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Safeguarding Sub (Community & Children's Services) Committee

Date: **TUESDAY, 6 FEBRUARY 2018**

Time: **1.45 pm**

Venue: **COMMITTEE ROOMS, GUILDHALL**

Members:
Randall Anderson (Chairman)
Ruby Sayed (Deputy Chairman)
Marianne Fredericks
Deputy Joyce Nash
Dhruv Patel
Deputy Elizabeth Rogula

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Lunch will be served in the Guildhall Club at 1pm

John Barradell
Town Clerk and Chief Executive

Part 1 - Public Agenda

1. **APOLOGIES**

2. **MEMBERS' DECLARATIONS UNDER THE CODE OF CONDUCT IN RESPECT OF ITEMS ON THE AGENDA**

3. **MINUTES**
   To agree the minutes of the previous meeting held on 27 September 2017.
   For Decision
   (Pages 1 - 6)

4. **HANDCUFFING OF JUVENILE STATISTICS**
   Report of the Commissioner, City of London Police.
   For Information
   (Pages 7 - 10)

5. **SAFEGUARDING CHILDREN'S BOARD ANNUAL REPORT**
   Report of the Independent Chair of The City & Hackney Safeguarding Board.
   NB. The full report will follow electronically
   For Information
   (Pages 11 - 14)

6. **THE CITY AND HACKNEY SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2016/17**
   Report of the Director of Community and Children's Services.
   For Information
   (Pages 15 - 88)

7. **INDEPENDENT REVIEWING OFFICER (IRO), ANNUAL REPORT FOR 2016 TO 2017**
   Report of the Director of Community and Children's Services.
   For Information
   (Pages 89 - 112)

8. **REPORT ON AN EXPLORATION OF HOW SOCIAL WORKERS ENGAGE NEGLECTFUL PARENTS FROM AFFLUENT BACKGROUNDS IN THE CHILD PROTECTION SYSTEM**
   Report of the Director of Community and Children's Services.
   For Information
   (Pages 113 - 162)

9. **SPECIAL EDUCATIONAL NEEDS AND DISABILITY (SEND) UPDATE**
   Report of the Director of Community and Children's Services.
   For Information
   (Pages 163 - 174)

10. **FINANCIAL ABUSE UPDATE**
    Report of the Director of Community and Children's Services.
    For Information
    (Pages 175 - 184)

11. **QUESTIONS OF MATTERS RELATING TO THE WORK OF THE COMMITTEE**

12. **ANY OTHER BUSINESS THE CHAIRMAN CONSIDERS URGENT**

13. **EXCLUSION OF THE PUBLIC**
MOTION - That under Section 100(A) of the Local Government Act 1972, the public be excluded from the meeting for the following items on the grounds that they involve the likely disclosure of exempt information as defined in Part I of the Schedule 12A of the Local Government Act.

For Decision

Part 2 - Non-Public Agenda

14. **NON-PUBLIC MINUTES**
To agree the non-public minutes of the previous meeting held on 27 September 2017 .

For Decision
(Pages 185 - 188)

15. **CHILDREN IN CARE ANNUAL REPORT 2016-2017**
Report of Looked After Children's Health Team.

For Information
(Pages 189 - 196)

16. **CHILDREN'S SAFEGUARDING REPORT FOR QUARTER TWO 2017/18**
Report of the Director of Community and Children's Services.

For Information
(Pages 197 - 212)

17. **REPORT ON CARE QUALITY COMMISSION (CQC) INSPECTION OF CHILDREN LOOKED AFTER AND SAFEGUARDING IN CITY OF LONDON**
Report of the Chief Officer, City and Hackney Clinical Commissioning Group

For Information
(Pages 213 - 250)

18. **ANNUAL REPORT VIRTUAL SCHOOL HEADTEACHER ACADEMIC YEAR 2016/17**
Report of the Director of Community and Children's Services.

For Information
(Pages 251 - 260)

19. **ADULT SAFEGUARDING PERFORMANCE REPORT**
Report of the Director of Community and Children's Services.

For Information
(Pages 261 - 264)

20. **NON-PUBLIC QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**

21. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT AND WHICH THE COMMITTEE AGREE SHOULD BE CONSIDERED WHILST THE PUBLIC ARE EXCLUDED**

SAFEGUARDING SUB (COMMUNITY & CHILDREN'S SERVICES) COMMITTEE

Wednesday, 27 September 2017

Minutes of the meeting of the Safeguarding Sub (Community & Children's Services) Committee held at the Guildhall EC2 at 1.45 pm

Present

Members:

Randall Anderson (Chairman)
Marianne Fredericks
Deputy Joyce Nash
Ruby Sayed (Deputy Chairman)
Deputy Elizabeth Rogula

Officers:

Officers:

Chris Pelham	-	Community and Children's Services
Pat Dixon	-	Community and Children's Services
Elizabeth Malton	-	Community and Children's Services
Rachel Green	-	Community and Children's Services
Kirstie Hilton	-	Community and Children's Services
Adam Johnstone	-	Community and Children's Services
Glory Nyero	-	Community and Children's Services
Julie Mayer	-	Town Clerk's Department
Inspector Ashlie May	-	City of London Police

1. **APOLOGIES**
   Apologies were received from Dhruv Patel.

2. **MEMBERS' DECLARATIONS UNDER THE CODE OF CONDUCT IN RESPECT OF ITEMS ON THE AGENDA**
   There were no declarations.

3. **MINUTES**

   RESOLVED, that – the public minutes and non-public summary of the meeting held on 7th June 2017 be approved.

   Matters arising

   Members noted that they would receive a report at their next meeting on the Carers' Strategy and this would include the use of cameras. A Member suggested seeking advice from other teams, within the City of London Corporation, who use cameras for enforcement.

4. **SERVICE IMPROVEMENT PLAN AND OFSTED IMPROVEMENT**

The sub committee received a report of the Director of Community and Children's Services in respect of the Service Improvement Plan and Ofsted Improvements. Members noted that most of the actions had been completed and the progress on 'ambers'.

1. *Given the majority of our Looked After Children and Care Leavers are Unaccompanied Asylum Seeking Children, what steps have been taken to address the issues raised by the recent events involving a young Asylum Seeking child and the Parson's Green Bomb?*

2. *Does the Improvement Planning set out in the SIP work consider risks in respect of radicalisation?*

In respect of the recent Palmers Green terrorist attack, a new risk assessment on radicalisation had been added, along with additional training for all staff and support for foster carers. In addition, all new unaccompanied asylum seeker children were included in the national referral system

RESOLVED, that – the report be noted.

