and includes agreements that the Housing Service will allocate housing to people moving out of the schemes. On the basis of these protocols
young people including care leavers and other vulnerable households in supported housing schemes were rehoused into suitable properties.

The Housing Service manages a budget of 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. There is regular monitoring and reviews of the provision and reporting requirements have been established, 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 in place to ensure early help is offered to prevent homelessness and provide support for families, young people and children. Teams participate and contribute to: Child Protection Plans, Case Conferences, Team Around the Child and Team around the Family meetings; agreeing plans to meet the housing needs of families, looked after children and care leavers.

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 (CRP) of senior managers, which considers cases of urgent housing need and determines whether a rehousing priority should be awarded. The CRP takes account of information and advice from partner agencies and will provide urgent assistance, for example where there are safeguarding concerns or risks associated with domestic violence. In addition, Housing Service staff participate in the Multi-Agency Safeguarding Hub and the Assistant Director is a member of the MASH Strategy Group.

Housing Service is represented on the GSCB work groups where they contribute to training delivery, multi-agency audits and awareness campaigns.

Supporting Families affected by the Welfare Reforms

A specialist Welfare Reform Team has been established to co-ordinate the provision of advice and support for families affected. The team have proactively identified and contacted families offering advice and support including on: housing and employment options; budgeting; assistance with childcare.

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. In addition, the Housing Service has been working with Registered Providers (Housing Associations),
assisting them with the implementation of policies and practices, relating to safeguarding, which includes ensuring that information on safeguarding is communicated to their staff. The Housing Options & Support Service which provides our statutory homelessness service and support services for a wide range of groups, including families and young people, has achieved national recognition for the quality of its practice.

The Homelessness Strategy 2014-2019 sets out key Safeguarding objectives and actions and it is our intention to include them in our other key plans and strategies.

Following the GSCB Section 11 audit, the Housing Service identified strong areas of preventative work such as in the Families and Young People’s service within HOSS, with a good understanding of safeguarding arrangements shown in many other areas of the service. In response to the audit, the Housing Service established a ‘Keeping Children and Adults Safe’ steering group with management and staff representatives from a range of services. This group has developed a shared work plan which features key actions such as: developing specialist safeguarding training for particular groups of housing staff; redesigning our intranet pages to feature local safeguarding arrangements and whom to contact for advice; reviewing job descriptions to ensure safeguarding duties are explicit responsibilities for staff; developing shared objectives within staff PRAD’s to address safeguarding learning and action. The work of the group will continue during 2016-2017, to ensure that we have an on-going focus on improving practice.

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

There has been a significant level of organisational change over the last six months which has seen a number of key staff and managers leave the service. These changes mean that the awareness and knowledge of safeguarding in some teams will be reduced and it is intended that through the ‘Keeping Children and Adults Safe’ steering group, we will identify priority areas of improvement. We recognise, for example, that there is a continuing need for bespoke training and information on safeguarding for non-specialist staff and this is an area that we intend to address in 2016-2017.

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**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 includes through The Point one stop shop for young people, where dedicated housing advice and support is provided. 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 more safely live in their home.
What did we do? Why?
The Greenwich Community Safety 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 and 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 the children and young people’s risk of radicalisation.

How have we made a difference for children?
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. Following on from our learning last year, DVIT officers have continued to work in plain clothes.
- Commissioning a programme for changing the behaviour of perpetrators of domestic violence who are willing to cooperate. This was available throughout 2015-2016.
- 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: [www.gdva.org.uk](http://www.gdva.org.uk)
- Continued to lead a domestic violence campaign during 2015/2016. The campaign aims to tackle attitudes towards DVA, to improve reporting and to inform those involved in DVA about how to obtain help. The latest stage of this campaign focused on the impact of DVA on children.
- Produced and distributed fact sheets to professionals about the different elements of VAWG.
- Chaired the VAWG Strategic Partnership. Meetings of this partnership have received presentations from members of the DVA User Group about their views of available DV services in the borough. As a result work has been undertaken to understand how Social Workers can improve their response to mothers who are victims of DV.
- Convening and supporting the Multi-Agency Risk Assessment Conference (MARAC). This prioritises the safeguarding of children and young people and informs children’s 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.

