NHS
North East London

Title: NEL Safeguarding children 2022-23

Subtitle: – Annual reports at place

Click to add name of place based partnership (if required)

Contents

Executive summary

1.0 Introduction

1.1 ICBs have a statutory duty to safeguard children as set out in Working Together to Safeguard Children (2018) statutory guidance. The NHS England Safeguarding Assurance and Accountability Framework 2022, clearly sets out safeguarding roles and responsibilities which apply to all ICBs. ICBs are required to set out how they have discharged duties in relation to child safeguarding in their annual report. This is the second safeguarding children ICB annual report for North East London.

1.2 As set out in Working Together to Safeguard Children 2018, ICBs are responsible for the provision of effective clinical, professional and strategic leadership in child safeguarding, including the quality assurance of safeguarding through their contractual arrangements with all provider organisations and agencies, including independent providers. The link to the NEL ICB's confirmatory statement that demonstrates that statutory assurance processes have been implemented in accordance with the Safeguarding Accountability and Assurance Framework, 2022:

NEL Safeguarding children declaration March 2023

1.3 This summary outlines how the ICB has discharged its duties in relation to safeguarding babies, children and young people. In addition, it incorporates the learning from national reviews and inquiries, legislative changes as well as national safeguarding priorities.

2.0 National review and panel report and independent inquiry recommendations

2.1 National reviews & incidents

- Arthur Labinjo-Hughes aged six years and Star Hudson 16 months old, were two children who were tragically murdered by the caregivers in 2020. The children lived in different parts of the country and the cases rightly caused national outrage being widely reported in the media. Both had experienced significant abuse and neglect were known to professionals and yet the safeguarding system had been unable to keep them safe from harm.
- In December 2021, the Secretaries of State for Education, Health and Social Care, the Home Office and Justice requested that the inspectorates carry out a Joint Targeted Area Inspection (JTAI) in Solihull, following the murder of Arthur Labinjo-Hughes. The JTAI looked at how all local agencies in Solihull worked together to respond to the identification of initial need and risk to children. www.gov.uk/government/news/government-action-following-murder-of-arthur-labinjo-hughes
- The National Safeguarding Practice Review Panel was commissioned to undertake a review into both child deaths in January 2022. The national panel also published a report following the tragic deaths of Star Hudson and Arthur Labinjo Hughes.

2.2 Dissemination of Learning to the system

- Shared via presentation and discussion at the NEL BCYP forum with an audience of a cross section in excess of two hundred health and care professionals in September 2022. The keynote speech was provided by the National Deputy director for safeguarding from NHSE.
- Key actions for the ICB were shared with the NEL QSI via the safeguarding exception highlight report in July 2022.

- Ongoing learning is shared via the LSCPs and associated sub-groups across the NEL footprint.

2.3 Some of the key messages for health system learning are:

Multiagency Safeguarding Hub (MASH)

- Improving the effectiveness of Health MASH provision (resource & model)
- Improving information sharing within MASH by ensuring access to health information
- Health involvement in decision making within MASH
- Health participation in strategy meetings.
- Promote the use of chronologies and genograms within health records.
- Introduce multiagency reflective practice.
- Need to understand gaps in our understanding of information sharing.
- Clarity about the distinction between child protection & safeguarding.

Leadership and Culture

- Leaders have a responsibility to create working conditions to support complex work.
- There is a need to ensure: clarity of vision; responsibilities and resource; robust governance and a culture of learning, improvement and challenge.
- There should be clear management oversight of complex safeguarding work, supported by reflective supervision for practitioners.

Wider Service and Multiagency Context

- A failure to trigger statutory, multi-agency *child protection* processes.
- A rapidly evolving safeguarding agenda has overshadowed the need for sharper, *specialist* child protection skills and expertise.
- There is a need to refocus on child protection through an *expert led, multi-agency model* for child protection investigations, planning, interventions and review.

Systems and processes

- Agencies should work together to understand the lived experience of children
- There should be clear processes in place to support information *sharing* and information *seeking*, within and between agencies.
- There is a need to develop *critical thinking* and *challenge* within and between agencies.

- Practitioners should address the impact of *domestic abuse* and understand the needs of children whose parents are in prison.

2.4 NEL System response

- Designated Nurses at place were tasked with developing and driving improvement plans at place.
- AD for safeguarding children met with the national health facilitator for safeguarding reforms for the DHSC and has continued to be a member of the regional MASH Group.

- AD for safeguarding children briefed NEL QSI and SMT in May & July 2022.
- MASH assurance and quality improvement has been incorporated into reporting templates at place and system level.

- Designated nurses at place are members of the MASH Steering Groups at place and are working with safeguarding partners and Borough directors on quality improvement and resourcing issues.
- Quarterly reporting to NHSE via Governance Heat maps keeps the issue visible.
- There are ongoing conversations with safeguarding partners regarding involvement of health in strategy discussions. Audits and appropriate reporting/data capture are under consideration with the use of appropriate escalation encouraged.
- The role of health agencies and professionals is captured in a seven-minute briefing which will be accessible to safeguarding partnerships and from NEL intranet & website from Q1 in 2023/24 to raise awareness among safeguarding partners.
- There is ongoing engagement with Place based partnerships regarding key issues requiring transformation and quality improvements such as MASH.
- NEL MASH self-assessment of the consistency of funding, resourcing, staffing, governance and data sharing across Multi-Agency Safeguarding Hubs (MASH) was undertaken in Q1 of 2022/23. The information from the audit will be used to profile NEL risks and reported in the NHSE ICB safeguarding governance heat map reports. Furthermore, to enable greater scrutiny the national safeguarding case tracker is being populated with information regarding Children Safeguarding Reviews (CSPRs), Rapid Reviews (RRs), Safeguarding adult Reviews (SARs) and Domestic Homicide Reviews (DHRs).

2.5 Child Q – CHSCP Practice Learning Review

This review was published in March 2022 https://chscp.org.uk/wp-content/uploads/2022/03/Child-Q-PUBLISHED-14-March-22.pdf

Child Q is a high-profile Local Child safeguarding practice review (LSCPR) regarding a 15-year-old girl of mixed race, who attended a local school in Hackney. The LSCPR provided significant learning nationally as well as for NEL. Adultification and racism were some of the key lessons learnt by the system. Child Q was not seen as a vulnerable child and professionals did not think of safeguarding her first, neither was she treated with dignity and respect.