5. **ANNUAL UPDATE ON THE CUSTODY OF VULNERABLE PERSONS (YOUNG PERSONS, CHILDREN AND MENTAL HEALTH)**

The Sub Committee received a report of the Commissioner, City of London Police, which provided an update on the custody of vulnerable persons.

The high proportion of juveniles restrained with handcuffs was being challenged and the Sub Committee would receive a further report in 6 months' time. Appropriate adult attendance was challenging if the details were not provided by the child. However, the Appropriate Adult Service attended very promptly and officers offered to split data in future reports. Anyone sectioned under the Mental Health Act was referred to hospital and there were very sound procedures in respect of mental health referrals. Should an episode occur during custody, the person would be assessed and referred, if necessary, but Members noted that very few detainees were sectioned.

Members commended the success of Street Triage as a good example of partnership working.

Members asked about recent cases of murder by school children and asked how mental capacity would be determined. Officers advised that detailed risk assessments take place on detention and the Police National Computer (PNC) contained markers on previous criminal activity and possible mental health issues. Officers agreed that there should be a risk assessment specific to children and this matter had been raised at a recent London Policing Forum.

All searches were sensitive and respectful, particularly to gender neutrality and officers were happy to share the procedure with Members. Members were also offered a copy of the Juvenile Detainee Guidance Note.

RESOLVED, that – the report be noted.

6. **CITY OF LONDON CORPORATION CQC INSPECTION - LOOKED AFTER CHILD AND SAFEGUARDING ACTION PLAN**

Members agreed to defer this report to the next meeting of the Sub Committee as the author had been indisposed at short notice.

7. **SOCIAL WORK MODEL IN THE CITY**

The Sub Committee received a report of the Director of Community and Children's Services in respect of the development of the above vision and ethos in practice.

- *How can we be reassured that the application of this approach will not lead to abandoning core statutory responsibilities , especially when linked to key performance indicators such as timescales for visits, assessments etc..? (This links to the performance Report at no 16 on the agenda)*

- *How will we know that this approach is effective and making the desired impact for our children and families?*

Members noted that looked after children (LACs) in the City really valued their social workers, evidenced from regular feedback and thematic quality reviews. Officers confirmed that this work would not impact on statutory duties.

RESOLVED, that – the report be noted.

8. **PRIVATE FOSTERING**

The Sub Committee received the Private Fostering Report for 2016-17 and noted there had been no private fostering arrangements identified in the City for 2016-17.

Are we satisfied that we are doing all we can to raise awareness around this? Have we liaised with health services to get their support to raise awareness?

Officers accepted that community engagement could be improved and were working on language and culture-friendly communications, with particular sensitivities to family fostering. Members noted the success of the new private fostering app, which had been launched last year and was praised by Ofsted for raising awareness. Officers were also planning more work in schools and health services.

RESOLVED, that – the report be noted.

9. **DESIGNATED OFFICER ANNUAL REPORT FOR 2016-17**

The Sub Committee received the Annual Designated Officer (DO) report for 2016-17.

- *Given the increase in referrals from 2 years ago, why do we think that the numbers dropped off in the last year?*

- *Did we maintain our high levels of awareness raising or did they drop off?*

Members noted the DO's work with Hackney's DO and the Metropolitan and City of London Police in respect of professional allegations and the training offered in various scenarios. The officer explained the importance of balancing confidence in raising allegations with the potential and severe impact of unfounded ones and this may have caused the numbers to drop.

RESOLVED, that – the report be noted.

10. **EDUCATION AND EARLY YEAR'S SERVICE SAFEGUARDING UPDATE**

The Sub Committee received the Education and Early Years' Service Safeguarding Update which demonstrated the work carried out over the past year.

- *How do we ensure that children educated at home are safe if they are not interacting with other services?*

- *The report helpfully references the learning from the Hackney case review of a tragic child death, in particular in terms of school procedures. More generally, how do we ensure that learning from reviews does help our practice in the City , especially given our much smaller size and fact we have not had any Serious Case Reviews in the City?*

Members noted a clear policy was in place for home education and all visits were recorded. Whilst there was no statutory duty to visit, education staff tried to make 2 visits a year, maintained regular contact via telephone, and Education Welfare Consultants also attended the visits. The visits also sought to identify parents with medical problems or access difficulties. The Local Authority were always notified of a child being removed from education and, given the financial responsibility on parents when their children sit exams away from school, they are often returned to school at this stage. Officers advised that, as part of the current service restructure, relationships with schools were being strengthened to ensure a holistic approach. Members noted that all City of London children attended external secondary schools and the Early Help Service provided new mothers with information on services available.

In respect of the tragic child death in Hackney, Members noted there would be a case review meeting the next day and Social Workers used a flow chart which concentrated on the first 3 days of a child missing education.

RESOLVED, that – the report be noted.

11. **QUESTIONS OF MATTERS RELATING TO THE WORK OF THE COMMITTEE**

There were no questions.

12. **ANY OTHER BUSINESS THE CHAIRMAN CONSIDERS URGENT**

Members noted that, due to a lack of business the next meeting of the Sub Committee would be cancelled. The next meeting would take place on 6th February 2018.

13. **EXCLUSION OF THE PUBLIC**

RESOLVED - That under Section 100(A) of the Local Government Act 1972, the public be excluded from the meeting for the following items on the grounds that they involve the likely disclosure of exempt information as defined in Part 1 of the Schedule 12A of the Local Government Act.

Item	**Paragraph**
14 - 19	1

14. **NON-PUBLIC MINUTES**

The non-public minutes of the meeting held on 7 June 2017 were approved.

15. **SUICIDE PREVENTION**

The Sub Committee received a report of the Director of Community and Children's Services in respect of suicide prevention in the City of London.

16. **CHILDREN'S SAFEGUARDING REPORT FOR QUARTER 4 AND YEAR END 2016/17**

The Sub Committee received a report of the Director of Community and Children's Services.

17. **ADULT SAFEGUARDING PERFORMANCE REPORT**

The Sub Committee received a report of the Director of Community and Children's Services.

18. **NON-PUBLIC QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**

There were no questions.

19. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT AND WHICH THE COMMITTEE AGREE SHOULD BE CONSIDERED WHILST THE PUBLIC ARE EXCLUDED**

There were no items of business

The meeting closed at 3.10 pm

Chairman

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NOT PROTECTIVELY MARKED

Committees	Dated:
Police Committee – For information Safeguarding Sub-Committee – For information	25th January 2018 6th February 2018
Subject: Handcuffing of Juvenile Statistics	**Public**
Report of: The Commissioner of Police	**For Information**
Report author: Detective Superintendent Woodall	

Summary

This paper aims to address concerns raised following submission of a paper to Police Committee and Safeguarding Sub-Committee that the City of London Police were using excessive force on juveniles when compared to other forces (specifically the MPS and Cambridgshire).