All of the above has contributed to meeting the first, second and third 2015-2016 priorities of the GSCB (i.e. those aspects that relate to Domestic Violence and VAWG (with specific reference to trafficking and FGM)).

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 2015-2016 to improve their knowledge and understanding of gangs in Royal Greenwich and highlight the interventions and services that are available.

All of the above has contributed to meeting the first 2015-2016 priority of the GSCB (“Address the challenges and risks to children from ….involvement in gangs”).

PREVENT and Radicalisation

A Home Office funded PREVENT Co-ordinator is based within the Safer Communities Team. Their 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 36-41 of the Counter Terrorism and Securities Act 2015 set 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 Royal Greenwich since 2011. The panel is chaired by the Royal Greenwich Safer Communities Manager and co-ordinated by the PREVENT Co-ordinator 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 co-ordinates 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 Dedicated Safeguarding Leads. The remainder of teaching staff on the borough have been encouraged to use an online self-training package.

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 Co-ordinator. 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 into extremism; workshops to explore the dangers associated with travelling to conflict zones and grooming/radicalisation.
All of the above has contributed to meeting the first 2015-2016 priority of the GSCB (“Safeguarding and promoting the rights of the child in relation to ……abuse and exploitation linked to faith, culture or belief including radicalisation.”)

What have we learned?

VAWG, including Domestic Violence

We have learned that programmes to change the behaviour of Domestic Violence perpetrators are generally unable to work with those individuals who are unmotivated to change, which is the majority of perpetrators in the borough. We also suspect that those who are motivated to change are those individuals who present some of the lowest risk. As a consequence the programme we have commissioned in the Royal Borough is not reaching sufficient numbers of perpetrators nor those perpetrators we most want to target.

Gangs and Serious Youth Violence

The Gangs Link Worker is essential to ensure someone is available in the borough to offer advice and guidance to frontline workers on appropriate actions when they suspect a young person is involved in gang activity.

The Gangs and Serious Youth Violence training has been essential for promoting effective intervention for gang affiliated young people.

Many St Giles staff have had personal involvement in gangs in the past. This gives then much greater credibility than other professionals are able to gain with young people involved in or at risk of gang involvement.

PREVENT

We’ve shown that one of the keys to having a successful Prevent programme in such a diverse, fast-changing, dynamic place is to have a wide range of varied activities. The challenge in the future will be to continue to do that at a time of drastically-reduced funding.

What do we need to do better?

VAWG, including Domestic Violence

We need to encourage partners to develop their response to types of VAWG other than DV that affect children and young people, namely FGM, trafficking, stalking, honour based violence and forced marriage.

Gangs and Serious Youth Violence

We need to work with the community and voluntary sector in RBG to improve the ability of staff and volunteers to identify early, prevent and detect gang related crime, peer on peer abuse and exploitation in community contexts.

PREVENT

We need to reassure professionals and the public that the PREVENT strategy, and the CHANNEL Panel in particular, is effective in terms of addressing concerns about radicalisation whilst at the same time applying appropriate proportionality and sensitivity.
GSCB Lay Members
GSCB Executive Board Members: Tracey McLevy and Harinder Pardesi

What do we do? Why?
Both Tracey and Harinder are becoming experienced Lay members of the GSCB and Communication & Engagement Work Group, having joined the board in 2014.

Harinder comes from a background in education, having worked in various roles throughout her career, including as Headteacher for over 25 years. Currently, she works with the Royal Greenwich based charity “MOSAC”, which offers support and services to non-abusing parents and their children as an Advocate and Help-Line Volunteer. She promotes the training of the Board and works to raise its profile.