The publication of the review triggered a high-profile media response as well as local community disharmony and protests outside Stamford Hill Police Station. Child Q is currently receiving support from Young Hackney, CAMHS and Education. There is a 3-phase plan response around Child Q, which is overseen and monitored through the City of London and Hackney Safeguarding Children Partnership (CHSCP) Board. The immediate plan involves supporting child Q and her family, listening to communities, working with schools, demanding cultural change across organisations and supporting professionals working with children and families and issues raised in the initial responses to the report. The longer-term plan is around tackling structural racism across all of our institutions, including health, and thinking about how we do that together, as an ICB.

2.6 Outcomes

- The Partnership action plan is in place from the LSCPR. CHSCP Board overseeing its implementation of actions.
- Racial disparities, Adultification and anti-racist practice are now features of LSCP dashboards and metrics across the NEL footprint.
- There has been greater scrutiny of stop and search data from policing and improvements to guidance and practice for police and education. NEL-wide dissemination of learning to the NEL EMT and Quality department in Q1. Designated safeguarding children professionals have had the opportunity to attend Adultification training commissioned by NHSE in December 2022.

3.0 Safeguarding Assurance

3.1 During the year under review, quarterly reporting and submissions to NHS England and Improvement (NHSE) continued throughout the year. Assurance was provided via governance heat maps which enabled NHSE to assure itself regarding the preparedness of the five regional ICSs for the transition to ICB. NEL has been consistently rated green during Q1- 3 of 2022/23. The heat maps are a maturity matrix self-assessment tool covering the domains of:

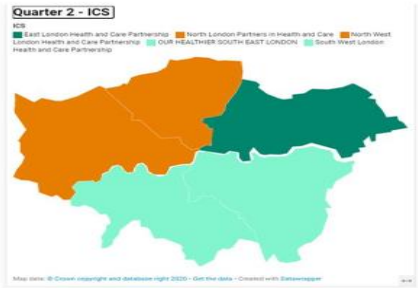
- System leadership and accountability for action on health inequalities
- Safeguarding structures and matrix working
- Appointment of a chief nurse with executive accountability for safeguarding
- Safeguarding priorities and workplan agreed
- Partnership arrangements and understanding
- Multiagency safeguarding hub (MASH) information of information sharing agreements and supervision of MASH Health Team colleagues.

3.2 In addition, reporting on the Safeguarding accountability and assurance tool (S-CAT) enabled an organisational assessment against the relevant domains within section 11 of the Children Act 2004 continued on a quarterly basis identifying areas requiring additional focus these mainly required the input of NEL communications and Human Resources departments.

3.3 Quarterly exception and highlight reports were submitted throughout the year, which enabled formal escalation of workforce sufficiency risks for both ICB and providers, Covid-related risks in relation to mental health and also risks associated with timely completion of statutory health assessments for Looked after children and adoption medicals. Throughout the year there were periodic surges of entrants into care, driven by both Covid-impacts and also the influx of refugees and unaccompanied asylum-seeking children (UASC) with related public health issues around health protection.

London Region ICB Strategic Safeguarding Governance & Assurance Development Heatmap Headlines

	Q1	Q2
Name	Rag Rating	Rag Rating
North West London ICB	AMBER	AMBER
North Central London ICB	GREEN	AMBER
North East London ICB	GREEN	GREEN
South East London ICB	GREEN	Light GREEN
South West London ICB	AMBER	Light GREEN



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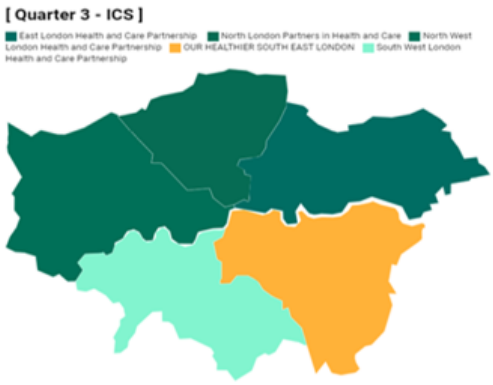
Name of Region: London

	Q2	Q3
Name	Rag Rating	Rag Rating
North West London	Amber	Green
North Central London	Amber	Green
North East London	Green	Green
South East London	Light green	Amber
South West London	Light green	Green



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4.0 Child Protection Information sharing System (CPIS) in Hackney

4.1 On 12 October 2020 Hackney Council suffered a cyberattack resulting in severe disruption to electronic systems across the London Borough of Hackney. The Council worked closely with the National Cyber Security Centre, National Crime Agency and other experts to investigate the attack and understand the impact on the council services and its residents.

4.2 **Levels of assurance and mitigation**

In June 2022 Hackney CP-IS was successfully reinstated. The CPIS connection to the NHS Spine was also reactivated for Hackney following the cyberattack on their IT system in October 2020. During the period of the outage there was full partnership engagement from the Senior Leadership Team and Hackney Executive Leads to all sub groups.

5.0 CPIS outage following a cyber-attack impacting Adastra and CP-IS systems

5.1 On the 4 August 2022 the Adastra system used by some NHS unscheduled care settings was taken offline to contain a cyber security incident at the service provider.

The settings within scope were:

- NHS 111
- Ambulance 111 Services
- GP Out of Hours services
- Local Authorities receive Access to Service Notifications (ASNs) to a greater or lesser extent. A drop in ASNs could be seen as children's interactions with impacted NHS sites could not be recorded on Adastra during the time.

5.2 Actions taken by the NEL system:

- Mapping and scoping of affected NEL systems was undertaken to identify system risks, incident management of impacted services, workforce issues, mitigation and actions that were being implemented to manage the CP-IS access issue to assure the ICB and NHSE London Region.

