NHS
North East London
Integrated Care Board

NEL Safeguarding Children Annual Report 2023/24

Executive summary

This is the third safeguarding children annual report for NHS North East London (NEL) Integrated Care Board. The purpose of this report is to provide a system overview and also update the NHS ICB Board and relevant committees on how statutory responsibilities have been discharged in the reporting period. The report covers the period of 1 April 2023 to 31 March 2024. The report is in two parts, Part A provides the NEL Overview and Part B incorporates the seven place- based reports and the NEL Child Death Overview reports.

This Annual report provides the Board with assurance on how statutory responsibilities for safeguarding children and child deaths have been fulfilled. The report outlines the NEL response areas of emerging risk, including the implementation of learning from both national and high-profile cases.

All ICS/ICB statutory responsibilities for Safeguarding babies, children and young people have been discharged during 2023/2024, primarily at place and also across the system when it makes sense to work at scale. Place-based designated professionals for Safeguarding children have worked closely with the NEL Deputy Director for Safeguarding children, Designated professionals for Looked after children, Named GPs/Nurse consultant for safeguarding in primary care, Child Death Hub Managers, Health provider partners, Local Safeguarding Children Partnerships (LSCPs), Community Safety Partnerships (CSPs) and Place based Partnerships and their associated sub-boards to deliver on statutory responsibilities.

The NEL ICB's confirmatory statement demonstrates how statutory assurance processes have been implemented in accordance with the Safeguarding Accountability and Assurance Framework, 2022.

This annual report builds on the achievements of the previous year and now looks forward to how safeguarding can be further embedded at place and across the whole integrated care system as we transition into a new way of working.

Key messages

Multiagency safeguarding arrangements

Under the Children and Social Work Act 2017 and Working together to safeguard children 2023: statutory guidance (publishing.service.gov.uk), three safeguarding partners (local authorities, chief officers of police, and ICB) must make arrangements to work together with relevant agencies to safeguard and protect the welfare of children in the area.

Therefore, NEL ICB executives have agreed to adopt a sub-regional approach, the model is being socialised with safeguarding partners across the NEL footprint. The following roles have been agreed within the model:

Lead Safeguarding Partner (LSP) role

The NEL CEO and CNO meet annually with NEL Local Authority CEOs at eight places and three BCU commanders/or London Region Public Protection Commander.

The CNO attends any other LSP meetings, deputising for CEO.

Delegated Safeguarding Partner (DSP) role

The NEL Director of Nursing & Safeguarding and NEL Deputy Director (safeguarding Children) provide additional capacity across eight places.

These arrangements were shared with the London SCP Executive Board in August 2024.

Plans for 2024/25

1. The focus for the coming year will be on a number of areas which include supporting the implementation of the wide-ranging Children Social Care (CSC) reforms. The ICB has selected a sub-regional approach to work in partnership with Local Authority and Police Lead Safeguarding Partners (LSPs) in the spirit of the updated statutory guidance and in alignment with its timetable for LSCPs to update their websites with details of their new multiagency safeguarding children's arrangements by December 2024.

2. There will be a continued focus on strengthening NEL safeguarding governance frameworks, improving workforce sufficiency and resilience.

3. We will continue to work to strive to make a difference to safeguarding outcomes for our local population by targeting areas of unwarranted variations to improve safeguarding and health outcomes and implementing our NEL Integrated Safeguarding Strategy and policy framework through collaborative working with system partners, Healthwatch and service user .

4. We will continue to raise awareness of safer sleeping advice and support partners to implement a Prevent and Protect model in relation to SUDI prevention. We will work with the Local Maternity and Neonatal System to monitor the increasing number of neonatal deaths. We will work with partners to raise awareness of child and teenage suicide and support measures to reduce suicide in children.

Contents

Safeguarding Children Annual Report - Part A NEL Overview

1.0 ICBs have a statutory duty to safeguard children as set out in the updated guidance, Working Together to Safeguard Children 2023. The NHS England Safeguarding Assurance and Accountability Framework 2022, clearly sets out safeguarding roles and responsibilities which apply to all ICBs. This includes the requirement on ICBs to set out how they have discharged duties in relation to child safeguarding in their annual report.

1.1 As set out in the statutory guidance, Working Together to Safeguard Children, 2023 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 from independent providers.

1.2 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 appears below via this link:
https://northeastlondon.icb.nhs.uk/download-attachment/32869
This report 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 Multiagency safeguarding arrangements

2.1 Multiagency safeguarding arrangements

Strategic leadership and accountability sits with the Lead Safeguarding Partner, (LSP) who is the head of each statutory agency. These are outlined for each agency within the statutory guidance as being:

- Police - the LSP is Chief Officer of Police
- Local Authority (LA) - the LSP is the Chief Executive
- ICB - the LSP should be the Chief Executive.

2.2 Roles of LSPs

The role of the LSP is to represent their agency/organisation, by using their authority to make decisions on behalf of their organisation or agency and commit them on policy, resourcing, and practice matters. LSPs are expected to be able to hold their own organisation to account on how effectively it participates and implements the local arrangements.

2.3 Delivering multiagency safeguarding arrangements

The three safeguarding partners as defined in legislation, have a joint and equal duty under the Children Act 2004 to make arrangements to work together as a team. For health this would be replicated across the eight places (including the City of London) to safeguard and promote the welfare of children.

2.4 These new arrangements have implications for both Health (ICBs) and Police who work across multiple local authority boundaries. Although the geographical boundaries for the three safeguarding partners may differ in size, multi-agency safeguarding arrangements should be coterminous with local authority areas. "**Arrangements can cover two or more local authority boundaries by agreement and where this is in place local authorities can agree to delegate their safeguarding duties to a single authority"** Working Together 2023, chapter 2, pp 25, para 4.1). The geographical area of a local multi-agency safeguarding arrangement can be changed over time by agreement with partners.

2.5 "In cases where the boundaries of the police and ICB extend over multiple local authority areas, LSPs may decide to meet at a more regional level so they can discuss all arrangements within their remit and ensure consistency of funding and resources" [Working Together (2023) chapter 2, pp 27, para 5.2] .

2.6 Model D is the preferred option which was agreed following consideration of four models which included do nothing. In March 2024, NEL Executive Management Team agreed to adopt the preferred approach which is outlined in Figure one below. This is because in comparison to the other available options this model strengthens the interface between the ICB executive leadership and safeguarding partnerships at place. It also makes the best use of the corporate safeguarding resource, thereby maximising the resource. The model has been shared with safeguarding partners across NEL, the London Coordination Group , DfE Safeguarding facilitators and the London Safeguarding Children Board (LSCB). A mapping exercise has also been undertaken to scope the current arrangements and the direction of travel for individual safeguarding partnerships in terms of

transformation to the model best suited to individual partnerships.