The figures previously presented actually showed different things and should not have been directly compared. Further comparable data has been acquired and presented in this report that demonstrates CoLP is performing in line with these other forces. In addition, dip-sampling of City Use of Force forms has shown no issues of concern and no complaints have been received in relation to the use of force on juveniles in the City.

Recommendation

Members are asked to note the report.

Main Report

Background

1. The Annual update on the Custody of Vulnerable Perons (Young Persons, Children and Mental Health) was given to Police Committee on 21st September 2017 and Safeguarding Sub-Committee on 27th September 2017.

2. Within that report at paragraph 33 the following information was detailed: “So far for the months of April to June of 19 individuals under 18 brought into custody, 12 have been handcuffed, this equates to 63%. As a comparison during the same period, 8% of all juveniles’ arrests made by Cambridgeshire Police and 13% of all juvenile arrests made by the Metropolitan Police service (MPS) show use of Force applied”

Current Position

3. The data from Cambridgeshire and the MPS used in paragraph 2 above was extracted from their external website and should not have been used as it was a wrong comparison. The City of London Police (CoLP) statistics quoted refer to the percentage of those arrested under 18 who were handcuffed and the MPS and Cambridge is a percentage of the total use of Force applied to under 17 year olds as compared with the use of Force on all persons detained.

4. Use of Force statistics will include handcuffing but is wider, including baton use.

5. Handcuffing statistics should detail compliant and non compliant handcuffing which is not shown within the original statistics at paragraph 2.

6. The MPS report the Use of Force on 12,605 people and 1,593 in the 11 to 17 year age bracket (13%).

7. CoLP's external website reports handcuffing on 405 people and 29 in the 16yrs and under age bracket (7%); 33 in the 17yrs to 20yrs age bracket (8%).

8. The figures for handcuffing young people in the City of London police as shown at paragraph 7 above (and Table 1 below) are not out of line with the figures presented by Cambridgeshire and the MPS for their use of force.

9. Table 1 below attempts to demonstrate the comparison between the three forces. However, this is hampered by the different type of data and the fact that CoLP figures are broken down by different age brackets than MPS. In addition, MPS and Cambs are reporting Use of Force (which includes use of Handcuffs - and also baton use and physical restraint) and CoLP figures report just the use of handcuffs specifically. Figures for each force, with their own age brackets, can be found in Appendix A.

Table 1: Use of force/handcuffs broken down proportionally by age for MPS, Cambs and CoLP.

Age*	MPS	CAMBS	COLP
0-16/17	12.8%	7.8%	7.2%
17/18-34/35	57.2%	61.6%	62.7%
35/36-50/51	22.7%	23.3%	18.8%
50/51 - 64/65	6.6%	6.4%	4.0%
65/66 +	0.7%	0.6%	7.4%
Not known / recorded		0.4%	
Total	100.0%	100.0%	100.0%

* CoLP uses different age brackets than MPS and Cambs so a precise comparison is not possible. Hence, slightly overlapping age ranges in this table.

10. It should be noted that Superintendent Bill Duffy has undertaken some dip-sampling on the Use of Force Forms for juveniles in the City and has found no instances of improper use of force. Further to this, no complaints have been received by CoLP for use of force on juveniles.

Conclusion

11. While it was regrettable that figures previously presented were wrong to compare, it is hoped the figures presented above allay any concerns that CoLP may be using excessive force on juveniles (in comparison to MPS and Cambs).

Appendices

- Appendix 1 – Indivudal force figures for MPS, Cambridgeshire and City of London.

Background Papers

Annual update on the Custody of Vulnerable Persons (Young Persons, Children and Mental Health), presented to Police Committee (21st September) and Safeguarding Sub-Committee (27th September 2017)**.**

Detective Superintendent Maria Woodall
Head of Professional Stantdards Directorate

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Appendix 1

Use of Force / Handcuffs broken down by age for Metropolitan Police Service, Cambridgeshire Constabulary and City of London Police.

MPS - Q1 2017-18		
Age	**Total individuals**	**% of total**
0-10	17	0.1%
11-17	1593	12.6%
18-34	7213	57.2%
35-49	2864	22.7%
50-64	830	6.6%
65 +	88	0.7%
Total	**12605**	100.0%

CAMBS - Jul 2017 to Sept 2017		
Age	**Total individuals**	**% of total**
0-10	5	0.4%
11-17	85	7.3%
18-34	714	61.6%
35-49	270	23.3%
50-64	74	6.4%
65 +	7	0.6%
Not known / Recorded	5	0.4%
total	**1160**	100.0%

COLP - April-Sept 2017 (Q1 and Q2 combined)		
Age	**Total individuals**	**% of total**
0-16	29	7.2%
17-20	33	8.1%
21-25	106	26.2%
26-30	58	14.3%
31-35	57	14.1%
36-40	35	8.6%
41-45	28	6.9%
46-50	13	3.2%
51-55	7	1.7%
56-60	6	1.5%
61-65	3	0.7%
66 +	30	7.4%
Total	**405**	100.0%

Committee(s):	Dated:
Safeguarding Sub Committee Community and Children Services	06/02/2018 09/02/2018
Subject: Safeguarding Children's Board Annual Report	Public
Report of: Jim Gamble, Independent Chair of The City & Hackney Safeguarding Board	For Information
Report author: Rory McCullum, Senior Professional Advisor	

Summary

The City & Hackney Safeguarding Board (CHSCB) annual report for 2016/17 is a transparent assessment on the effectiveness of safeguarding and the promotion of child welfare across the City of London and the London Borough of Hackney.

- The report describes the **governance and accountability** arrangements for the CHSCB, outlining the structures in place that support the CHSCB to do its work effectively.
- It sets the **context for safeguarding children and young people** in the City of London, highlighting the **progress made by the City partnership** and the challenges going forward.
- It sets out the lessons that the CHSCB has identified through its **Learning & Improvement Framework** and the actions taken to improve child safeguarding.
- The report also describes the range and impact of the **multi-agency safeguarding training** delivered by the CHSCB and a brief account of the single agency training delivered by partners.
- It sets out the **priorities going forward** and the **key messages** from the Independent Chair of the CHSCB to key people involved in the safeguarding of children and young people.

Recommendation(s)

Members are asked to:

- Note the report and the conclusions set out in this cover report.

Main Report

Background

The publication of an annual report by the CHSCB is a requirement set out in the statutory guidance Working Together 2015.