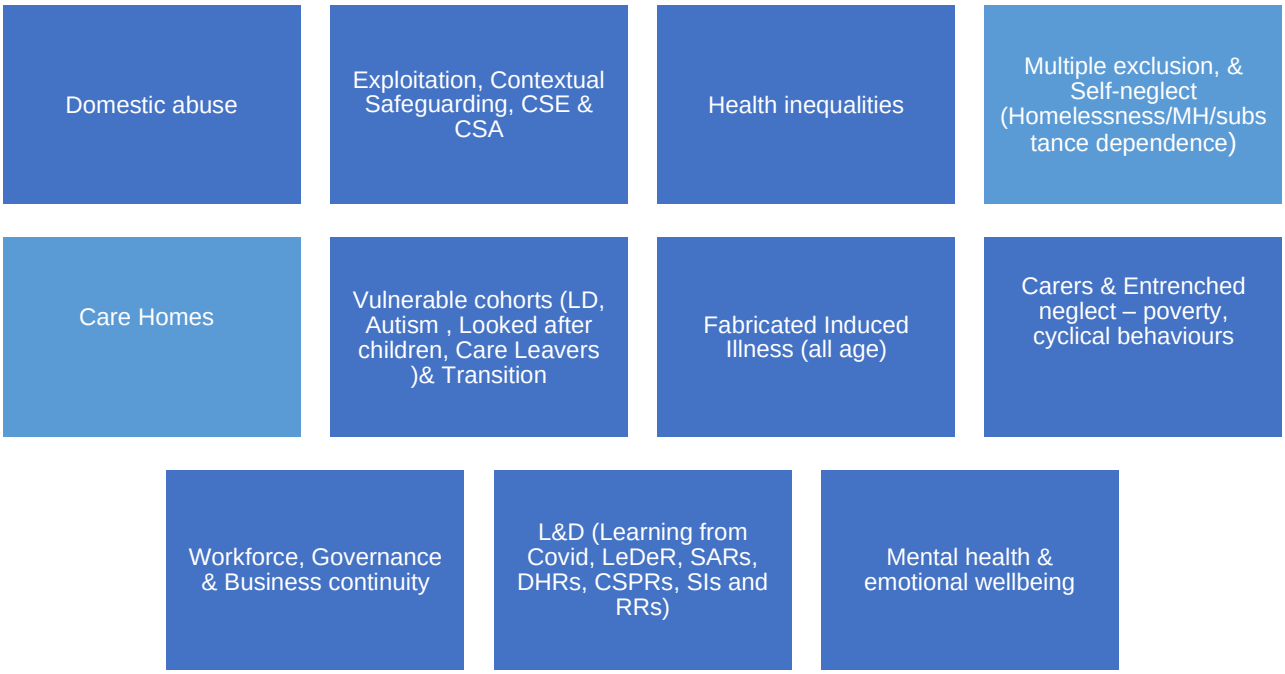
- Designated professionals assisted with the development of a risk profile for the NEL system.

6.0 NEL Safeguarding Priorities 2021/23

6.1 NEL has been part of the national Female Genital Mutilation FGM pilots for community clinics targeted at non-pregnant women. Formal Evaluation of the pilot clinics has taken place during Q3-4 of 2022/23. The final evaluation report is awaited from NHSE.

6.2 As well as borough specific responsibilities, safeguarding professionals are also allocated NEL-wide projects to support matrix working and professional development. Eleven clinical reference groups were established across the all age safeguarding team to drive forward the eleven NEL safeguarding priorities which also overlapped with NHSE safeguarding priorities. Delivery was through a programme management approach, with two portfolio leads per safeguarding priority workstreams.

Figure 1- NEL Safeguarding priorities 2021-23



7.0 Child Death Overview Panels (CDOP)

7.1 There are 2 CDOP hubs across NEL. During the year and efficiency review has been commissioned and recommendations will be implemented. The CDOP assurance meetings for the system have been established providing system oversight. These meetings and the learning from the thematic reports have identified key areas for learning in relation to sudden infant deaths (SUDIC), although learning events have occurred at place. There is a plan for a NEL SUDIC conference in Q1 -2 of 2023/24.

8.0 Multiagency safeguarding arrangements

8.1 Under the Children and Social Work Act 2017, three safeguarding partners (local authorities, chief officers of police, and clinical commissioning groups) must make arrangements to work together with relevant agencies to safeguard and protect the welfare of children in the area. The published safeguarding arrangements for each of the safeguarding partnerships within

the NEL ICB footprint some of which is reflected in their annual reports for 2021/22 can be accessed via the links:

BHR partnership multi agency children safeguarding arrangements (havering.gov.uk)

Published-2223-Safeguarding-Arrangements-.pdf (chscp.org.uk)

THSCParrangements.PDF (towerhamlets.gov.uk)

Newham Safeguarding Children Partnership Published Arrangements (newhamscp.org.uk)

new arrangements for waltham forest local safeguarding partners june 2019

Tower Hamlets Safeguarding Children Partnership (childrenandfamiliestrust.co.uk)

9.0 New Serious violence duty

9.1 The 'Serious Violence Duty' (the duty) is a legal duty on organisations/bodies to collaborate locally to work together to prevent and reduce 'serious violence'. The definition of 'serious violence' now includes domestic abuse and sexual. offences. It came into force on 31 January 2023 and specifically applies to Integrated Care Boards. The SVD statutory guidance is for specified authorities (Chief Officers of police, fire and rescue authorities, Integrated Care Boards, local authorities, youth offending teams and probation services). All ICBs are encouraged to have conversations about the Duty with relevant PCCs and Local Authorities and utilise Integrated Care Partnerships to continue these discussions.

9.2 Mandatory Products

The Strategic Needs Assessment (SNA) is a document that must be created jointly by all of the specified authorities within a local area in order to formulate a robust, common understanding of the serious violence problem within that area. Used to develop a definition of serious violence for the purpose of the Duty and inform the development of a local strategy to address the findings. The Local 'response' strategy sets out how actions will be undertaken to address findings of the SNA. ICBs need to demonstrate that they are meeting the Multi-Agency elements of providing both short-term and long- term solutions. In line with the legislation, ICBs will need to prepare this for their area by 31 January 2024.

10.0 Conclusion

10.1 The report has demonstrated how NEL ICB has fulfilled its statutory duties in relation to Safeguarding babies, children and young people, and outlines the NEL response to areas of emerging risk, including the implementation of learning from both national and high-profile cases. In the coming year the focus will be on a number of areas which include supporting the implementation of the new serious violence duty for ICBs. This will also be a focus on strengthening NEL safeguarding governance frameworks during the period post consultation, improving workforce sufficiency and resilience. We will be working closely with partners including Healthwatch to embrace opportunities to develop our NEL Safeguarding strategy.

Barking and Dagenham (B&D) Safeguarding Children Annual Report 2022/23

1.0 Introduction

1.1 This year's annual report provides a synopsis of work at place which sets out how objectives have delivered on throughout the year.

2.0 Synopsis of work at place with impact/issues/mitigations

- Four Rapid Review Meetings and four local CSPRs were initiated in this reporting period in line with statutory guidance (see section 3).
- The Early Help offer to families has been strengthened through the Best Chance Strategy (Children and Young Peoples Plan). Family Hubs are in the early stage of development and propose co-location of multi-disciplinary teams to best support children and families at the earliest point.
- The domestic abuse improvement lead has undertaken a review of the offer to both survivors and perpetrators of domestic abuse. Some of the accomplishments are a robust training offer, establishes the VAWG group meeting and the MARA steering group. There is also collaborative working ongoing across the BHR footprint.
- A SEND thematic review of alternative provision took place at the end of the reporting period. There were no actions or gaps noted for health.
- Ofsted and SEND inspection readiness preparation continues and it is expected that an Inspection of Local Authority Children's Services will be announced in the next reporting period.