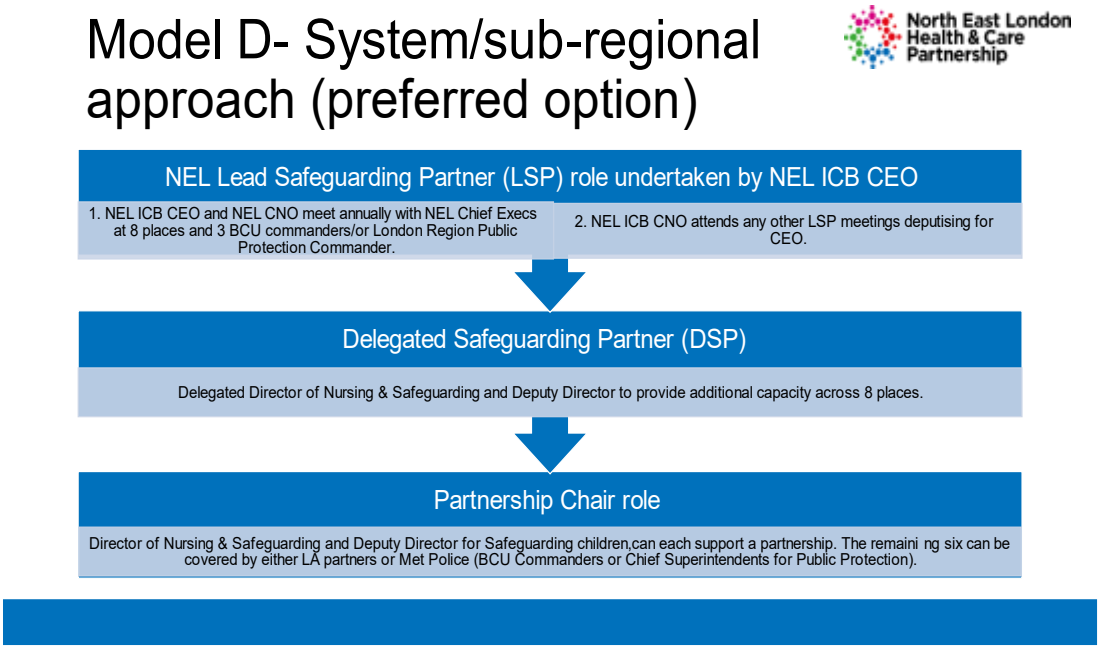

Figure 1- NEL ICB approach

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 organisations that transitioned to ICBs. The heat maps are a matrix self- assessment tool covering system leadership and accountability for action on health inequalities, safeguarding structures and matrix working, safeguarding priorities (see figure 2 below), workplan, chief nurse with executive accountability for safeguarding and partnership arrangements.

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.

3.3 Quarterly exception and highlight reports were submitted throughout the year, which enabled formal escalation of workforce sufficiency risks for both the ICB and providers, 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, and also an increased number of people seeking refuge and unaccompanied asylum-seeking children (UASC) with related public health issues around health protection

Figure 2- NEL Safeguarding Priorities

4.0 Best Practice

4.1 Some examples of achievements and best practice during the reporting period:

- NEL GP Safeguarding Handbook has been developed and is available on the Primary Care website.
- Looked after children workshop and interface with Children in Care Councils for strategy development took place in October 2023.
- A Specialist Service for child victims of domestic abuse is available in City & Hackney
- NEL Safeguarding Standards and Self-Assessment Tool has been developed and implemented with positive feedback from our provider partners.

5.0 Child Protection Information Sharing (CPIS)

5.1 CPIS is active across the NELFT footprint and there have been no outages or incidents reported, unlike the previous years. The ICB has supported reporting to NHSE in response to information requests.

6.0 NEL Child Death arrangements

6.1 In NEL there are two child death overview panels (CDOPs) across the inner and outer London footprint. One is a nurse led model and the other is led by public health, as a result of this different funding arrangements apply. All the relevant parties have signed up to a memorandum of understanding around how these statutory responsibilities will be discharged and funded.

6.2 NEL Quarterly Assurance Meetings for the two CDOPs (please see figure 2) have been established to provide system oversight and assurance. These meetings and the learning from the thematic reports have identified key areas for learning in

relation to sudden infant deaths although learning events have also occurred at place. A NEL ICS thematic conference focused on sudden infant deaths is scheduled for March 2024.

7.0 Equity Learning Network update: Using Quality Improvement to improve equity of access, experience, and outcomes

7.1 NEL ICB is leading a programme of work across the seven boroughs to oversee provision of SUDI training resources through lunch and learn sessions, assess best practice and gaps across the area and develop a coordinated approach to SUDI prevention, with the aim of reducing the number of SUDIs across NEL with modifiable causes related to unsafe sleep practices and known family vulnerabilities.

7.2 A NEL Steering Group has begun meeting monthly and will steer local borough level SUDI Task and Finish groups, who will report to their local safeguarding children partnership and back to the SUDI Steering Group. The network of projects using Quality Improvement

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using Quality Improvement methodology to improve services for babies, children and young people (BCYP) in NEL have been making great progress, and an update on progress has been reported in the monthly NEL BCYP Newsletter.

7.7 Child death structures for inner and outer London footprint

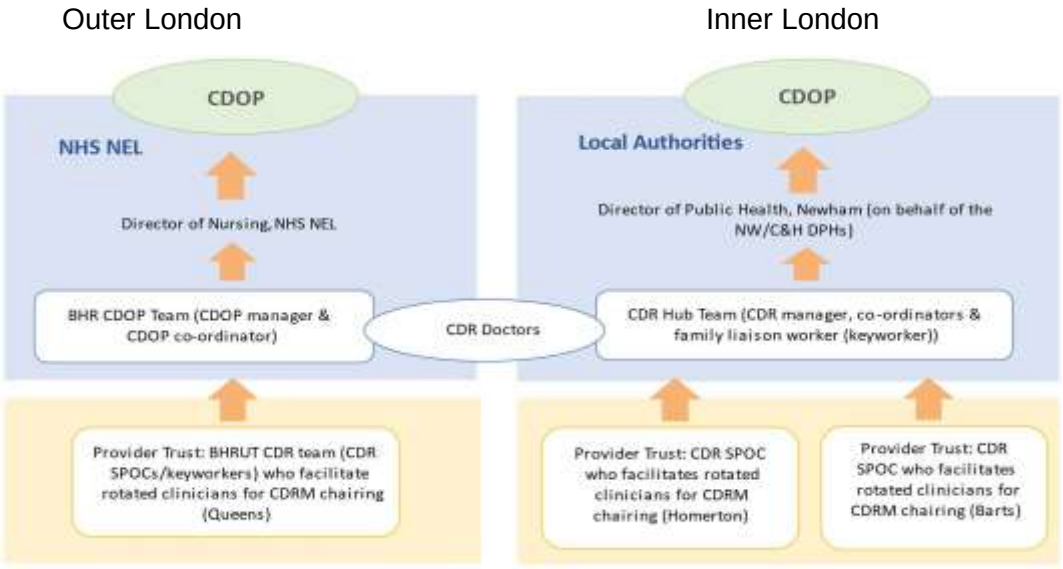

Figure 3- NEL CDOP Structures for inner and outer London

7.8 Improving understanding and prevention of Sudden Unexplained Deaths (SUDI) in Infants

The team developed an approach for using Quality Improvement to reduce avoidable SUDI deaths across North East London. Front-line teams are being supported to identify and test changes which will then be scaled up and spread as they are found to be effective.

7.9 Improving access, experience and outcomes of care through addressing health literacy challenges

The team developed improvement initiatives aimed at the challenges faced by the low levels of literacy, numeracy, and health literacy in our population. Initiatives include co-designing a speech and language therapy service; training frontline staff; and improving language and communications with families.

Recent learning from NEL CDOPs which is informing practice improvements has also pointed to the importance of:

- Early recognition of sepsis and giving the right treatment, escalating accordingly.
- Situational awareness – junior doctors are being educated further on spotting signs of sepsis and antibiotics given earlier.
- Information for the public should contain details about diarrhoeal outbreaks and fluid loss.
- To ensure support is available to staff at any time in the process of handling difficult cultural sensitivities.