Its purpose is to provide a transparent account of the strength and weaknesses of local child safeguarding practice – as determined by the Independent Chair and the Board itself.

Current Position

The report sets the context for child safeguarding activity over 2016/17. During this time period both the City of London Corporation and the CHSCB were subject to external scrutiny by Ofsted.

The City of London Corporation was judged to be Good overall, with Outstanding leadership and management. The CHSCB was the first local safeguarding children board in the country to receive an Outstanding grading.

'This is an outstanding LSCB. It is a dual board covering both the City of London and Hackney. The board demonstrates an unwavering determination to safeguard children, with a firm commitment to sustaining and improving partnerships.' Ofsted 2016

The report reflects many of the strengths identified through this inspection process and can be read in full here. (*electronic copy to be circulated separately)*

Conclusion

In terms of past performance, the City of London Corporation has a strong and positive story to tell – as reflected in previous CHSCB annual reports.

The UK as a whole has one of the most sophisticated safeguarding systems in the world and whilst there will always lessons to learn and practice to improve, it is important to reflect the enormous efforts made by front-line staff from a variety of different agencies. Staff who come to work every day with the intention of helping people and making them safer.

It is also important to reflect the inherent risks that are evident in the national system right now.

- Workload – CP investigations up 60% over 10 years
- £2 billion funding gap by 2020
- 5 million children in poverty by 2020
- Austerity – More in need & fewer getting help
- Mental health and emotional resilience for children and YP
- Threats of exploitation and abuse
- Organisational Change

In addition to the above, the Children & Social Work Act 2017 has led the way for the abolition of LSCBs and revised statutory guidance – Working Together 2018. This is seen by both the Independent Chair and the Senior Professional Advisor to the CHSCB as one of the most significant risks facing safeguarding partners given its permissive approach.

Experience in this field would evidence that such an approach will not work. Lord Laming was not wrong. Multi-agency working does not happen by itself or even via the good will of dedicated staff. Multi-agency work needs to be harnessed and driven and must at its heart be open to independent and continuous challenged to do better.

A framework that encourages constructive ambiguity won't help us improve.
Left to their own devices and steered by a 'permissive' framework (if any framework at all), partners will delegate responsibility, but not authority. We will be left with no guarantee that important issues will be identified and addressed at the right strategic level or with the appropriate expertise or experience set.

Building on what has worked well, strengthening the independent insight and challenge provided by boards as well as enhancing their relationship with and between Inspectorates would have had a far greater positive impact. A framework is necessary to ensure compliance with the basics and it is the basics that often go wrong.

If the answer to this criticism and concern is that a new arrangement will deliver the same singular child centric focus in a new and similar format - why change? Why introduce a dangerous level of ambiguity and the potential for post code confusion in future safeguarding arrangements? – particularly in the context of the demands set our above.

Given the permissive nature of the new approach, many LSCBs will change in name only and whilst the CHSCB will always continue to seek ways to improve and enhance our partnerships to deliver better outcomes for children; all partners have agreed locally to retain our current systems and approach (*notwithstanding those areas where statute will drive explicit and non-negotiable change* (i.e. SCRs and CDOP))

After years of experience we have learnt that to be effective, safeguarding must be everyone’s business. That statement is not and never should be treated as mere rhetoric.

Appendices

None

Rory McCallum
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Committee(s):	**Dated:**
Safeguarding Sub Committee Community and Children's Services Committee	06/02/2018 09/02/2018
Subject: The City and Hackney Safeguarding Adults Board Annual Report 2016/17 presented by Dr Adi Cooper Independent chair of the CHSAB and Melba Gomes, Interim CHSAB Manager.	**Public**
Report of: Director of Community and Children's Services	**For Information**
Report author: Melba Gomes, City and Hackney Safegurading Adults Board Manager	

Summary

The City and Hackney Safeguarding Adults Board is a statutory Board and Annual Report is statutory

In summary during 2016/17

- City partnership has being driving forward work on financial abuse and social isolation.
- There have been 4 Safeguarding Adult Reviews in 2016/17 , none of which were for City residents
- Learning has come back into the City however via the SAR workshops.

Recommendation

Members are asked to:

- Note the report.

Main Report

1 Background

1.1 The London Borough of Hackney and the City of London have diverse, vibrant communities, with many organisations and individuals not only providing effective adult safeguarding, but also committed to the Safeguarding Adults Board and the partnership it represents. The City and Hackney Safeguarding Adults Board is a multi-agency partnership of statutory and non-statutory stakeholders. This report sets out an appraisal of safeguarding adults activity of those agencies across the City of London and Hackney boroughs in 2016/2017.

1.2 The Care Act sets out a clear statutory framework for how local authorities and other key partners, such as care providers, health services, housing providers and criminal justice agencies, should work together to protect an adult's right to live in safety, free from abuse and neglect. It introduces new safeguarding duties for local authorities including: leading a multi-agency local adult safeguarding system; making or causing enquiries to be made where there is a safeguarding concern; carrying out Safeguarding Adults Reviews; arranging for the provision of independent advocates; and hosting Safeguarding Adults Boards.

1.3 In setting out a statutory requirement for Safeguarding Adults Boards for the first time, the Care Act establishes three core duties for those Boards: The Board must:

a) Publish a strategic plan for each financial year that sets out how it will meet its main objectives and what the members will do to achieve this.

b) Conduct any Safeguarding Adults Reviews as may be required.

c) Publish an annual report detailing what the SAB has done during the year to achieve our main objectives and implement its strategic plan.

This annual report is provided in line with this requirement.

2 Key Achievements

In line with its strategy, key achievements for the Board in 2016/2017 include:

2.1 Following the presentation by Detective Inspector Phil Brewer on Modern Slavery in the previous year, each partner identified a lead for Modern Slavery. A policy was adopted which provided guidance on how to work with child and adult victims

2.2 Arising from findings from a SAR, the 'self-neglect policy' was reviewed and improved. A multi-agency file audit was instigated, which focused on the theme of self-neglect, and priorities for improvement identified by SARs.

2.3 In response to the findings of a SAR, the CHSAB commissioned a report and best practice guide for supported housing service providers on sexuality, consent and sexual relations when working with older people.

2.4 An escalation protocol was produced to provide a process for partner agencies to resolve, or escalate for resolution, professional disagreements regarding the actions, inactions or decisions of another partner agency in exercising its responsibilities.

2.5 To prevent cases that would be appropriate for consideration under the SAR protocol from slipping through the net and improve understanding, a referral process was agreed, circulated in all agencies and disseminated to staff.

2.6 The Board has recognised the need to identify and support safeguarding champions in the voluntary sector.

2.7 The CHSAB funded training to build staff competence and to increase knowledge in particular areas of practice to prevent recurrence of issues identified in the SARs.