3.0 Key system issues to include successes/issues/mitigations and impact

3.1 Within the 2022-2023 financial year, four new Local Child Safeguarding Practice Review's (LCSPR) have commenced where the criteria have been met, in which:

- abuse or neglect of a child is known or suspected
- the child has died or been seriously harmed.

These include:

- Child H and Child I relates to a sibling group and CSA concerns, dating back over 10 years. This was referred to the national panel and agreed that a LCSPR should be convened. The first panel meeting took place on 3 February 2023 to meet with the reviewer and agree the terms of reference. A second panel meeting is due to be held on 11 July 2023.
- Child J relates to the shooting of a 16-year-old boy who sustained life changing injuries, by a boy aged 14 years old, both residents of Barking and Dagenham. The rapid review meeting was held on 16 November 2022 and it was agreed to proceed to local CSPR, the first panel meeting was held in May 2023.
- Child K and L relates to the tragic death of two children found dead in December 2022 at home in their bed when in the care of their mother. The Joint Agency Response meeting and the rapid review meeting took place with good multi agency participation. Following the Rapid Review it was agreed that this case should proceed to a local CSPR. A meeting was held with colleagues from LB Hackney on 8 February 2023 to discuss possible terms of reference. The first panel meeting with the reviewer was held on 12 June 2023.
- Child M is a looked after child with a neurodiversity diagnosis. Concerns about how the child was managed by the Met Police in relation to her transfer to a custody suite from her placement were escalated and a serious incident notification was submitted to BD LA/SCP. The Rapid Review meeting was held 5 April 2023 with agreement to proceed to a LSCPR.

3.2 The designated nurse for safeguarding children joined the BD Youth Justice Board in 2022. This has allowed improved oversight into the health needs of vulnerable young people who have offended and are going through the court system or are at risk of offending.

4.0 Priorities for the coming year (2023-2024)

4.1 For the following year 2023-2024 the following priorities have been agreed by the BD SCP:

- Health and Stability of the Safeguarding Workforce,
- Mental Health and Emotional Wellbeing of our Children and Young People,
- Children with SEND and Complex Needs,
- Neglect,
- Child Sexual Abuse

City & Hackney Safeguarding children annual report 2022/23

1.0. Introduction

1.1 The Safeguarding Children Annual Report 2022/23 provides an opportunity for us in NHS NEL ICB City & Hackney, to consider how health agencies are delivering on the duty to safeguard and promote the wellbeing of all children in the City of London and Hackney as required under Section 11 of the Children Act 2004.

1.2 This report provides an update on the progress made against the safeguarding children priorities agreed in 2021/22. It also provides an overview on how we have worked with the City & Hackney Safeguarding Children Partnership and our health care providers to support our workforce and to support high quality safeguarding practice across our health and social care systems. The report concludes with a summary of our key risks, priorities and focus areas for 2023/24. A separate annual report has been written for our Looked After Children.

2.0. **Objectives for last year with an update:**

No	Objectives	Progress	Outcome
1.	To ensure safeguarding children is robustly considered as we move towards an Integrated Care Board	BCYP Workstream imbedded – Designated Professionals in C&H attend this workstream and delivered a presentation showcasing some of the safeguarding system work across NHS NEL.	Objective met
2.	To support the City and Hackney Safeguarding Partnership in delivering its priorities	SUDI Task & Finish Group chaired by Designated Nurses (C&H) to ensure latest research and learning from National Panel Review is embedded locally.	Objective met Full partnership involvement
3.	To review the new CDOP arrangements and consider how we capture the feedback from families and professionals. To advance how we implement learning at scale to enable a reduction in future deaths	This is a priority for the child death review nurse who regularly captures feedback from families. Designated nurses included in NEL ICB SUDI steering group to expand the work undertaken in C&H across the NEL footprint.	Objective met
4.	To develop and facilitate a safeguarding training programme for Primary Care Networks and neighbourhoods in order to share learning and to support GP safeguarding leads.	GP surgeries across City of London and Hackney are offered Level 3 safeguarding training sessions delivered by the Named GP and Designated Nurses. They are also invited to attend GP reflective safeguarding sessions on a quarterly basis. All sessions are well attended and well evaluated.	Objective met
5.	To continue to work collaboratively with all safeguarding leads across NELCCG and the upcoming transition to ICB to learn from and support each other and to design a safeguarding system that protects and supports the vulnerable in our population.	- Development of Clinical Reference Groups to focus on key NEL safeguarding priorities with an all age safeguarding approach. - Strengthening of place-based system meetings to ensure robust governance and procedures are in place.	Objective met
6.	To contribute to the anti-racist work that is taking place across the partnership.	Learning from LSCPR (Child Q) shared with the London and National	Objective met

		Safeguarding Children Forums. Working with local partners in line with the Systemic Trauma and Anti-Racist (STAR) approach	

3.0. **Synopsis of work at place**

3.1 The areas include:

Childhood Adversity, Trauma and Resilience (chATR) Training Learning and Development (TLD) CHSCP Sub-Group to deliver training to support and embed a partnership-wide community of practice for ACEs and Trauma-Informed Practice, building on the training offer to support the development of trauma-informed organisations and workforce.

Children Young People, Maternity and Families(CYPMF) Neighbourhood Teams Through the City and Hackney Neighbourhoods Programme we piloted work between Feb - Sept 2022 with 10 GPs and 10 Primary Schools in Hackney to increase partnership working between Primary School staff and GPs. This led to the provision of key contact directories for each agency, information sharing guidance and an overview of existing early help services.

Disproportionality in Maternity Services Hackney is one of the 3 boroughs in NEL in which stillbirths to Black and Asian women are concentrated. The proportion of babies born with low birth weight born to Black and Asian women is nearly three times as high as for White women (14% and 15% versus 5%). We have set up a Black and Black Mixed Heritage (B&BMH) maternity voices partnership sub group to work with and capture feedback from this cohort of women. We have a targeted antenatal group for B&BMH women with tailored and culturally sensitive information.

We are working with a VCS organisation on co-designing a Hackney Navigator service for pregnant women at risk of having a child removed at birth. This work aligns with the Maternal MH service OCEAN work around perinatal MH support and developing safeguarding pathways around women at risk of having a baby removed and providing support. It also aligns to the Family Hubs work around perinatal support and work to reduce substance misuse in pregnancy.

Poverty Informed Practice – Poverty Reduction Framework Webinar delivered by Hackney CSC across City and Hackney to inform and share current practice that fosters looking at poverty sentimentally, through a trauma lens, and through an anti-racist lens. Multi-agency, community and voluntary interventions into poverty shared as well as Identifying multi-agency, community and voluntary resources for children and families.