Tracey comes from a legal background, having practised as a Barrister over 20 years and now specialises in Family and Children work, particularly public law proceedings. Tracey’s second child arrived in June, and was the youngest attendee at November’s GSCB Annual Conference! She continues to attend various early years and educational setting within the Royal Borough, where she promotes the work of the Board and works to raise its profile.

Both are residents of the Royal Borough of Greenwich and share a passion for and commitment to making an active contribution to the safeguarding of children within Royal Greenwich and the wider community.

How have we made a difference for children?
We believe that our unique knowledge base and independence has enabled us to continue to make valuable contributions to the strategic work of the Executive and the Communication & Engagement Work Group, through discussion, exploration and where appropriate challenge.

We are also active in the reviewing role of the Board meetings, in all areas including the reports relating to Serious Case Reviews and reports of the Work Group, as well as more recently, reviews of the Board’s structure.

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

We have been active in reviewing the GSCB website and the online resources, especially the section relating to Parents & Carers. We help with reviewing the content of the Board’s newsletter and give input to the campaigns as they arise, including the current Self-Harm Campaign.

Harinder, with other Board members, attended the Great Get Together, a community day aimed at promoting the work of the board and gathering community views. This gave the opportunity to capture, first hand, the views of parents, carers, children and young people on a range of safeguarding issues, to help establish the priority for the next campaign.

As a trained ‘PitDA’ (Parenting in the Digital Age) facilitator, Harinder has run parents’ sessions with some primary schools and the HER Centre on ‘Authoritative Parenting in the Digital Age’, as a part of the GSCB’s e-safety campaign.

What have we learned?
Our learning continues to grow through attendance at and contribution to the Executive Board Meetings, Communication & Engagement Work Group and Development Days as well as participation in partnership meetings, i.e. BME Forum and Children and Young People’s Forum.

As a result of our participation at meetings throughout the year with individuals and teams, we have increased our knowledge and awareness of the wide range of issues affecting children and young people in Royal Greenwich and have better understood how partnerships and involved organisations are working together to promote safeguarding of children and young people in the Statutory and voluntary sectors in Royal Greenwich.
We have contributed to the evaluation of GSCB multi-agency training. Between us, we have attended and observed further courses, including: Safeguarding Children across Culture & Faith, Child Abuse Linked to Faith or Belief, Radicalisation and The Voice of the Young Person with additional attendances at the Annual Conference and GSCB Development Sessions.

Training on the Youth Participation seminar enabled Harinder to re-focus and concentrate on how to hear the 'authentic voice of the young person', and work continues on the issue of child trafficking to which Tracey had input via a Task and Finish group.

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

We hope in the year to come to continue to improve our efficacy as Members 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 through our growing knowledge base and strengthening networks and understandings.

Lay members will be part of the challenge sessions with agencies following the S11 audit process.
Essential Information

Approval Process:

<table>
<thead>
<tr>
<th>Approval Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Final Draft agreed at GSCB Business Group</td>
<td>March 2016</td>
</tr>
<tr>
<td>Final Report received and agreed at GSCB Executive</td>
<td>28th April 2016</td>
</tr>
<tr>
<td>Final Report received by Children’s Trust Board</td>
<td></td>
</tr>
<tr>
<td>Final Report received by Cabinet</td>
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</table>

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
As a member of the London Group of Local Children's Safeguarding Board Chairs we are disappointed that the Metropolitan Police continues to choose to fund partnership safeguarding in London 45% less than all the other large urban Metropolitan Police Forces in England. The guidelines which we adhere to (Working Together 2015) makes it clear that funding arrangements for Safeguarding should not fall disproportionately and unfairly on one or more partner to the benefit of others. In London this burden does fall unfairly on Local Authorities because the Metropolitan Police does not provide rational or reasonable levels of funding to local safeguarding boards.

We acknowledge that the Safeguarding structures in London are due to change in the next two years. When they do there will still be a need to resource whatever arrangements are put in place. The Police are a key partner in the future arrangements for safeguarding and we ask that the Metropolitan Police and The Mayor’s Office for Policing and Crime increase their funding to a level which is fair to the other partners and which will assist in keeping London’s children safe.