2.8 In line with good practice stipulated in the Care Act 2014 and further amplified in the Multi Agency Pan London Policy and Procedures, a representative of local Housing organisations was .invited to join the CHSAB.

2.9 In response to the absence of representation from the Care and Support services on the Board, as identified by this group themselves, members of the adult social care Provider Forum elected a representative to join the CHSAB.

2.10 Partners of the CHSAB and the Chair have visited community groups to engage with the wider community on safeguarding issues. It has agreed a SAR communication strategy and is working on a model for user engagement.

2.11 Members of Board have audited themselves to identify where they need to make improvements in adult safeguarding and have created action plans to address the deficits

2.12 In line with the City of London's Safeguarding Adults business plan, work has been undertaken by the City of London Financial Abuse Task and Finish Group. A Data sharing agreement is being drawn up with key partners and stakeholders, including the police, trading standards, housing and commissioned advice service. Work has also been done on social isolation, which has been reported to the subgroup.

2.13 City of London is represented on all SAB sub groups, with the Assistant Director chairing the SAR sub group of the Board. A new performance digest including key safeguarding performance indicators will be fully reportable in 2017-2018, due to the recent appointment of a performance strategist.

3 Safeguarding Adult Reviews

During this year 4 Safeguarding Adult Reviews were completed. While each SAR has identified specific issues for learning, there are some shared themes for learning i.e. the need for:

a) Effective working together arrangements across agencies
b) Coordinated working together on a case with one agency taking the lead, including effective communication between all parties
c) Thorough risk assessment and risk management
d) Shared ownership of risk
e) Understanding of the Mental Capacity Act and its application

All four SARs from previous years were completed during 2016/17. The Board noted that these have taken some time to complete. Various processes were used to complete the SARs and it is becoming clearer about the way forward to ensure timely completion of SARs to improve learning and impact. The Board has agreed a series of events during 2017/18 to promote learning from the SARs

4 2016-17 Data

4.1 Safeguarding - The number of safeguarding concerns received from April 2016 to March 2017 was 29: 25 were within the City of London and 4 were outside the City. There has been a slight decrease in alerts raised this year: in comparison there were 34 alerts raised in 2015-2016, with 3 alerts regarding residents placed outside the City. Of the 25 City of London concerns, 13 were progressed to a Section 42 enquiry. The other concerns were diverted from the formal safeguarding process but support and care was provided in all cases. The highest category of risk was neglect and omission, followed by physical abuse and closely by financial abuse. I person was subject to domestic abuse. All people subject to the safeguarding process had their desired outcomes met.

4.2 Deprivation of Liberty Safeguards - The requests for authorisations for the Deprivation of Liberty Safeguards in the City of London has continually increased following the 'Cheshire West' judgement in 2014. However, it appears that they have begun to plateau. The demand for DoLS is unpredictable as there can be an increase in the number of applications received if people are admitted to hospital.

5 Priorities for 2017/18

1. We will continue to raise awareness
2. We want to engage with service users to get feedback
3. We aim to make services personal
4. We will meet our duties to commission safeguarding adult reviews and improve services in line with learning gained including through commissioning relevant training
5. We evaluate improvements through multi-agency case file audits and self-audits
6. We will promote advocacy to support people
7. We are aiming to devise a prevention and early intervention protocol
8. We will gather appropriate data to provide reassurance and improve service

6 City Specific Contribution

Case Examples

6.1 City of London Adult Social Care

6.2 City of London Police

Partner Contributions

6.3 City of London Adult Social Care
6.4 City of London Police
6.5 Trading Standards

7 Corporate & Strategic Implications

7.1 Safeguarding is a Corporate and Departmental priority.

8 Attachment

8.1 CHSAB Annual Report 2016-2017

Melba Gomes
City and Hackney Safeguarding Adults Board
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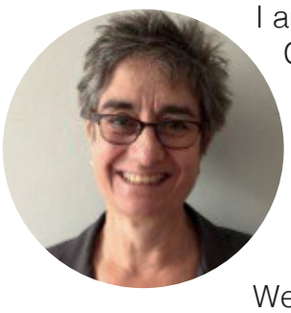
CHSAB Annual Report 2016 – 2017

People should be able to live a life free from harm in communities that are intolerant of abuse, work together to prevent abuse and know what to do when it happens

City and Hackney
Safeguarding Adults Board

Contents

Message from the Independent Chair



I am very pleased to introduce the Annual Report for the City and Hackney Safeguarding Adults Board 2016/17. As the Independent Chair of the Board, I continue to be very grateful to all partners for their contributions to the Board, and their ongoing support. The partnership has continued to grow and develop, as reflected in this annual report.

We have been looking at the patterns in safeguarding activity to inform our priorities for improvement. We have looked at cases where people have died and Safeguarding Adults Reviews were undertaken to understand what happened. We want to learn from these terrible circumstances how we can work together to improve processes, systems and practice and therefore the better support and protect people who may experience abuse or neglect (see page 23).

We continue to work on raising awareness of safeguarding in City and Hackney's communities, which is so fundamental to ensuring people can protect themselves and seek help and support when needed. We continue to address the newer areas of safeguarding activity, included in the Care Act 2014, for example how we can support children and adults who might be victims of modern slavery.

This annual report is important because it shows what the Board aimed to achieve during 2016/17 and what we have been able to achieve. It shows that we have an ambitious agenda on behalf of the residents of City and Hackney. Most of the tasks were completed during the year, which shows how we are progressing. The annual report provides a picture of who is safeguarded in City and Hackney, in what circumstances and why. This helps us to know what we should be focussing on for the future. It includes the Delivery Plan for 2017/18, which says what we want to achieve during the next year. In particular I am mindful that the joint work on fire safety and vulnerable adults started with the learning from Safeguarding Adults Reviews, will be expanded in the light of recent horrific events at Grenfell Tower.

I am very mindful of the pressures on partners in terms of resources and capacity, so want to thank all partners and those who have engaged in the work of the Board, for their considerable time and effort. In this context, we understand the absence of a contribution to this annual report from the London Fire Brigade, who continue to be committed partners of the Board.

I know that there is a great deal that we need to do and want to do to reduce the risks of abuse and neglect in our communities and support people who

are most vulnerable to these risks. This is a journey that we are all making together, and I look forward to chairing the partnership in the next year to continue this journey.

Dr Adi Cooper OBE,
Independent Chair City and
Hackney Safeguarding Adults Board

City & Hackney Safeguarding Adults Board (CHSAB)

Who Are We?