Cost Of Living Crisis Collaborative working with partnership colleagues to support families and children with the cost of living crisis. NHS NEL held a cost of living crisis workshop with Designated Professionals to scope current and future need across the system potentially impacting on the health and well-being of CYP and their families. The City and Hackney Children's Partnership also held a cost of living exceptional meeting so that partners could consider impact and share the work currently underway to support children and families.

Anti-Racist Practice CYPMF workstream collaboration continues in developing London Borough of Hackney (LBH) Anti-Racist practice. The workstream is a key partner of the newly formed Children and Education Anti-Racism Staff Reference Group. This has included contributing to the development of the Anti-Racist Practice SRG principles, as well as the

development of LBH Anti-racist practice resources and content - bringing a cross system approach to this work.

4.0. **Systems work with partners**

CP-IS - London Borough of Hackney suffered a cyber-attack in October 2020. NHS Cyber Security severed their connection to the NHS Spine which prevented CP-IS uploads and downloads. Although now reset audits continue to ensure system is robust.

SUDI – Following the publication of the Sudden Unexpected Deaths in Infants (SUDI) report, a SUDI Task Group was formed to consider local and national findings. This group initially met to map current initiatives and identify areas to strengthen the local approach. Resultant activity undertaken.

IRIS/DAIS - Domestic Abuse Training and Consultation Service commenced in 2022 and is a joint funded service by NEL CCG (C&H) and the City and Hackney Public Health Team. The service has two parts:

- Identification and Referral to Improve Safety (IRIS) model of training and advocacy for primary care. The IRIS model for primary care provides both training and advocacy for clinical and admin staff working at practices in City & Hackney.
- Early identification training for a wide range of professionals. An early identification training is offered for a wide range of professionals with a focus on those working within NHS and council services (including Hackney council and City of London Corporation) but may also include workers in the voluntary and charity sector (VCS) and external agencies such as the Metropolitan and City of London Police and the London Fire Brigade.

Delivery of CHSCP training around safeguarding children with disabilities As part of the CHSCP Training Learning and Development Programme, the Designated Nurses contributed to the delivery of this training with other delivery partners to provide a multi-agency focus.

Bespoke training session for Homerton, ELFT and BARTS Safeguarding Children Teams Designated Nurses facilitated a training session around Children Safeguarding Practice Reviews and Immediate Management Reviews (IMRs) report writing.

Bespoke reflective session facilitated by the Designated Children's Professionals to Homerton, ELFT and BARTS staff following the unexpected death of a Hackney child Unexpected death of a child with complex health and learning needs who was known to a variety of local health services. Designated Professionals facilitated a safe reflective de-brief session for staff. This was not to replace direct psychological therapeutic support for practitioners if required.

5.0 System successes

5.1 Funding was secured from NHS NEL ICB to enable Joint Fund with Public Health, two additional trainer posts within the Domestic Abuse Intervention Service (DAIS) in supporting delivery partners and voluntary services around domestic abuse. We also jointly commission the IRIS service.

Designated safeguarding children support with the procurement process of the New Health Visiting Service in Hackney

Designated safeguarding support with the procurement process for bereavement services

6.0 System learning

6.1 Case Study: Local Child Safeguarding Practice Review Child Q

In 2020, Child Q, a Black female child of secondary school age, was strip searched by female police officers from the Metropolitan Police Service (MPS). The search, which involved the exposure of Child Q's intimate body parts, took place on school premises, without an Appropriate Adult present and with the knowledge that Child Q was menstruating.

Due to the level of her distress, Child Q's mother took her to the family GP who made a referral for psychological support leading to contact with Hackney Children and Families Services (Hackney CFS).

Following a multi-agency Rapid Review, the City and Hackney Safeguarding Children's Partnership commissioned a Local Child Safeguarding Practice Review. The report and statement of the CHSCP's Independent Child Safeguarding Commissioner, Jim Gamble QPM, can be found **HERE.**
The review reflected on how adultification bias might have been evident in practice with Child Q, this can be seen in the fact that she received a largely criminal justice and disciplinary response from the adults around her, 'rather than a child protection response'
This concept is where adults perceive Black children as being older than they are. It is 'a form of bias where children from Black, Asian and minoritised ethnic communities are perceived as being more 'streetwise', more 'grown up', less innocent and less vulnerable than other children. This particularly affects Black children, who might be viewed primarily as a threat rather than as a child who needs support'
One year following publication an updated report on progress was published **Why was it me?**

7.0 City & Hackney Safeguarding Children Challenge / Risk

NO	RISK	MITIGATION/ACTION TAKEN/PROPOSED	RAG RATING
1.	Increased demand creating long waiting times for Children's Mental Health Services (inc. specialist CAMHS, Eating Disorders, First Steps & CYP Autism Assessment)	Response at NEL level via CAMHS Alliance to offset risk	
2.	There is a 0.4 WTE Vacancy for the Designated Nurse LAC Post. This post covers both the City of London and Hackney Boroughs. This is a Statutory Role. Potential to impact on Looked After Children / Care Leavers meeting their health outcomes.	Interim staff not in place due to NHS NEL Consultation which has frozen all recruitment to posts at present. Designated Nurses for Safeguarding Children currently covering urgent LAC queries in the absence of current post holder due to non-working days.	
3.	Vacant permanent post for Designated Doctor for Looked After Children. This post covers both the City of London and Hackney Boroughs. This is a Statutory role, potential impact on Looked After Children/Care Leavers meeting their health outcomes.	Interim Designated Dr for LAC current in post until August 2023 on 4 PAs. Recruitment to post currently on hold due to the NHS NEL ICB Consultation.	

8.0 Priorities for 2023/24

- To ensure collaborative working with our delivery partners across NEL ICB to ensure priority, focus and delivery of outcomes in relation to NEL Clinical Reference Groups.

- Ensure the learning from Child Q LSCPR and the recent update report is embedded within systems.
- To challenge anti-racist practice and behaviours that suppress in our day to day practice.
- To engage with delivery partners in the serious violence duty at place.

Havering Safeguarding children annual report 2022/23

1.0 Introduction

1.1 This is the second Havering safeguarding children annual l report for North East London ICB and covers the reporting period April 2022 to March 2023. The report will highlight delivery of the previous year's objectives, work undertaken at place, key system issues, and set the place-based priorities for 2023-2024.

2.0 Objectives 2022-2023

2.1 Improvement of workforce sufficiency and resilience

Following an extensive consultation in relation to safeguarding children, looked after children and safeguarding adults, a business case was approved for the separation of the safeguarding children and looked after children functions into two separate roles. This brought Havering in-line with the inner north-east London structure and created capacity within the team.