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

8.1 Workforce capacity has been an area of challenge for both Health and Care. Whilst, significant recruitment has taken place there remain hard to fill posts, particularly in relation to Designated doctor roles commissioned by the ICB for three of the inner London places and Named doctor for Looked after children roles in the outer London footprint within the NELFT workforce. During the year aside from the independent review commissioned by the ICB into NEL medical safeguarding provision which included Looked after children in its scope, there have also been two ICB consultations during this period impacting the ability to recruit personnel. Although, interim capacity has been sourced by the ICB where possible and contingency arrangements are in place for areas with vacant posts this poses as a system risk.

9.0 Dissemination of learning to the system

9.1 There have been a variety of learning events to support the system in the past year. Examples appear below:

- The ICB hosted a NEL safeguarding conference in which learning from local and national reviews were shared. This included an expert by experience and the theme was regarding serious violence and violence against women and girls. There was an audience of over two hundred health and care professionals participating in the virtual conference in May 2023. The keynote speech was provided by the National Deputy director for safeguarding from NHS England.

- Ongoing learning is shared via the Local Safeguarding Children Partnerships (LSCPs), NEL.
- In line with the recognition of children as victims of domestic violence an in-person workshop hosting designated and Named safeguarding professionals from the ICB and provider organisations. The session discussed the learning from a thematic review of domestic abuse survivors commissioned by the Home office.

- There was also a facilitated virtual system learning event enabling priority setting for ICS safeguarding and an after-action review of the

impact of Clinical Reference Groups which were established to drive priorities using a whole family and programme management approach (please see figure 2).

- There have been two further in-person learning events in November 2023 and a third in February 2024.
- A system event for over six hundred professionals from both the ICS and Safeguarding Partnerships, took place in March 2024. This event was facilitated by the national panel and focussed on the learning from the recently published annual report which captures thematic learning from national reviews.
- Key learning was also shared with Executive Management Team, Quality, Safety and Improvement Committee, NEL Safeguarding & Looked after children forums and associated sub-groups of the LSCPs across the system.
- NEL conference on the prevention of sudden infant deaths was held in March 2024.

10.0 NEL System response to the learning from national incidents

10.1 In response to the key learning from the national review into the tragic deaths of Arthur Labinjo Hughes and Star Hudson in 2020, business cases have been approved for reducing the unwarranted variation in Health Multiagency Safeguarding Children Hub (MASH) resources for NEL. This has resulted in additional investment in the Health Resource for MASH in Redbridge and Tower Hamlets. 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 actively encouraged.

10.2 The review also highlighted the importance of effective supervision to support professionals dealing with increasingly complex cases. NEL ICB has implemented a comprehensive supervision framework for its safeguarding workforce which included access to restorative safeguarding supervision training and an externally facilitated safeguarding supervision offer for the ICB safeguarding workforce in line with the NEL Safeguarding Supervision Policy.

10.3 The ICB contributes to the national safeguarding tracker, this is to enable greater scrutiny and better understanding of themes from statutory reviews. 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) conducted across the NEL footprint.

10.4 There are still many lessons to learn from the safeguarding failures in the case of Child Q both nationally and locally, the follow-up report enables ongoing learning and promotes system challenge. The Partnership action plan is in place following the local safeguarding practice review with the City and Hackney

Safeguarding Children Partnership Board overseeing its implementation of actions.

10.5 Children appear to be over-represented in the serious youth violence data captured, a number of thematic reviews have been undertaken in Waltham Forest and Newham where there have been clusters of incidents. Designated professionals for safeguarding children continue to work with Local Safeguarding Children Partnerships (LSCPs), Community Safety Partnerships (CSPs) and Violence Reduction Units (VRUs) in developing safeguarding responses for children.

11.0 Update on the Progress with Priorities for 2023/2024

11.1 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. During the year the team worked with LSCPs, Violence Reduction Units and CSPs in relation to areas of concern and risk such as serious youth violence and supported the implementation of the serious violence duty for ICBs. The focus on strengthening NEL safeguarding governance frameworks continued throughout the year culminating with the ratification of a suite of policy documents including the NEL Integrated Safeguarding strategy.

11.2 This summary has demonstrated how NEL ICB has fulfilled its statutory duties in relation to safeguarding children, looked after children and care leavers and outlines the NEL response 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 and the implementation of the wide-ranging Children Social Care (CSC) reforms. The timetable for LSCPs to update their websites with details of their new safeguarding arrangements is for December 2024.

12.0 Conclusion

12.1 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 :

1. The implementation of the wide-ranging Children Social Care (CSC) reforms. The ICB has selected a sub-regional approach to work in partnership with Local Authority and Police Lead Safeguarding Partners (LSPs) in the spirit of the updated statutory guidance and in alignment with its timetable for LSCPs to update their websites with details of their new multiagency safeguarding children's arrangements by December 2024.

2. There will be a continued focus on strengthening NEL safeguarding governance frameworks, improving workforce sufficiency and resilience.

3. We will continue to work to strive to make a difference to safeguarding outcomes for our local population by targeting areas of unwarranted variations to improve safeguarding and health outcomes and implementing our NEL Integrated Safeguarding Strategy and policy framework through collaborative working with system partners, Healthwatch and service users.

13.0 Next Steps and Priorities for 2024/25

Our Top Priorities 2024/25

Top 5 Priorities 2024/25:	**Key Actions:**
1.Improving safeguarding workforce capacity and resilience for ICB/Providers 2.Improving outcomes for looked after children and care leavers 3. Implementing children safeguarding reforms 4. NEL ICS safeguarding priorities 5. Learning from safeguarding incidents	1.Prioritising recruitment, staff development , retention and resilience. 2. Co-design and co - production of the implementation plan for the NEL ICS Looked after children strategy. 3.Development of a NEL ICS Looked after Children Dashboard 4. NEL Clinical Reference Groups to deliver on the 7 priority areas over the next 2 years. 5. NEL ICS Safeguarding Dashboard.
Key Enablers: Organisational values and culture Skilled and resilient Workforce Good governance: • NEL Safeguarding Handbook for primary care . • Approved safeguarding policies and suite of related documents • NEL looked after children strategy • NEL safeguarding strategy • NEL safeguarding supervision offer • NEL safeguarding training offer • NEL review of medical safeguarding provision report , recommendations & implementation plan Relationships within ICB, Providers and Safeguarding Partners Intelligent Data QI improvement approaches and tools	**Key measurables:** • Improved NHS Staff survey for the Team • Team temperature checks at huddles, team days, away days and appraisals. • 75% reduction in the use of interim and locum staff. • B5 staff are upskilled at the QI foundational level • Band 8a and above have access to and access leadership development opportunities. • 100% compliance of the ICB safeguarding children workforce with supervision . • 100% of clinical workforce are either compliant or working towards achieving their intercollegiate competencies. • Improved data quality. • Data driven conversations to improve safeguarding children and learning from child deaths. • Implementing the care leavers covenant.

Anticipated Outcome:

1. Safe, highly skilled, stable, motivated and resilient ICB safeguarding workforce with sufficient capacity to deliver on statu tory responsibilities and compliant with intercollegiate frameworks.
2. Strong healthy relationships within the ICB and across the ICS evidenced by co -creation, collaboration, matrix working and inno vation.
3. **Ultimately, translating into improved outcomes for all children in NEL, and for vulnerable cohorts such as care experienced children, children in transition, mental health problems, unaccompanied asylum seekers, children with special/complex needs,**

Part B - Safeguarding children annual reports for 2023/4 at place:

- Barking & Dagenham
- City & Hackney
- Havering
- Newham
- Redbridge
- Tower Hamlets
- Waltham Forest
- NEL CDOP Annual Report

Barking and Dagenham (B&D) ICB Safeguarding Children Annual Report 2023-24

1.0 Objectives from last year's annual report and how we are measuring up against these.

1.1 The Start for Life programme aims to join up and enhance services delivered through transformed family hubs in local authority areas, ensuring all families can access the support they need. Through adopting this programme, the early help offer has strengthened in B&D with Family Hubs established in localities. Work is progressing to co-locate staff in the family hubs and family navigators are now recruited to and support families with accessing support from a wide variety of settings and agencies (money and debt hub, family hubs, food banks, housing etc). The Designated Nurse for Safeguarding Children continues to chair the 0-5 Early Intervention Panel with excellent partnership participation, aiming to address need at the earliest point.