<table>
<thead>
<tr>
<th>Income</th>
<th>Budget</th>
<th>Actual</th>
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<tbody>
<tr>
<td>Royal Greenwich</td>
<td>£119,990</td>
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</tr>
<tr>
<td>CCG</td>
<td>£59,823</td>
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<tr>
<td>Schools</td>
<td>£21,750</td>
<td>£21,750</td>
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<tr>
<td>Oxleas</td>
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<td>£14,956</td>
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<td>L&amp;G NHS Trust</td>
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<tr>
<td>Police</td>
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<tr>
<td>Probation</td>
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<tr>
<td>CAFCASS</td>
<td>£550</td>
<td>£550</td>
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<tr>
<td>London Fire Brigade</td>
<td>£500</td>
<td>£500</td>
</tr>
<tr>
<td>Total contributions</td>
<td>£239,726</td>
<td>£239,726</td>
</tr>
<tr>
<td>Training income target</td>
<td>£5,000</td>
<td>£17,737.00</td>
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<tr>
<td>TOTAL INCOME 2015-2016</td>
<td>£244,726</td>
<td>£257,463</td>
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The GSCB budget has ended 2015-2016 in a good position with an underspend of £74,177. This was mainly due to two vacancies within the GSCB over the financial year and the income generated through the training programme. The GSCB will recruit to these vacancies during 2016/17.

<table>
<thead>
<tr>
<th>Expenditure</th>
<th>Allocated Budget</th>
<th>Actual end of year</th>
<th>Variance</th>
<th>Notes</th>
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<tr>
<td>EMPLOYEE COSTS</td>
<td>£166,900</td>
<td>£107,614.04</td>
<td>-£59,286</td>
<td>Underspend due to two vacant posts over the year</td>
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<tr>
<td>SUPPLIES &amp; SERVICES</td>
<td>£69,550</td>
<td>£54,659</td>
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<tr>
<td>Corporate overheads</td>
<td>19,170</td>
<td>19,170</td>
<td></td>
<td></td>
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<tr>
<td>Staff Advertising</td>
<td>0</td>
<td>200</td>
<td>200</td>
<td>Advert for Business Support officer</td>
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<tr>
<td>Travel Expenses</td>
<td>360</td>
<td>74.4</td>
<td>-285.60</td>
<td></td>
</tr>
<tr>
<td>Catering (Training)</td>
<td>0</td>
<td>211.2</td>
<td>211.20</td>
<td></td>
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<tr>
<td>Printing</td>
<td>1,500</td>
<td>544.94</td>
<td>-955.06</td>
<td></td>
</tr>
<tr>
<td>Professional Fees</td>
<td>31,940</td>
<td>9,750.00</td>
<td>-22,190.00</td>
<td>Independent Chair fees</td>
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<tr>
<td>Serious Case Reviews</td>
<td>0</td>
<td>1,906.14</td>
<td>1,906.14</td>
<td></td>
</tr>
<tr>
<td>GSCB Training</td>
<td>16,000</td>
<td>19,731.59</td>
<td>3731.59</td>
<td>Overspend includes GSCB conference and L&amp;D activities</td>
</tr>
<tr>
<td>Totals</td>
<td>£236,450</td>
<td>£162,273</td>
<td>-£74,177</td>
<td></td>
</tr>
<tr>
<td>Appropriation to Reserves</td>
<td>£95,190</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2 - Agency Attendance at GSCB Executive Meeting

Attendance by agency (in %)

- Public Health
- Children & Family Court Advisory
- Voluntary Services
- Lewisham & Greenwich NHS Trust
- Oxleas
- Greenwich Clinical Commissioning Group
- Borough Police
- Child Abuse Investigation Team
- Schools
- Community Safety
- Probation
- Youth Offending Services
- Lay Members
- Housing
- Adult's Services
- Children's Services
- Independent Chair

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

The majority of attendees (35%) were from the Children’s Services and the Third Sector (14%). During the year there has been a major increase in representation from schools with significantly more attendees from Housing and Adults’ Services. 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).
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
• training of people who are in contact with children or their families
• recruitment and supervision of people who work with children
• investigation of allegations concerning people who work with children
• safety and welfare of children who are privately fostered
• co-operation with neighbouring children’s services authorities (i.e. local authorities) and their LSCB partners.