2.2 Strengthening of NEL safeguarding governance

- To strengthen the NEL safeguarding governance arrangements, the safeguarding team have undertaken the following activities:
- Review of safeguarding policies and procedures
- Representation at place-based boards
- Procurement activities
- All age safeguarding meetings
- Delivery of priorities in line with agreed clinical reference groups

2.3 Staff development

To ensure the safeguarding teams continued professional development, the following activities have been undertaken:

- Strengthening of the safeguarding supervision offer
- Attendance at national conferences
- Safeguarding supervision course attendance (carried over to quarter one of 2023/2024)
- Engagement with the national networks for designated health professionals
- NEL ICB training opportunities
- Local safeguarding board/partnership training offers
- access for routine dental assessments for Looked After Children

3.0 Work at place

3.1 **Case Review Working Group**: The case review working group is co-chaired by the designated nurse for safeguarding children and is a decision-making group for undertaking child safeguarding practice review (CSPR) and other learning events emerging from serious incidents. For the year 2022-2023, a total of four child cases were considered for a CPSP with the recommendation that one is taken for a CSPR (relating to the physical abuse of a 3-year-old child) and another forms part of scrutiny piece of work following the fatal stabbing of a teenager. In addition to this, Havering is also undertaking a joint CRSP with Barking and Dagenham in relation to a child sexual abuse case.

3.2 **Independent scrutiny of Harold Hill**: Following several fatal stabbings linked to the Harold Hill area, the independent scrutineer for Havering Safeguarding Children Partnership has undertaken a focused piece of work looking at the provision of services in the Harold Hill area. The ICB has

contributed to this piece of work and a further focused review of sexual health and mental health services is planned for quarter 2-3 of 2023-2024.

3.3 **Obesity workstream**: Havering has the highest rate of childhood obesity in the whole of London and as a result this has now become a priority for the placed based partnership. As a result, the designated nurses for safeguarding children and looked after children are working with public health on the development of an all-age healthy weight strategy. There have been several workshops in relation to this and a strategy will be published in 2023-2024**.**

3.4 **Neglect strategy**: The designated nurse for safeguarding children has developed a neglect strategy that has been adopted by the safeguarding partnership. Through the implementation of the strategy, there has been a significant increase in the identification and referral for concerns around neglect. The strategy will be taken forward in 2023-2024 focusing on early intervention.

4.0 Key system issues

4.1 **Child sexual abuse (CSA) hub**: It has been identified that there is a low level of referrals into the CSA hub by Havering despite there being a high level of child sexual abuse cases in the borough. The designated nurse for safeguarding children is working with the local authority and the CSA hub to raise awareness of the service and increase referrals. This has also been added to the HSCP risk register.

4.2 **Increase in incidence of domestic abuse**. It has been noted that there has been an increase in domestic abuse incidents in the borough and a number of potential domestic homicides are being considered. To address this, Havering have submitted a bid for the IRIS project in 2023/2024.

4.3 **CAMHS provision**. There continues to be issues around access to tier 4 CAMHS beds which is resulting in delayed discharges from hospital. To mitigate this, there is a multi-agency response to provide wrap-around support to families whilst appropriate placements are being identified. Additional concerns have been raised in relation to substantive qualified psychiatrist provision accepting the devolved medical accountability for the CAMHS.

5.0 Priorities for 2023-2024

- Embedding of learning from CSPRs
- Improvement in referral rates into the CSA hub
- Development of professional curiosity practice guidance and tools
- Bidding for IRIS project
- Further embedding of the neglect strategy
- Procurement of a NEL wide outreach service for refugee and asylum seekers
- Preparedness for statutory inspections

Newham Safeguarding children annual report 2022/23

1.0 Progress against objectives set out in 2022-23 annual report:

1.1 Support with Newham local authority children's social care inspection

- Designate nurse safeguarding children acted as single point of contact for the inspection and coordinated the health review for the children chosen to be inspected within Annex A.
- Looked after children health's services were highlighted for their excellent work with children in care and care leavers.

1.2 Support Newham LA with health MASH resource

ICB have funded a whole-time equivalent health practitioner post into Newham MASH.

2.0 Synopsis of work at place with impact/issues/mitigations

- Strengthened health response to supporting victims of Domestic Violence and Abuse, the ICB have commissioned IRIS model within Primary care and supported Newham CSC continuing to implement the Safe and Together model.
- Supported the safeguarding partnership and embedding of learning from safeguarding reviews: Co-chairing the practice quality and assurance sub-group, chaired local children practice safeguarding review for "Sadie" and "SY", chaired the stakeholder panel for a thematic review into extra and intra familial harm of young boys who have been criminally exploited and involved with serious youth violence, member of safeguarding governance boards for delivery partners and local authority.
- Newham place based board is set up and governance agreed. There has been commitment from provider, ICB and LA staff to ensure that children's voice is present and key personnel identified who can influence change if needed, this includes safeguarding and quality leads within the ICB.

3.0 Key system issues to include successes / issues/ mitigations and impact

3.1 Leads from across Newham ICB, LBN and health delivery partners met to discuss the increasing number of children presenting to unscheduled care in mental health crisis, agreed to hold weekly huddle of services leads meeting to discuss complex cases to unblock any barriers in response to the children's needs. ICB commissioned home treatment service for children, to provide intensive support for children at home to prevent crisis and need for attendance to acute services.

- DN safeguarding children and Adults have jointly supported Newham's migrant health lead within LBN Public health, due to concerns raised around the hotel's management of safeguarding concerns. ICB safeguarding leads supported a community impact assessment following notification from the Home Office docking a boat in Newham with 1000 asylum seekers and increasing capacity of asylum seeker hotels within Newham.
- NEL CSA Hub Procurement of Emotional health and wellbeing service. DNSC Newham and B+D were both panel members on the procurement of this service across NEL. This work has come from clinical reference groups which is chaired by both nurses, and ensures that the safeguarding response from the bids is robust.
- National Review –Children with disabilities and complex health needs placed in residential settings. DNSC supported LBN with this process by reviewing the children's physical, mental and medication health care plans.
- Member of perplexing presentation CRG and supported the planning of a multi-agency learning event, looking at the issues perplexing presentations bring to safeguarding systems, using case examples and expert panel.

4.0 Priorities for the coming year (2023-2024)

4.1 Newham Safeguarding children Partnership:

- Mental health
- Child Sexual abuse
- Domestic abuse
- Criminal/ Sexual exploitation

4.2 Newham Place ICB Priorities:

- Ensure a whole system response to embed learning from safeguarding cases involving children with complex mental health concerns, to access early mental health support across Newham's safeguarding partnership.
- Build on the work Newham safeguarding partnership are developing in tackling children being exploited, and ensuring that health play a critical role in responding to exploitation and ensuring children are safe, and the workforce are aware of how to respond to exploitation.
- Strengthen the relationship between the ICB safeguarding team and commissioning/ contracts leads at place, to ensure national guidance and lessons from safeguarding reviews are embedded into commissioned health services.