2.0 Synopsis of work at place with impact/issues/mitigations (succinct)

2.1 Ofsted announced its Inspection of Local Authority Children's Services (ILACS) in July 2023. Judgement remains at 'Requires Improvement', noting that progress from 2019 inspection is not consistent nor equitable for some children living in B&D. There is a lack of decisive interventions for children who are exposed to long-term neglect and domestic abuse and in delays in progressing permanence plan. It was noted that MASH engages quickly, however risk grading against the threshold document is not always consistent. The additional health resource into MASH is effective and informs decision making about children's welfare. The experiences and progress of care leavers was acknowledged as good. Ofsted acknowledged the high levels of deprivation and that of migrant families whilst recognising that staff are passionate about improving the lives of the children and young people that they support.

3.0 Key system issues to include successes/issues/mitigations and impact – to include work done in Clinical Reference Groups (CRG's).

3.1 There are four ongoing Child Safeguarding Practice Reviews (CSPR) in B&D:

- Child H and Child I relates to a sibling group where CSA concerns were noted, dating back over 10 years.
- 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 B&D. The draft report is due Spring 2024.
- 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. This is a review undertaken with the London Borough of Hackney as the family had recently moved to B&D. The final report is expected back at the end April 2024.
- 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 Looked After Children placement were escalated. The report is due for sign off in Spring 2024 by the SCP Executive.

- SCR Child F (10-month-old child who died – shaken baby) was not fully published in December 2023 following conclusion of parallel court processes.
- SCR Family D (fabricated and induced illness of four children) hold on publishing due to ongoing legal processes (sits with Treasury Council).
- In December 2023, a number of significant documents were published including Working Together 2023 which outlines changes to multi agency safeguarding arrangements. B&D are in the early stages of embedding new arrangements.

4.0 Priorities for the coming year (2024-2025)

4.1 The BDSCB considered the following priorities for 2024-2025:

- Improving multi-agency partnership working to safeguard adults and their families
- Reducing inequality across the diversity of B&D's communities and developing safeguarding practice that meets the needs of the many different communities.
- Strengthening priorities across Adults, Children, Community Safety, and Heath & Wellbeing partnership working arrangements and the respective responsibilities and opportunities of the four partnership boards.

NHS NEL ICB City & Hackney Safeguarding Children Annual Report 2023/24

Date	July 2024
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1.0. Introduction:

The Safeguarding Children Annual Report 2023/24 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.

This report provides an update on the progress made against the safeguarding children priorities agreed in 2022/23. 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 2024/25.

Two separate annual reports have been written for our Looked After Children in both Hackney and City of London. There is also a Safeguarding Adult annual report for City and Hackney.

2.0. Objectives for last year with an update:

No	Objectives	Progress	Outcome
1.	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.	Full collaborative engagement to clinical reference groups	Objective met
2.	Ensure the learning from Child Q LSCPR and the recent update report is embedded within systems.	2nd report published June 2023 Why Was It Me?	Ongoing, Full partnership involvement

3.	To challenge anti-racist practice and behaviours that suppress in our day-to-day practice.	CHSCP Anti-Racist Safeguarding Arrangements Our Commitment The CHSCP condemns racism in all its forms. It also recognises the importance of our multi-agency safeguarding system being fundamentally anti-racist. Only through the eradication of systemic racism, discrimination and injustice will we be able to effectively safeguard Black children and those from other marginalised ethnic groups.	Ongoing, Full Partnership involvement
4.	To engage with delivery partners in the serious violence duty at place.	Designated professionals linking in with Community safety Partnerships from both City of Londen and Hackney.	Objective met
5.	To ensure SUDI practices across City & Hackney are robust and recommendations from the Safeguarding National Panel are embedded.	NHS NEL SUDI Conference held March 2024. Quality Improvement work underway to capture potential to further improve	Ongoing

3.0. Synopsis of work at place:

- The Director for Integrated Health and Commissioning (joint post with NHS NEL ICB, London Borough of Hackney (LBH) and City of London Corporation (COL), responsible for commissioning and delivery of NHS Maternity and children's health services is part of the Children and Education Leadership Team, reporting to the Director of Children's Services. **Integrated children's health arrangements** have been in place since 2017 and are well embedded.
- Key **NHS and public health funded roles embedded across the Children & Education directorate** - the 'Preparing for Adulthood' partnership lead (partnership wide remit), mental health commissioners, an immunisations / vaccinations co-ordinator, and the super youth hub development roles. Recently developed **Health Needs Assessment on our Youth Justice and SEN and Disability cohorts.**
- City and Hackney's Designated Medical and Clinical Officers **(DMO and DCOs)** work closely with the Designated Social Care Officer, are members of the Early Help and Care Plan (EHCP) Needs Assessment and High Needs Panels
- Hackney is in the **top 10 performers for Child and Adolescent mental health service provision** (Office of Children's commissioner report 2022), with some of the highest financial investment in England. Our 'Tree of Life' wellbeing work, exploring cultural identity in schools to promote mental health won both a **Health Service Journal and CYP Now award in 2023**. We have strong partnerships through our CAMHs alliance, our CAMHs single point of access, embedded clinical service in Children and Families, and with our Wellbeing and Mental health programmes and Mental health support teams in almost all of our schools.

- Our Maternity service is CQC rated 'GOOD' and has an embedded '**Equality and Inclusion Specialist midwife**, leading our anti racist and health inequalities programme.
- A range of co-delivered **services for specific communities** - Orthodox Jewish SaLT, OJ CAMHS, OJ school health check, Improving outcomes for Young Black Children's mental health programme and 'Growing Minds' for Global Majority children
- Other examples of joint working which result in children's needs being viewed holistically with the right support provided in a timely way**:**
- Cross representation from health and DCS at the **Continuing Care Panel** (called the Joint Complex Care Panel or JCCP) and DCS Resource Panel
- The **Joint Agency Panel** (JAP) recommends partner agency contributions to high-cost residential placements or interventions for children looked after
- Well-embedded monthly **Dynamic Support Register meeting** with representation from all agencies and aligned system wide work on pre-crisis support
- 12-month health funded pilot of very early intervention to address **Emotionally Based Non-School Attendance** (EBNSA).

3.1 City and Hackney Childhood Adversity, Trauma and Resilience Programme (ChATR)

Launch of ACEs and Trauma-informed Practice Training on the City and Hackney Children Safeguarding Partnership (CHSCP) Training Platform

ACEs and Trauma-informed Practice Training, developed by the ChATR programme has been launched on the City and Hackney Children Safeguarding Partnership (CHSCP) Training Platform. The training content includes foundations of Adverse Childhood Experiences (ACEs) and Trauma - including Racial Trauma and Intergenerational Trauma and Trauma-informed Practice and has been developed in collaboration with Tavistock and Portman Trauma Service. The aim is to ensure that professionals supporting Children, Young People and Families across City & Hackney have an increased understanding of the impact of ACEs and Trauma from a physiological, and psychological perspective and are enabled to share good practice in TI approaches between different contexts, organisations and disciplines. The first training session on the CHSCP platform took place in March 2024. Quarterly sessions will be delivered on the CHSCP platform during 2024/25.