The City & Hackney Safeguarding Adults Board (CHSAB) is the statutory board for the City and Hackney and is a partnership of statutory and non-statutory organisations, representing health, care and support providers and the people who use those services across the City of London and the London Borough of Hackney.

The work of the Board is driven by its vision, that in the City and Hackney:

> People should be able to live a life free from harm in communities that are intolerant of abuse, work together to prevent abuse and know what to do when it happens

The main objective for the Board, to achieve this vision, is to assure itself that effective local adult safeguarding arrangements are in place and that all partners act to help and protect people with care and support needs in the City and Hackney.

The CHSAB has three core duties under the Care Act 2014 that it must fulfil in achieving its main objective:

- Develop and publish a Strategic Plan setting out how it will meet its objective and how its partners will contribute to this;
- Publish an Annual Report detailing how effective their work has been; and
- Commission Safeguarding Adults Reviews (SARS) for any cases that meet the criteria for these reviews.

This Annual Report sets out:

- How effective the CHSAB has been over the 2016/17 year;
- What we have accomplished in relation to the Boards Strategic Plan for 2016/17;
- The Boards Strategic plan for 2017/18;
- Details of the SARS that the board has commissioned; and

How its partners have contributed to the work of the Board to promote effective adult safeguarding.

Our Principles

Public consultation, undertaken during 2015/16, agreed that four principles should underpin our 5-year strategy. These principles are:

- **All of our learning will be shared**
- **We will promote a fair and open culture**
- **We will understand the complexity of local safeguarding needs**
- **The skill base of our staff will be continuously improving**

Governance

The CHSAB partnership consists of representation from:

- **City of London Corporation**
- **London Borough of Hackney**
- **City and Hackney Clinical Commissioning Group**
- **East London NHS Foundation Trust**
- **Homerton University Hospital NHS Foundation Trust**
- **City & Hackney Older People Reference Group**
- **Metropolitan Police Service (Hackney)**
- **London Fire Brigade**
- **London Ambulance Service**
- **Care Quality Commission**
- **Barts Health NHS Trust**
- **National Probation Service**
- **Housing Providers**
- **City of London Healthwatch**
- **Hackney Healthwatch**
- **City of London Police**
- **Hackney CVS**

Dr Adi Cooper was the independent chair of the Board during 2016-2017.

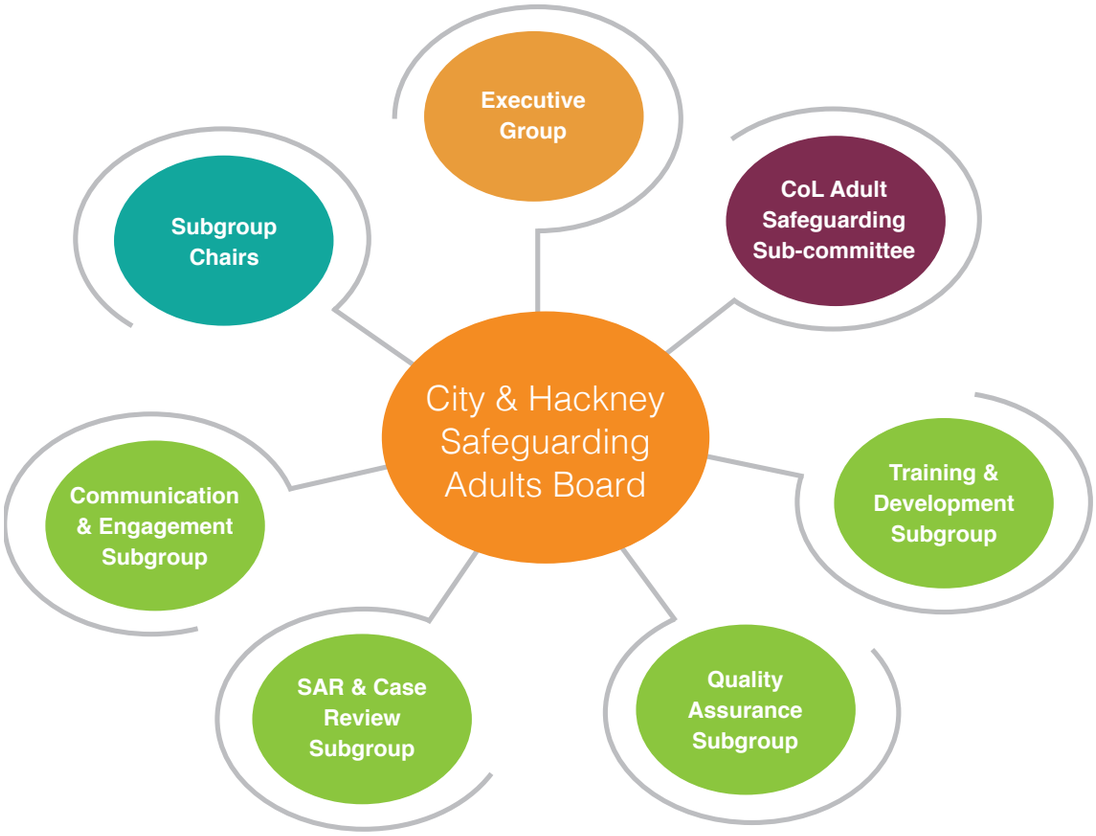
The full CHSAB partnership meets quarterly, and arranges extra meetings when required

The CHSAB Executive Group supports the work of the CHSAB. This Group consists of senior managers from some of the key partner agencies of the Board. The Executive Group meets regularly in between the full CHSAB's quarterly sessions and is also chaired by Dr Cooper. It serves as a link between the sub groups and the Board to support the CHSAB to run effectively.

The City of London Adult Safeguarding Sub-Committee consists specifically of agencies working in the Square Mile. The Sub-Committee provides a clear recognition of and focus on safeguarding arrangements in the City, enables communication with the full CHSAB and is a means of developing a City-focused adult safeguarding in line with the CHSAB's priorities. Dr Cooper who is the chair of the CHSAB also chairs this Sub-Committee.

The CHSAB has established a number of multi-agency subgroups to help it deliver on its objective and annual priorities. These are considered in more detail the '2016-2017 - What We Have Done' section below.

Our overall structure is illustrated below:



Our Strategic Links

The CHSAB has links with partnerships and boards also working with communities in the City of London and Hackney, including: the City and Hackney Children's Safeguarding Board, Community Safety Partnerships; and Health and Wellbeing Boards. We have continued to develop our relationships with these local strategic bodies. This enables the Board to help ensure that local arrangements are working to support people with care and support needs who experience, or are at risk of, abuse and neglect.

Financial Arrangements

This year the CHSAB received total contributions of £164,138 from partners as listed below.