Redbridge Safeguarding children Annual Report 2022/23

1.0 Delivery and contribution to ICB objectives set for 2022-2023

1.1 This covered three areas:

- strengthening of NEL safeguarding governance
- Staff development
- Improvement of workforce sufficiency and resilience.

2.0 Redbridge – Work at place

2.1 Participation and engagement with Redbridge Safeguarding Children Partnership and subgroups has been consistent throughout the reporting period. This work included coordinating health responses for the child criminal exploitation (CCE) checklist and a JTAI on the Early Help offer and a CSA multiagency themed audit.

2.2 The interim Designated Nurse for Safeguarding Children and Designated Dr for Safeguarding Children completed a review of the health system children's enuresis/continence pathway in Redbridge following local learning review AJA. This included recommendations for the service.

2.3 The interim Designated Nurse for Safeguarding Children has contributed to and has been a member of the RSCP Metrics Working party for the proposed new multiagency dashboard sub group ensuring a health perspective is captured.

2.4 Child Safeguarding Local Learning Reviews: There have been two Local Learning reviews (LLR) during the reporting period. LLR Child AA found learning included multi-agency working, transition at key times in a child's life and delay in strategy meetings. LLR Child AJA identified learning in information sharing and triangulation at CAF level, the importance of 'Think Family' approach, the importance of professional curiosity and professional understanding regarding child sexual abuse and the need to understand children's lived experience. The interim Designated Nurse for Safeguarding Children carried out a review into the enuresis service and pathways following LLR AJA. The actions and recommendations from both LLR's have been achieved or are ongoing.

2.5 There were two Child Safeguarding Practice Review's during the reporting period. National Child Safeguarding Practice review (yet to be named) will be begin in September 2023 following the death of a baby who was born in January 2023. The Designated Dr for Safeguarding Children worked with system partners offering expert advice during the investigation. The incident and case were extensively reported in the national press and received high media interest. The Designated Nurse for Safeguarding Children and Designated Dr for Safeguarding Children worked with statutory partners and ICB colleagues to manage this. Local Child Safeguarding Practice Review Baby 'A' identified seven recommendations. The Designated Nurse for Safeguarding Children is leading on recommendation 6 which is to review the Redbridge Neglect Strategy and Tool Kit. This piece of work is ongoing and has involved semi-structured interviews with different agency groups for their views and contributions.

2.6 The designated Nurse for Safeguarding Children is the Co-Chair of the RSCP training subgroup.

3.0 Key system issues

3.1 **Redbridge MASH**: There is inequity of funding and staffing within the Health component of the Redbridge MASH compared to the other outer London boroughs (BD, Havering and WF) which is impacting on the ability of MASH health to perform their functions. The Designated Nurse for safeguarding Children has been supporting the Health system to strengthen the Health component. Constructive meetings have been held with managers in NELFT and benching against the outer London boroughs has occurred. An agreement of whom will provide the

necessary increase in funding has not yet been agreed between public health and the ICB. This has been escalated to the AD Safeguarding Children.

3.2 **Asylum Seekers**: The London borough of Redbridge (LBR) is host to a number of contingency hotels providing accommodation to approximately 400 – 500 asylum seekers and refugees. LBR chairs a fortnightly meeting to review any concerns, gaps in service provision and safeguarding issues for the asylum seeker and refugee cohort which is attended by the Designated Nurse for Safeguarding Children. There are future multi-agency visits planned for these hotels which the Designated Dr and Designated Nurse for Safeguarding Children will participate.

3.3 **Child and Adolescent Mental Health Service (CAMHS):** The Designated Dr for Looked After Children has highlighted concerns in the provision of CAMHS services for LAC across BHR.

3.4 **Transitional Safeguarding** is a key priority for both the adult and children safeguarding partnerships. It was noted that provision in Redbridge does not always meet the transitional safeguarding needs for young people with complex care needs or those who have had complex backgrounds and upbringings. A Transitional Safeguarding Panel was set up in December 2022 with the aim of addressing some of these gaps and allowing a more integrated way of working between agencies. The Designated Dr, Nurse and adult professional for Redbridge are all members of this group.

3.5 **Health Inequalities**: The Designated Nurse for Safeguarding Children is a member of the Health Inequalities Clinical Reference Group.

4.0 Priorities for 2023-2024

- Embedding and promoting learning from Child Safeguarding Practice Reviews, Local Learning Reviews or Serious Incidents across health delivery partners.
- Complete the review and update of the LBR neglect strategy and neglect toolkit seeking assurance that there is an awareness of this by system partners.
- The creation of an all age repository of content in preparedness for any CQC statutory inspections.
- Audit and improve health organisations responses to reporting to the reporting of children in in-patient beds for 12 weeks or more via a NEL wide sec 85 audit.

- Create and work to a Redbridge All Age Safeguarding Workplan.

4.1 **Redbridge Safeguarding Children Partnership Priorities 2022-2023**

- Transitional Safeguarding
- Contextual Safeguarding
- Responding to National Reviews and reports
- Children and Young People Mental Health
- Child friendly Redbridge

Tower Hamlets Safeguarding Children Annual Report for 2022/23

1.0 Delivery of objectives set for 2022/23

1.1 The objectives that were set for 2022/23 were in collaboration with our network of place- based delivery partners. These included Tower Hamlets GP Care Group, Barts Health NHS Trust, East London Foundation Trust as well as our colleagues in Children Social Care and the Tower Hamlets Safeguarding Children Partnership. The progress of some key objectives can be found below.

2.0 Work at place

2.1 In 2022/23 there were changes implemented to the rapid review process to ensure that any notifications to the DfE, regarding serious safeguarding harm, were discussed quorate between the ICB, the local authority and the police as previously health were missed from initial discussion. The Designated Nurse for Safeguarding Children continued to co-chair Rapid Review related workstreams which involved review of delivery partner audit, local pathway and update of policies such as a THSCP Disclosure of Non-recent Abuse policy and a review of thresholds. There has been progression made with multi-agency partners with actions that have been identified through previous rapid reviews, thematic reviews and SPRs.

2.2 SPR Julie was published in 2022, with themes of Infant Safety. The document can be found Child Safeguarding Practice Reviews | Children and Families Partnership (childrenandfamiliestrust.co.uk). The ICB supported a face-to-face training event when the SPR was published.

2.3 The safeguarding partnership priorities were *Domestic Abuse, Staying Safe Online and Exploitation & Adolescent Safeguarding*, with the ICB chairing the priority of *Domestic Abuse*. These priorities are due to be closed in early 2023/24 and further details will be found in the THSCP annual report.