2. Communicate the need to safeguard and promote the welfare of children and participate in local planning.

3. Undertake a Serious Case Review where abuse or neglect of a child is known or suspected, a child has died, or been seriously harmed, and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

4. Review the deaths of all children who are normally resident in their area and put in place procedures to ensure that there is a co-ordinated response by relevant organisations to an unexpected death of a child.

5. Monitor and evaluate the effectiveness of what is done by partners individually and collectively to safeguard and promote the welfare of children and advise them on ways to improve. This should include as a minimum:
   • assessing the effectiveness and impact of the help being provided to children and families, including early help
   • quality assuring practice, for example through joint audits of case files involving practitioners and identifying lessons to be learned

6. Assess whether Board partners are fulfilling their statutory obligations under Section 11 of the Children Act 2004 and parallel duties and asking Board partners to self-evaluate.

7. Monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.

8. Produce and publish an annual report on the effectiveness of safeguarding and promoting the welfare of children in the local area. The purpose of this report is to ask whether safeguarding arrangements are working, and if not, why not. It should provide local partners and the public with a rigorous and transparent assessment of the performance of local services. Once published the annual report should be submitted to the Chief Executive and Leader of the Council, the local Police and Crime Commissioner and the Chair of the Health and Well-being Board.

How does the GSCB hold partners to account?

The GSCB does not commission or deliver services. Each Board partner retains their own existing line of accountability for safeguarding. While the GSCB does not have the power to direct other organisations, the GSCB is committed to making it clear where improvement is needed.

The GSCB holds organisations to account through Serious Case Reviews, multi-agency case audits, reports to the GSCB, 1:1 meetings with the Chair, Section 11 reports, and review of the local multi-agency performance framework. Areas requiring improvement and action needed to address risk will be formally agreed and reviewed at the GSCB Executive Partnership Meetings. In order to support multi-agency engagement, the GSCB Business Group monitors attendance and partners’ contribution to GSCB Work Groups and training via twice yearly reports from the Business Manager. Any difficulties will be reported to the GSCB Executive Partnership Board.

Governance Arrangements

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 (including Participation JCG, Family Support JCG and Children with Disabilities JCG)
- Safer Greenwich Partnership (including 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
- GCCCG – 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 Business 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 focused 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 Business Group** is the forum whereby the Work Group Chairs and key representatives from voluntary sector, health, police and Children’s Services will:

1. Monitor GSCB Business Plan including Work Group and Thematic Group activities
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. Agree and monitor the Multi-Agency QA and Audit programme
5. Identify and address cross-cutting themes including:
   - Capacity
   - Ownership
   - Engaging children, young people and families
   - Diversity
   - Forward Planning
   - GSCB priorities
6. Identify development needs for the effective functioning of the LSCB
7. Set the Agenda for the GSCB Executive Partnership
8. Identify lessons to be learned from SCR’s conducted locally, regionally and nationally
9. Produce the Annual Review of Safeguarding report

The Business Group will meet eight times per year and will be chaired by the GSCB Independent Chair.

**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 Business 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
- Quality Assurance
- Communication and Engagement
- Toxic Trio
- Health
- Schools

**Strategic Partnership Groups** sit within the Governance of other strategic partnerships but report into the GSCB Business Group as they maintain strategic oversight of specific issues related to safeguarding children. They will report into the Business Group as indicated. A report on the activity of the Thematic Groups will be presented to the Executive Partnership at least annually.

The Thematic Groups include:

- Missing Children
- Children with Disabilities

**Professional Support to the GSCB**

In order to meet the demands of the work plan the GSCB has a Board Manager, 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