Development of a sustainable facilitation model to support increased delivery of ACEs and Trauma-Informed Practice Training

In collaboration with Consultant Medical Psychotherapist and Trauma Services Lead at Tavistock & Portman Foundation Trust, we have developed a Train the Trainer model in order to train facilitators to deliver the ChATR ACEs & TIP Training on the CHSCP platform.

We have recruited a group of facilitators from multi-disciplinary settings across City & Hackney with direct experience of working with children, young people and families (previous or current experience). The first Train the Trainer session was delivered on 3rd July 2024.

Continuing development of the ChATR Portal

We are currently reviewing and updating the ChATR Digital Resource Portal to align it with the ACEs and TIP Training. The ChATR portal includes a range of practice tools, academic

research and case studies.

3.2 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 to Black and Asian women is nearly three times as high as for White women (14% and 15% versus 5%).

Our local Maternity and Neonatal Voices Partnership (MNVP) group will be working closely with our maternity unit to improve patient experiences for all women based on feedback received from local service users.

We have recruited maternity community champions from diverse backgrounds to support in gathering feedback from the South Asian, Black and Black Mixed Heritage, Turkish, Vietnamese & Orthodox Jewish community.

We have a targeted antenatal group for B&BMH women with tailored and culturally sensitive information.

We also set up an Equity & Equality Subgroup, with membership from a wide range of stakeholders with specific focus on reducing stillbirths and neonatal deaths, premature births and babies admitted to neonatal care.

In partnership with the Population Health Hub, we have secured funding to develop a Doula support service and will recruit doulas who are bilingual and represent our birthing population. We will also be translating important maternity leaflets into the top six languages.

In collaboration with two local HCVS organisations Birth Companions and the Bump Buddies project run by Shoreditch Trust, we will be reaching out to vulnerable and socially deprived service users to gather information and insight on their experience of the maternity pathway.

We have also recently launched the IZZY Project (formerly called the Perinatal Navigator Project) for women who are 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 focus on perinatal support and work to reduce substance misuse in pregnancy.

3.3 The Super Youth Hub

This project **aims to** develop a more comprehensive and youth-centric approach to health and wellbeing care for young people (aged 11-25) in City and Hackney; so that young people's autonomous and independent access to a range of services increases; which will prevent health and wellbeing needs escalating and reduce the demand on higher tiers of support and more specialist services.

The two-year pilot will take place in one pair of neighbourhoods (quadrants) in City and Hackney which is '**London Fields, Shoreditch Park, and The City**'. The primary objectives of this pilot programme include:

1. **Streamlining access to services** through coordinating services into the places that YP access (including VCS and education) and establishing a 'HealthSPOT' inspired by Tower Hamlets in Young Hackney's Forest Road Youth Hub. This also includes coordination of outreach to wider spaces and places that young people access in partnership with Public Health's community wellbeing van.
2. **Improving awareness and understanding of support available** through developing coordinated and accessible communications that are co-produced with young people.
3. **Ensure efficient coordination** through establishing a network of communication between services (a Youth Health and Wellbeing Network).

The delivery of holistic health and wellbeing support for young people relies on a partnership between services, that can support young people in the following areas:

- Wellbeing and Social Prescribing
- GP Primary Care
- Mental Health
- Sexual Health
- Substance misuse
- Smoking cessation
- Youth Support and Early Intervention
- Relationship advice
- Employment, Training and Education support and signposting.

3.4 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.

The Tree of Life

The local CAMHS Alliance, in partnership with Hackney CVS and local schools have been implementing a pioneer and three times awarded programme running Peer Lead African and Caribbean Tree of Life in Schools. The programme trains young adults from African, Caribbean and mixed heritages to deliver Tree of Life (narrative based intervention developed in Zimbabwe) in Secondary schools to students from the same backgrounds as a form of early intervention and prevention using culturally relevant approaches to increase access to early support, increase resilience and remove stigma around mental health.

Hackney Thinking Spaces

We have recently commissioned the Hackney Thinking Spaces, a 12-month joint community-based project with Hackney Council and I Found Me Therapeutic Counselling funded by C+H Public Health. Hackney Thinking Spaces creates community spaces to openly discuss and process the impact of systemic racism on residents' emotional wellbeing and mental health. This project is a direct response to recent events of systemic racism which have profoundly impacted upon Black and Global Majority children, young people and families in Hackney. HTS has a specific focus on creating real change to the system.

Led by IFoundMe qualified therapists, these Thinking Spaces will combine interactive learning with practical exercises and focus on the following areas:

- Psychoeducation on inherited trauma and systemic racism
- Empowerment to recognise and cope with your experiences
- Telling your story as it should be told
- Reflecting on events in Hackney impacting the Black and Global Majority Community

3.5 Work between Homerton Healthcare and City of London

Over the past year the Homerton has focussed on having a better understanding through a safeguarding lens on the provision of community services both universal and specialist to City of London residents.
Heads of Services were asked to feedback on:

1. The service they provided
2. What were worked well
3. What needed to be strengthened.

In addition, the City of London Head of Children Services was invited to attend two Homerton Safeguarding Children Operational Forums to discuss the findings and receive their feedback. Overall service provision was felt to be good particularly from Health Visiting. There were some concerns about the Looked After Child Designated Nurse post which is vacant but has been filled on an interim basis until the substantive post holder starts in September. In addition, parents of children with special education need and disabilities fed back that they find it difficult travelling to Hackney Ark the centre located geographically in Hackney where this group of children are seen by specialist health practitioners such as paediatricians, children's therapists and CAMHS Disability Service. This was a particular challenge for parents whose children need to see a speech and language therapist. A meeting has taken place between the City of London and Hackney Ark Service Leads to discuss providing a satellite service in a suitable venue in the City.
Working in collaboration in such a way fosters strong trusting relationships across the partnership and enables a better service provision tailored to the needs of children and families.

3.6 Sudden Unexpected Deaths in Infancy

Following the publication of the Sudden Unexpected Deaths in Infants (SUDI) report by the National Panel HERE 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. Work is underway at NEL level to replicate the work undertaken in C&H. Im March a NEL wide conference was held to promote safer sleeping.

3.7 Identification and Referral to Improve Safety (***IRIS***) and **Domestic Abuse early intervention, Training and Consultation Service** are specialist domestic abuse services jointly commissioned by the ICB and by Public Health.

The services have 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.

3.8 MARAC Liaison Service

The Primary Care MARAC Liaison Service is an HSJ award winning service set up in 2014/15 in collaboration with City & Hackney CCG (now NELICB), Public Health at Hackney Local Authority and Homerton Healthcare to address the gap in provision between the MARAC (Multi Agency Risk Assessment Conference) where the highest risk cases of domestic abuse are discussed, and safety plans made for victims. At the time Primary Care were unaware when their patients were being discussed, what the outcomes were and were unable to provide vital health information to feed into the process, in turn improving safety planning.

The service has gone from strength to strength, it has grown and adapted to meet the changing needs nationally with the introduction of the Domestic Abuse Act 2021 and locally where there is now provision for work with perpetrators of domestic abuse and specialist panels outside of MARAC to address the complexities of intergenerational abuse. The MARAC Liaison Nurse is a key member of the MARAC and other panels providing expert advice regarding the health needs of victims, perpetrators and dependants as well as being able to support multiagency colleagues in understanding the impact of these health needs on risk, safety and recovery from domestic abuse. The value of the service has been confirmed by the undertaking of clinical audits which have shown overtime the positive impact and personal value to patients as well the cost savings of having GP's linked into and having a referral pathway to the MARAC in place.