Income Received from Partners:	£
City of London Corporation	(25,000)
East London NHS Foundation Trust	(25,000)
Homerton University Hospital	(12,000)
NHS City and Hackney CCG	(11,750)
Metropolitan Police Authority	(5,000)
Barts and London NHS Trust	(5,000)
City of London Police	(3,000)
London Fire Brigade	(500)
City of London Corporation (FB)	(500)
LB Hackney	(76,388)
CHSAB Underspend 2015/16	(103,500)
Total Income:	**(267,638)**

CHSAB Expenditure:	£
Staff Related	97,444
External Training	12,677
Independent Chair	14,300
Misc. Expenditure	39,717
Other Planned	-
Total Expenditure	**164,138**
Net Position	**(103,500)**

Other partners were not able to make financial contributions but they have contributed with their time and commitment to the Board's work and by providing access to resources such as meeting venues, conferences, etc.

This year, the budget balanced with outgoings met by contributions. The Budget retains a reserve (including an underspend carried over from 2015/16).

Work of the CHSAB 2016/17

The CHSAB held four meetings and a development day during 2016/17. The development day focused on 'scamming'. It convened two additional meetings to consider the findings of two Safeguarding Adult Reviews (SARs) that had been commissioned in the previous years. It had a workshop to align its priorities with Making Safeguarding Personal (MSP) and the principles for safeguarding within the Care Act 2014, and a reflective session on what it achieved during the previous year, to inform its current priorities.

During this year:

- Following the presentation by Detective Inspector Phil Brewer on Modern Slavery in the previous year, each partner identified a lead for Modern Slavery. A policy was adopted which provided guidance on how to work with child and adult victims.
- Arising from findings from a SAR, the 'self-neglect policy' was reviewed and improved. Included in this review was the review of the Community MARAC, which included recommendations to redefine it as a 'High risk panel' to avoid confusion with domestic abuse, and to lower the threshold for referral, in line with the principle of prevention of abuse and neglect. A multi-agency file audit was instigated, which focused on the theme of self-neglect, and priorities for improvement identified by SARs.
- In response to the findings of a SAR, the CHSAB commissioned a report and best practice guide for supported housing service providers on sexuality, consent and sexual relations when working with older people.
- An escalation protocol was produced to provide a process for partner agencies to resolve, or escalate for resolution, professional disagreements regarding the actions, inactions or decisions of another partner agency in exercising its responsibilities.
- To prevent cases that would be appropriate for consideration under the SAR protocol from slipping through the net and improve understanding, a referral process was agreed, circulated in all agencies and disseminated to staff.
- The CHSAB funded an assurance tool for grant giving services to ensure that the organisations that they fund have suitable adult safeguarding policies and procedures, and a toolkit to support voluntary organisations to develop safeguarding policies. Safeguarding awareness training was made available to the voluntary sector. The Board has recognised the need to identify and support safeguarding champions in the voluntary sector.
- The CHSAB funded training to build staff competence and to increase

knowledge in particular areas of practice to prevent recurrence of issues identified in the SARs.

- The collection and presentation of appropriate data on safeguardin activity and trends were reviewed and revised to inform the CHSAB works.
- In line with good practice stipulated in the Care Act 2014 and further amplified in the Multi Agency Pan London Policy and Procedures, a representative of local Housing organisations was .invited to join the CHSAB.
- In response to the absence of representation from the Care and Support services on the Board, as identified by this group themselves, members of the adult social care Provider Forum elected a representative to join the CHSAB.
- Partners of the CHSAB and the Chair have visited community groups to engage with the wider community on safeguarding issues. It has agreed a SAR communication strategy and is working on a model for user engagement.

Self-Audits

Partners of the CHSAB completed an audit of their organisations effectiveness in keeping people safe. They were candid in their self-appraisal and identified some good practice and improvements they needed to make. They demonstrated their commitment to the CHSAB and this is key to affecting change and improving safeguarding activities in the partner organisations. These organisational self-audits were used to inform the priorities for the Strategic Plan for 2017/18.

Joint Working

The Board is supported to have an overarching view of risk across the different areas through Adult Social Care attendance at Multiagency Risk Assessment Conference (MARAC), Multiagency Public Protection Arrangements (MAPPA), Violence against Women and Girls (VAWG) and the Anti-social Behaviour Risk Assessment Panel.

The Community MARAC in the City of London has adult social care representation and the Head of Safeguarding Adults chairs the multiagency High Risk Panel in Hackney.

A representative from Children's services attends the CHSAB. In 2017-18 this arrangement will be reciprocal. The Board was made aware of the 'Think Family approach and a briefing has been circulated to be disseminated to all staff to enable staff to work holistically.

The Board has been working with the Community Safety Partnership on the PREVENT agenda.

Continuous Development

This year the roles and composition of the CHSAB subgroups were consolidated to ensure that they continue to support the work of the Board and deliver on its annual strategic plan. Each subgroup reviewed its Terms of Reference in line with CHSAB's strategic priorities. The subgroups benefit from multi-agency representation, with

Subgroups

This year the roles and composition of the CHSAB subgroups were consolidated to ensure that they continue to support the work of the Board and deliver on its annual strategic plan. Each subgroup reviewed its Terms of Reference in line with CHSAB's strategic priorities. The subgroups benefit from multi-agency representation, with staff from statutory and non-statutory agencies attending and contributing to the work.

Communication & Engagement

The Communication & Engagement subgroup was tasked with the responsibility to devise a plan to engage with the wider community, community groups and users, in order to raise awareness of safeguarding adults and communicate their views to the Board. The group is in the process of producing a User Engagement Protocol that will identify the best way to ensure peoples' views are heard.

From reaching into the community and 'hard to reach' groups, the sub-group has identified that there is a need to further raise awareness and maintain safeguarding on the communities' agenda. It has proposed the training of safeguarding champions in local community groups, which is being explored. The group also devised a SAR Communication Strategy that has been ratified by the Board. It is overseeing the development of a website for the CHSAB.

Quality Assurance

The Quality Assurance subgroup role is to ensure that appropriate and timely quantitative data and qualitative information is available to the Board to consider and respond to where necessary. The core data includes: 1) The location of abuse; 2) groups more susceptible to abuse; 3) types of abuse; 4) timeliness of interventions by professionals; and 5) users satisfaction with interventions (MSP). This enables the Board to be informed of local adult safeguarding activity, trends and patterns that the intelligence may highlight, in order to effect early intervention or to prevent risk. As a result, during 2016/17, the City of London focussed on promoting awareness about financial abuse. Further development in data collection and presentation is expected to provide a comprehensive dashboard that has all safeguarding activity in Hackney and the City of London in one place. Activity captured is based on statutory data collection requirements, priority areas of learning from SARs, and includes data from partner organisations. The dashboard will be available to relevant

partners to access and will have up to date data at the point of logging in. The group was also tasked with creating a mechanism to assess the impact from learning from SARs on improving safeguarding practice, which it is developing. A multi-agency case file audit has commenced which will track cases through the safeguarding processes to assess practice against the themes of Making Safeguarding Personal, mental capacity, risk assessment and information sharing, focussing on self-neglect.