2.4 The THSCP arrangements can be found Safeguarding Children Partnership Arrangements (towerhamlets.gov.uk).

2.5 Further work in 2022/23 involved our Named GPs for Safeguarding have linked in with primary care commissioners and supported GP practices to develop child safeguarding administrators, ensure coding of Children Looked After and Child Protection plans on software systems and refine processes to support working together with multi-agency partners. Practices are completing 'Was not Brought' to appointment audits – as we know this is a key marker of possible neglect as highlighted in national learning reviews.

3.0 Key system issues

3.1 With the implementation from CCG to ICB in July 2023 this has altered some of the meeting structures at place. Delivery partners continue to invite ICB safeguarding leads to committees and other relevant governance meetings.

3.2 Prior to 2022/23 there had also been a change in staff, across the multi-agency partnership, which had led to some drift. Factors included the Rapid Review Working Action plan and increasing the health capacity within the Multi-Agency Safeguarding Hub (MASH). In the past year there has been reduced funding which has impacted on the original business case request. There is also discrepancy across the country in regards to whether MASH provisions should be funded by the ICB or the Local Authority. Further discussion has taken place across senior leads and the increase in health staff for MASH will continue to be pursued in 2023/24.

3.3 Delivery partners have not always been able to release staff to participate in partnership working and learning. This has been escalated to senior leads and there was some improvement in partnership across the year, however staffing pressures can provide limitations with this.

4.0 Key System Issues

4.1 Joint Strategic Needs Assessment

In Tower Hamlets we do not fully understand the health and wellbeing of our local children who are looked after and those that are living out of borough. An objective for 2022/23 was to complete a JSNA that include children who are looked after. Due to shortages within the public health team they were not possible. The ultimate goal is to provide evidence-based recommendations to inform policy, planning, and resource allocation for looked after children.

4.2 Immunisation Data

Immunisation data is only successfully collected by the local authority at the end of the financial year. During the past year some progress had been made in ensuring that immunisation data is collected regularly so that health needs of the CLA population are identified. This data is still not 100% accurate and further progress needs to be made.

4.3 Additional Capacity

Prior to 2022/23 it was identified that additional nursing and doctor capacity was required to support the delivery of health assessments. There has been progression with introducing locum doctors, with experience of delivering IHAs, which has increased timeliness of completing IHAs. There has been restrictions in funding which delayed securing funding for additional nurse capacity. Funding was agreed for a named nurse post at the beginning of 2023/24.

4.4 Designated Professionals for Looked After Children

The Designated Doctor for Looked After Children post has remained vacant during the 2022/23. An external review of the medical safeguarding arrangements across the ICB has been undertaken and the next steps are being finalised. There continues to be 0.6 wte vacancy for our Designated Nurse for Looked After Children post. WE are currently running a consultation process to develop and agree a new safeguarding and looked after children structure to meet the statutory requirements for these functions.

5.0 Priorities for 2023-2024

5.1 To work collaboratively with the multi-agency team and seek clarification that learning from previous SPRs has been implanted. There will be a focus on evidencing previous learning from rapid reviews with increased auditing via the THSCPP.

5.2 In previous years *Infant Safety* has been a focus within Tower Hamlets, this has now become a priority set by the THSCP. Within the ICB there has been minimal information shared regarding our older cohort of children so a priority for the ICB is to establish further detail around this. This will be also be explored through the THSCP other priorities of *Neglect, Peer on Peer Harm* and *Racism*.

5.3 A further SPR commenced at the end of 2022/23 with themes of overcrowding. This is due to be published in early 2023/24 and will identify the priorities that the ICB will support. The theme of overcrowding will also link in with the local and national concerns of the increase of ‘cost of living’.

Each priority will be explored from a place-based approach whilst linking into the NEL wide agenda.

Waltham Forest Safeguarding children annual report 2022/23

1.0 Progress against objectives set out in 2022-22 annual report

1.1 **Embed learning from statutory reviews and safeguarding incidents**

- Strengthened safeguarding children visibility and input at the learning and improvement forum
- Named GP for Safeguarding Children co-authored Child Safeguarding Practice Review Kubus and development of action plan to oversee delivery of recommendations
- Active engagement in transitional safeguarding task and finish group
- Local implementation of the national case review tracker ongoing.

1.2 **Strengthen safeguarding arrangements**

- Collaborative working with new provider of 0-19 yrs services in Waltham Forest
- Use of the newly developed safeguarding standards to evidence safeguarding arrangements within looked after children and paediatric palliative care services
- Strengthened safeguarding oversight of the continuing care and complex care cohort
- Established an all age Waltham Forest place based safeguarding meeting
- Work to improve communication between children's' social care and primary care ongoing.

2.0 Synopsis of work at place with impact/issues/mitigations

- Undertook visit of asylum seeker stand up accommodation and inputted to action plan to address health inequalities
- Worked with partners across the system to further communication between CDOP and One Panel with regards to rapid reviews to ensure learning is captured
- Resource pack disseminated to front line professionals in response to increase in sudden unexpected death in infancy and childhood (SUDIC)
- Led on complex care case meetings to ensure smooth transition to adult services
- Led the multi-agency audit into partnership response to initial identification of need and risk
- Led health perspective on implementing the serious violence duty.

3.0 Key system issues to include successes / issues/ mitigations and impact

- Leading clinical reference group (CRG) into mental health and emotional wellbeing with a focus on transitioning arrangements, hospital presentations, performance and mental health of parents and carers. Collaborative working with NEL suicide prevention group. Has led to broader understanding and evidence base of mental health arrangements across NEL and a Focus on standardisation of data and oversight arrangements
- Co-member of learning and development CRG, with a focus on standardised approach to implementing the national case review tracker
- Development of a longer term response to increase in SUDIC incorporating the "Prevent and Protect" model
- Development of a set of safeguarding standards to ensure safeguarding robust safeguarding arrangements in place in procurement of new services.

4.0 Priorities for the coming year (2023-2024)

4.1 Waltham Forest Safeguarding Children Board priorities are:

- Safeguarding children outside the home
- Children's emotional wellbeing
- Cross cutting priorities of violence reduction, protecting communities from alcohol and drug related harm and health inequalities.

4.2 NEL ICB Safeguarding priorities are:

- Ensuring that all health staff are equipped with the skills, knowledge, confidence and supervision to effectively safeguard the local population.
- Ensuring that robust mechanisms are in place to ensure that safeguarding practice, systems and processes are effective.
- Ensure services are integrated and share intelligence about vulnerable children and adults and by doing so improve safeguarding in their services and our local health and social care system.