There is scope for expansion and improvement to the service provision both locally in City & Hackney, across the NEL partnership and nationally. The MARAC Liaison Nurse has worked successfully with other local authorities to set up their own service, most recently in Lambeth where they now have a MARAC Liaison Nurse in post. The MARAC Liaison Nurse is keen to discuss with other areas and support with the setup of provisions in other areas.

3.9 Delivery of CHSCP training around safeguarding children with disabilities

As part of the City and Hackney Safeguarding Children Partnership 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.

4.0. City & Hackney Safeguarding Children Challenge / Risk 2023/2024:

NO	RISK	MITIGATION/ACTION TAKEN/PROPOSED	RAG RATING
3.	Risk that low levels of childhood immunisations in the borough may	A national incident was declared following an outbreak of measles	

	lead to outbreaks of preventable disease that can severely impact large numbers of the population.	in the West midlands. There have been outbreaks of Measles in London outside City & Hackney. This has heightened the likelihood of a wider outbreak within City and Hackney. Modelling suggests there could be as many as 40,000 - 160,000 cases in London if an outbreak occurs. Probable and possible cases are being notified more frequently in North East London including within the Borough. NEL has awarded Hackney £112k for a MMR focused piece of work with Primary Care Networks. This funding is short term from March-May 2024. The MMR funding is passported from NHS England who are the official commissioner at this point, through the NEL ICB to place. There have been several short term funded immunisation and vaccination programmes over the last couple of years. Non recurrent funding has also been utilised for wider childhood immunisations. We are expecting delegated commissioning responsibility (from NHSE to NEL ICB in April 2025).	

5.0. Priorities for 2024/25:

- To seek funding for an ASD/LD Practitioner post at Homerton University Healthcare Trust to support children and their families, who present in A&E and when accessing healthcare services to ensure that these children are supported by practitioners who can advocate effectively for them.
- To continue to challenge anti-racist practice across the partnership in collaboration with partners to ensure the system is actively taking steps to ensure black and global majority groups are not marginalised when accessing support and healthcare services.
- To support the resubmission of a business case for increased funding for the Marac Liaison Service to enable a better use of clinical time.
- To support the safeguarding children partnership to embed the changes required as a result of the Working Together 2023 Guidance.
- To engage with partners across the ICS in relation to the clinical reference groups.
- To continue to support the NEL CDOP agenda and the SUDI strategy development that sits beneath CDOP.

Havering Safeguarding Children Annual Report 2023/24

1.0 Introduction

1.1 This year's annual report provides a synopsis of work at place which sets out how objectives have been delivered on throughout the year 2023/2024.

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

2.1 Seven rapid review meetings and one child safeguarding practice review (CSPR) were initiated in this reporting period in line with statutory guidance (see section 3).

2.2 Initiation of the MASH referral and threshold working group to improve the quality of referrals and application of thresholds across the professional network.

2.3 The London Borough of Havering received an inadequate OFSTED rating in December 2023. An improvement plan has been developed and NEL ICB are working collaboratively with partners to address relevant actions in relation to the health pathway for looked after children.

2.3 Havering successfully won a bid for the introduction of the IRIS programme across primary care. The top priority GP practices have been identified and training has begun to be rolled out.

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

3.1 The designated nurse for safeguarding children chairs the case review working group which is the decision-making panel for rapid reviews. Within the 2023-2024 financial year, one new child safeguarding practice review was commenced where the criteria outlined in working together to safeguard children (2018/2023) was met. In addition to this, a further seven rapid reviews were undertaken with recommendations for either local learning or CSPR:

- 'Herny' CSPR relates to a three-year-old male who sustained serious injuries whilst under the care of his mother and his mother's boyfriend. The case involves four local authority areas and themes have been identified regarding transient families, previous removal of children, stepping down from child protection plans/child in need plans. The CSPR should be published in 2024 pending criminal proceedings.
- AC relates to a three-year-old male who was injured by his mother whilst under her care. A joint learning event with case EB was undertaken in September 2023 which resulted in a multi-agency action plan.
- EB relates to an eleven-year-old female injured by her mother whilst under her care. A joint learning event with case AC was undertaken in September 2023 which resulted in a multi-agency action plan.
- HM relates to a female baby found deceased at home. There are ongoing criminal proceedings in relation to a concealed pregnancy, illegal termination of pregnancy, and not reporting a child death. A local action plan has been developed.
- SA realest to a five-year-old female with concerns regarding neglect at home whilst under the care of her parents. Her parents are known to have language and disability needs. A local action plan has been developed.

- FA relates to a female baby found dead in care of her mother. There is an ongoing police investigation re: use of cannabis / suffocation in bed with mother. Learning has been taken forward via the SUDI work stream and a Havering task and finish group has been developed to deliver on SUDI priorities.
- KX relates to a 6-year-old female who fell out of a first-floor window at home resulting in serious injury. KX and her brother were subject to child protection plan at the time with a history of domestic abuse and neglect. The national panel recommended joining up FA and KX in a CSPR due to housing issues, transfer of care from local authority areas, and history of domestic abuse. The CSPR is due to commence in September 2024.
- UK relates to a four-year-old female who died from sepsis. Learning has been identified around the management of sickle cell and adherence to prophylactic medication. Learning is being taken forward via local action plan.

3.2 There are ongoing system challenges relating to children presenting with mental health conditions, learning disability or placement breakdown, who are having extended stays in the emergency department. This is resulting in children being looked after in an inappropriate environment whilst alternative accommodation is being procured. The designated nurses are working closely with other stakeholders to ensure that appropriate escalations are taking place and that actions are delivered upon in a timely manner.

4.0 Priorities for the coming year 2024-2025

4.1 For the year 2024/2025, the following priorities have been identified for Havering:

- Refresh of the neglect strategy.
- Working with key partners towards the improvement plan following the December 2023 OFSTED inspection.
- Embedding learning from CSPRs/local learning reviews.
- Increased stability in the safeguarding workforce.
- Embedding the new safeguarding children arrangements as outlined in working together to safeguard children (December 2023).
- Further embedding of the SUDI workstream in Havering.
- Review of the emergency department escalation process for children presenting with mental health issues, learning disability, or placement breakdown.

NHS North East London Safeguarding Children Annual Report Newham 2023/24

Newham Place ICB priorities 2023-24 annual report:

1. 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.
2. 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.
3. 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.
4.

Progress against priorities for 2022-23:

1. The ICB children's commissioners continue to facilitate weekly huddle's to discuss how to meet the complex mental health and social care needs children and families who are admitted to Newham University Hospital. This meeting is well attended by London Borough of Newham, NHS North East London (NHS NEL), Barts Health and East London Foundation Trust (ELFT) community mental health services. Due to this huddle's success in prioritising children and family's needs to facilitate discharge from hospital, other boroughs across NEL are replicating the process.
2. Designate nurse safeguarding children (DNSC) chaired Extra Familial Harm and Intra-Familial Abuse Thematic Review- *The Review was commissioned in May 2023 and focused on the Rapid Review of seven (7) children under the age of 18 years who had been the victims (56% - 4/7) and/or the caused serious youth violence (100% - 7/7) between September 2021 – March 2023. The report is the culmination of extensive information gathering and consultation involving multi-agency partners; children/YP, and their families and practitioners.*
3. DNSC and Designate Professional safeguarding adults has regular monthly safeguarding catch up meetings with Newham's ICB Director. Impact of this has been evident when a Newham provider was placed under enhanced surveillance due to quality and safeguarding concerns, which was escalated to Newham's borough Director. Designate nurse safeguarding children attended all enhanced surveillance meetings and invited to future contractual review meetings with children's commissioners and Borough Director to ensure improvements to safeguarding were embedded within the provider organisation.

Synopsis of work at place with impact/issues/mitigations

- Newham has seen an increase to our medical safeguarding capacity, with the recruitment of interim Designated Doctors for Safeguarding Children and Looked after Children. Following an all-staff NHS NEL consultation, there was no reduction in the overall safeguarding capacity across the organisation.

- NHS NEL has jointly funded with London Borough of Newham, a specialist nurse into the Multi-Agency Safeguarding Hub. To ensure there remains an adequate capacity within the MASH to complete health checks and attendance to strategy meetings within the borough.
- DNSC has continued to support all areas of Newham's safeguarding children's partnership work and led on the health response into the partnership. Including co-chairing Practice Quality Assurance and core attendance to the Learning Workforce Development and Safeguarding Practice Review subgroups. Health safeguarding partners have chaired three out of the four local child practice safeguarding reviews cand two rapid reviews for children experiencing significant harm within the borough.
- The ICB named GP safeguarding continues to provide bespoke level 3 training and support to all GP's across Newham and is well attended by GP's and safeguarding leads within Primary Care. Training has focused on national and local safeguarding children themes, utilising learning from a number of safeguarding reviews conducted by NSCP. There is also a separate session for safeguarding leads and safeguarding administrators in practice where further support , supervision and training is offered in recognition of their more specialist roles. This year we have also offered training on the child death process and run a webinar designed to start the upskilling of designated administrative staff to safeguarding administrators who will help to support clinicians to deliver timely information to children's social care and manage the vulnerable child practice registers. A NEL wide safeguarding practice handbook is available which provides a comprehensive overview a reference guide . This also includes local appendixes which contain telephone numbers/ contact details and local pathways. Training has focused on national and local safeguarding children themes, utilising learning from a number of safeguarding reviews conducted by NSCP.

Key system issues to include successes / issues/ mitigations and impact – to include work done in CRG's

After making child sexual abuse a priority for the partnership, safeguarding children team at place have been promoting the Sunrise child sexual abuse service. This included creating links between London Borough of Newham (LBN's) sexual abuse practice lead and Sunrise's social work liaison officer (SWLO), to ensure social workers have access to a consultation line to discuss difficult cases involving CSA. In addition the SWLO has supported with Newham Safeguarding Children Partnership (NSCP) Harmful Sexual Behaviour's policy. Sunrise has also provided bespoke training to NSCP including Harmful sexual behaviours, child sexual exploitation, online safety and sibling on sibling abuse. Sunrise has also shared their quarterly report with NSCP Practice Quality Assurance sub-group to scrutinise the services data and ensure referrals into Sunrise from Newham are increased.

Priorities for the coming year (2024-25)

Newham Safeguarding children Partnership:

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

NHS NEL

- Support the ICB safeguarding team and on-boarding of new designated professionals.
- Work with statutory partners across NSCP to embed the learning from three completed local child practice safeguarding reviews.
- Continue to promote and support Sunrise (NEL ICB CSA hub) across the ICB and London Region. Ensure NEL ICB continue to review the activity of Sunrise across all NEL ICB Boroughs, attend contract review meetings for TIGER and seek potential new pathways for extra resources are sought.
- Ensure a whole system approach to tackling children attending acute hospital in crisis with prolonged admission.

Redbridge All Age Safeguarding Annual Report 2023-2024

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Safeguarding Children 2023-2024

1.0 Progress against priorities set out in 2022-2023 annual report for safeguarding children.

1.1 Embedding and promoting learning from Child Safeguarding Practice Reviews, Local Learning Reviews or Serious Incidents across health delivery partners - Achieved by contribution to all Redbridge safeguarding reviews. Designated Dr and Designated Nurse for Safeguarding are chairing a task and finish group following a local learning review.

1.2 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 – Achieved by facilitating focus groups for multi-agency partners which informed an updated Redbridge neglect toolkit. A multi-agency audit is underway to measure the impact.

1.3 The creation of an all-age repository of content in preparedness for any CQC statutory inspections - Achieved.

1.4 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 – Achieved with improvements identified by individual health partners.

1.5 Create and work to a Redbridge All Age Safeguarding Workplan – Partially achieved. The place-based safeguarding team are meeting bi-monthly.

2.0 Redbridge – Work at place

2.1 Participation and engagement with Redbridge Safeguarding Children Partnership (RSCP) 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 (LLR). 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.

Child Safeguarding Local Learning Reviews: There have been two Local Learning reviews (LLR) during the reporting period. One LLR found learning included multi-agency working, transition at key times in a child's life and delay in strategy meetings. The second LLR 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 for the second LLR. The actions and recommendations from both LLR's have been achieved or are ongoing.

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 six 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

2.7 During the reporting period the LBR submitted a bid to The Department for Education to become a pilot site for the Families First for Children pathfinder. In April 2024 it was announced that this bid was successful.

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 and additional funding has been secured to increase the MASH health resource by 1.4 wte.

3.2 Asylum Seekers: The London borough of Redbridge (LBR) is host to contingency hotels providing accommodation to approximately 400 – 500 asylum seekers and refugees at any one time. There are both operational and strategic meetings chaired by LBR to review any concerns, gaps in service provision and safeguarding issues for the asylum seeker and refugee cohort including health related concerns raised by health delivery partners. These meetings are attended by the Designated Nurse for Safeguarding Children. It has been identified that there are a number of units of Dispersed Accommodations in Redbridge with an estimated additional 400 people across these units, including families.

3.3 Designated Dr for Looked After Children: There has been a gap in Designated Dr for Looked After Children provision in LBR during the reporting period due to sick leave.

3.4 Health Delivery Partners – The Designated Nurse for Safeguarding Children has worked with and supported health delivery partners with service and system challenges. This includes

business continuity plans for the 0-19 service and Looked After Children services. Workforce capacity within safeguarding teams for some health delivery partners has impacted on their team's capacity during the reporting period. Where appropriate this has been mitigated by the delivery partner or identified on the ICB risk register.

3.5 There has been some incidences of long hospital stays for children in emergency departments or hospital paediatric wards during the reporting period. Children affected have included both children looked after and children living with family. Placement breakdowns and challenges in finding suitable accommodation for often complex physical, emotional, and mental health needs have resulted in inappropriately long hospital stays. A multiagency after-action review was held in January 2024 which identified the need for a new multi-agency escalation process. This work has started.

4.0 Priorities for 2024-2025

4.1 Embedding and promoting learning from Child Safeguarding Practice Reviews, Local Learning Reviews(LLR) or Serious Incidents across health delivery partners.

4.2 Complete the actions from the health led T&F group following an LLR.

4.3 Contact and share details of the ICB all age safeguarding team with CQC registered private healthcare providers in the Redbridge footprint.

4.4 create a survey for pharmacies and dentists to understand their experience of patient presentations with domestic abuse or violence against women and girls' concerns.

4.5 Create and work to a Redbridge All Age Safeguarding Workplan

4.6 Chair and lead the NEL wide Training CRG

Redbridge Safeguarding Children Partnership Priorities 2023-2024

- Contextual Safeguarding
- Child Mental Health
- A suitable home for every child

Tower Hamlets Annual Safeguarding Children Report 2023/24

1.0 Objectives at place for 2023/24

1.1 The Tower Hamlets Safeguarding Children objectives that were set for 2023/24 were in collaboration with the Tower Hamlets Safeguarding Children Partnership and 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, the police and local voluntary organisations. The progress of some key objectives can be found below.

1.2 The THSCP Safeguarding Priorities were agreed based on themes from local learning and children representative feedback. These include:

- Infant Safety
- Anti-Racism
- Neglect
- Peer on Peer Harm

1.3 Objectives for Tower Hamlets were also set following NEL ICB workstreams such as the:

- Sudden Unexpected Death in Infants Task and Finish Group
- Care Leavers Compact

2.0 Working Together to Safeguard Children (DE, 2023)

2.1 Working Together to Safeguard Children (DE, 2023) was updated this year so this was reviewed within NEL ICB and THSCP to ensure that we adjust to the new recommendations. Prior to the published document THSCP had already implemented some of the recommendations. Workstreams within Tower Hamlets, such as the safeguarding priorities, are inclusive of education and voluntary organisations.

2.2 The independent scrutineer has also had opportunity to attend health related meetings and meet with Designated and Named professionals within the safeguarding team.

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

3.0 Key System Issues

3.1 In 2023/24 the Designated Nurse for Safeguarding Children progressed the Infants Safety Priority. This utilised the same workstream as the SUDI Task and Finish Group. This was co-chaired with the Named Nurse for Child Death and consisted of a multi-agency membership. Multi-agency delivery partners used a scoping tool to establish the current arrangements in regard to supporting babies, families and carers in preventing SUDI. This has fed into the wider NEL arrangements and the awareness raising in Tower Hamlets led to a high attendance of Tower Hamlets colleagues to the NEL ICB Safer Sleep Conferences in March 2024. Details from the scoping tool also contributed to the delivery planning for Child Safety Week in June 2024.

3.2 The Designated Dr for Safeguarding Children has also led on the THSCP priority of Neglect. Key elements to this workstream is a Neglect toolkit designed with a multi-agency approach. The aim is for this to be completed in 2024.

3.3 The ICB Named GPs for Safeguarding continue to provide bespoke Level 3 training and support to all GPs across the borough. Training sessions have focused on national and local safeguarding themes, utilizing learning from safeguarding reviews conducted by THSCP. In addition, separate sessions are provided for safeguarding leads and safeguarding administrators in practice. These sessions offer further support, supervision, and training in recognition of their more specialist roles.

3.4 There has been training for GP administrative staff with focuses on the child death process, completing forms for children social services requests and record keeping. A key focus was on linking families records together and the correct recording of safeguarding information.

3.5 This has been supported by the updated NEL-wide safeguarding practice handbook is available, which provides a comprehensive overview and reference guide. This includes local appendices with telephone numbers, contact details, and local pathways.

4.0 Priorities for 2024/25

4.1 During 2023/24 an increase health offer was agreed for the Multi-Agency Safeguarding Hub (MASH). This is to meet the demand for sharing of health information regarding children safeguarding and attendance of strategy meetings. The additional staff will commence their roles in 2024 and the value of the increased offer will be reviewed.

4.2 The NEL ICB safeguarding professionals will continue their contribution to the THSCP Safeguarding priorities with key learning of Infant Safety webinars planned for June 2024 and will have oversight of health representation for the other safeguarding priorities of Neglect, Peer on Peer Harm, and Anti-Racism.

4.5 In Tower Hamlets a Section 11 audit is planned for Q2. A priority in Q1 is to co-create the audit with THSCP and the outcomes will determine ongoing work for Q3/4.

4.6 A CSPR commenced in 2022/23 with themes of overcrowding. This is due to be published in 2024. Recommendations from the CSPR will continue to be supported by the ICB as the Designated Nurse for Safeguarding Children remains the chair of the Rapid Review/CSPR Working Group.

5.0 Report author

Lyn Glover, Designated Nurse for Safeguarding Children

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Waltham Forest Safeguarding Children Board priorities for 2023-2025:

- **Cross cutting priority of Safeguarding Children Outside The Home.**
  The Designated Nurse and Named GP have attended and contributed to the safeguarding children outside the home subgroup. The Partnership has increased their collaborative working with Newham Safeguarding Partnership, supported by the Designated Nurses in these areas. Supporting a multi-agency audit into children missing.
- **Children's Emotional Wellbeing** – The Designated Professionals and Named GP have worked with the Safeguarding Children Partnership to support this priority and ensure the emotional wellbeing of Waltham Forest children. The Designated Nurse has attended and contributed to the Waltham Forest Children and Young Peoples Mental Health and Well Being Committee. A shortage of specialist beds for Mental Health, eating disorders and challenging behaviours remains a national and local issue, with children remaining on ED for long periods due to this shortage. This continues to be raised with NHSE.
- **Cross cutting priorities of Violence Reduction, Protecting Communities From Alcohol And Drug Related Harm And Health Inequalities. -** The Designated Professionals have been active members in the Violence Reduction partnership, the Community Safety Partnership and serious violence duty and community safety partnership. The Designated Nurse has linked in with the NEL ICB Violence Reduction Lead.

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**.
  The Named Professionals in provider organisations receive independent safeguarding children supervision as do the Designated Professionals. The Designated Professionals meets regularly with the Named Professionals to provide advice and support and to gain assurance regarding the above. Assurance has been sought regarding levels of safeguarding children supervision and training delivery within provider organisations. The ICB has completed a training needs analysis, developed and are now delivering face to face level 3 training to appropriate ICB staff.
- **Ensuring that robust mechanisms are in place to ensure that safeguarding practice, systems and processes are effective.**
  The Designated Professionals work collaboratively with members of the Safeguarding Children Partnership and provider organisations to ensure robust mechanisms are in place across provider organisations and within the ICB. There is a Think Family, all age approach to safeguarding in Waltham Forest. The One panel is a multi-agency panel that reviews Waltham Forest Rapid Reviews, Safeguarding Children Practice Reviews and Safeguarding Adult Reviews. The One Panel is currently chaired by the ICB's Deputy Director for Safeguarding Children There has been a revision of the Rapid Review process with the multi-agency Rapid Review panels have meeting regularly throughout the year. The chairing of these panels is now rotated between the

three statutory partners with the Designated Nurse for Safeguarding Children acting as the ICBs chair.

- **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)** The Designated Professionals for children, adults and looked after children meet twice monthly to share intelligence about vulnerable children and adults and to support transition from children's to adult services.

Embed learning from statutory reviews and safeguarding incidents

- Strengthened safeguarding children visibility and input at the learning and improvement forum
- To support providers to disseminate learning from reviews throughout their organisation and to ensure learning from rapid reviews and CSPR is implemented in practice.
- Local implementation of the national case review tracker ongoing.

Strengthen safeguarding arrangements

- Collaborative working continues with multi agency partners and provider organisations to strengthen safeguarding arrangements.
- Pathways for Child Protection medicals are currently being reviewed by the Designated Doctor.
- Designated Nurse now attends the complex care meeting to strengthen safeguarding oversight of the continuing care and complex care cohort
- Work to improve communication between children's social care and primary care is ongoing .

Synopsis of work at place with impact/issues/mitigations (succinct)

- The WF asylum hotels have now been stood down, with some previous occupants being accommodated within the NEL area.
- The Designated Nurse co-chairs the WF SUDI multi-agency task and finish group
- Two child safeguarding practise reviews are taking place involving child neglect.
- Thematic review of five cases of knife crime there have subsequently been 10 rapid reviews 7 of which involved knife crime.
- Knife crime remains a concern and is above the statistical average in Waltham Forest .

Key system issues to include successes / issues/ mitigations and impact – to include work done in CRG's

- All age approach to complex transition cases
- Development of a longer-term response to increase in SUDI 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

Priorities for the coming year (2024-2025)

- To support the priorities of the Safeguarding Children Partnership
- To ensure learning from reviews is being effectively communicated and implemented across health organisations
- To work with both children and adult partners to ensure safe and effective transition from children to adult services
- To review the pathways for Child Protection Medicals .