Training & Development

The Training & Development subgroup is responsible to ensure that people who work to safeguard people have the knowledge and expertise commensurate with the role they perform. It recognises that each statutory partner is guided by its own training requirements in relation to safeguarding adults, and that commissioned services are required as part of their contract to provide safeguarding training to its staff. It fills the gap to provide training that stems from the strategic priorities of the CHSAB, and to improve practice in relation to findings from SARs. This year it provided training on the following topics:

Safeguarding Adults: coercion and Emotional cbuse	Mental Capacity Assessment (MCA)
Safeguarding Adults: domestic violence	Deprivation of liberty safeguards (DoLS) awareness
Safeguarding Adults: modern slavery	MCA/DoLS/Safeguarding Adults for Managers
Safeguarding Adults: self neglect and hoarding	MCA/DoLS/Safeguarding Adults for staff
Safeguarding Adults Leads: non-statutory	SAR: Positive risk taking and Risk Management
SAM Training	SAR Models and Methodology
Safeguarding enquiries	

The group has submitted a request to the Board to develop competency standards for training and a training evaluation framework, which are being explored. It is also tasked with producing supervision standards regarding adult safeguarding. It has agreed to carry out an evaluation of training including content, quality, relevance and delivery, using a ‘mystery shopper’ process.

SAR & Case Review

The SAR & Case Review subgroup is the primary mechanism by which the CHSAB exercises its statutory duty to arrange a SAR when someone with care and support needs within its locality dies, as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more effectively together to protect the person. The subgroup is well established and during the course of the year has considered a number of SAR referrals and overseen several Reviews. The subgroup makes recommendations to the CHSAB Chair on when a statutory Review is required and when an alternative approach to identify learning is appropriate. The subgroup will monitor and report to the CHSAB on the development and implementation of multi-agency action plans that may flow from SARs to ensure that the learning from the Reviews has a meaningful and lasting impact on how services work with adults with care and support needs. This year it also was responsible for creating a protocol so that understanding of referrals for SARs was increased amongst frontline staff.

City of London Adult Safeguarding Committee

In line with the City of London's Safeguarding Adults strategic plan, work has been undertaken by the City of London Financial Abuse Task and Finish Group. A Data sharing agreement is being drawn up with key partners and stakeholders, including the police, trading standards, housing and commissioned advice service. Work has also been done on social isolation, which has been reported to the subgroup.

City of London is represented on all SAB sub groups, with the Assistant Director chairing the SAR sub group of the Board. A new performance digest including key safeguarding performance indicators will be fully reportable in 2017-2018, due to the recent appointment of a performance strategist.

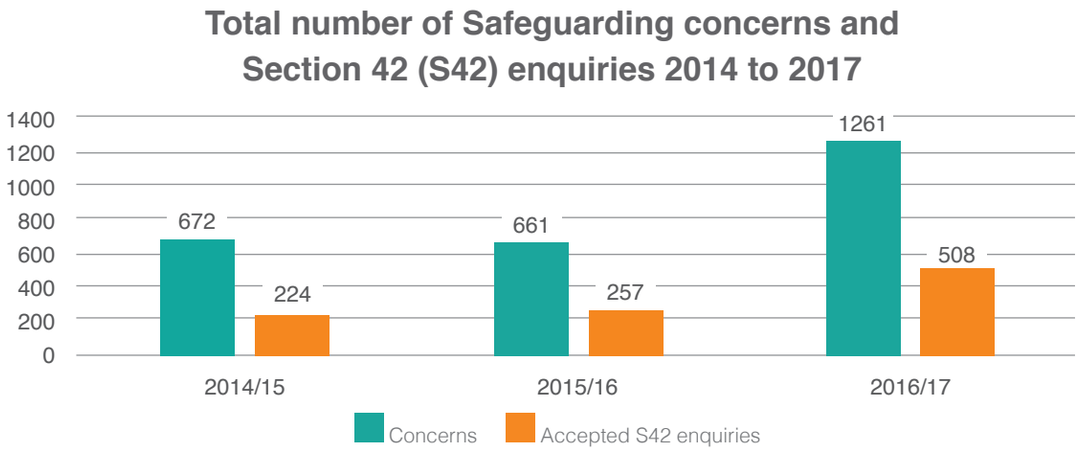
Supporting the CHSAB

The CHSAB Business Support Team comprising of a full-time Board Manager and a full-time Business Support Officer has supported the work of the Board, ensuring that the business of the Board is managed in a timely and efficient manner.

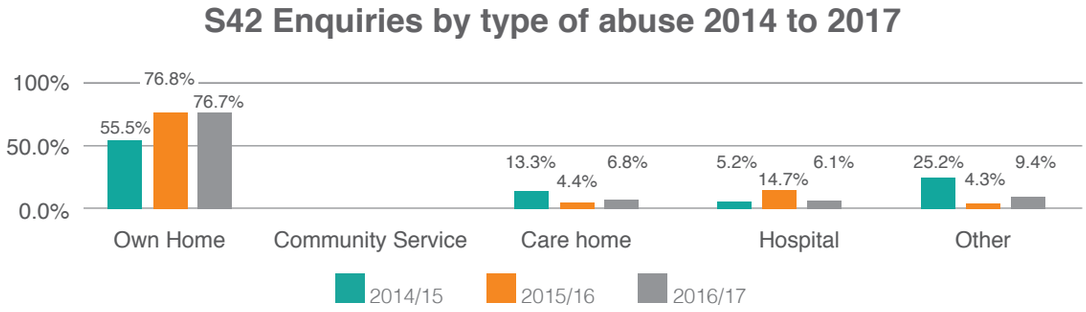
Safeguarding Data

The safeguarding data for the year 2016-2017 is presented separately for the two authorities. City of London and Hackney submit annual statutory returns on safeguarding activity, known as the Safeguarding Adults Collection, and this is included in the data below.

Safeguarding Data - London Borough of Hackney



The number of safeguarding adult concerns raised almost doubled this year, compared to the previous year, 2015/16. 508 of the 1261 concerns were progressed as S42 enquiries. This increase in Section 42 enquiries relates to a consistent application of safeguarding guidance



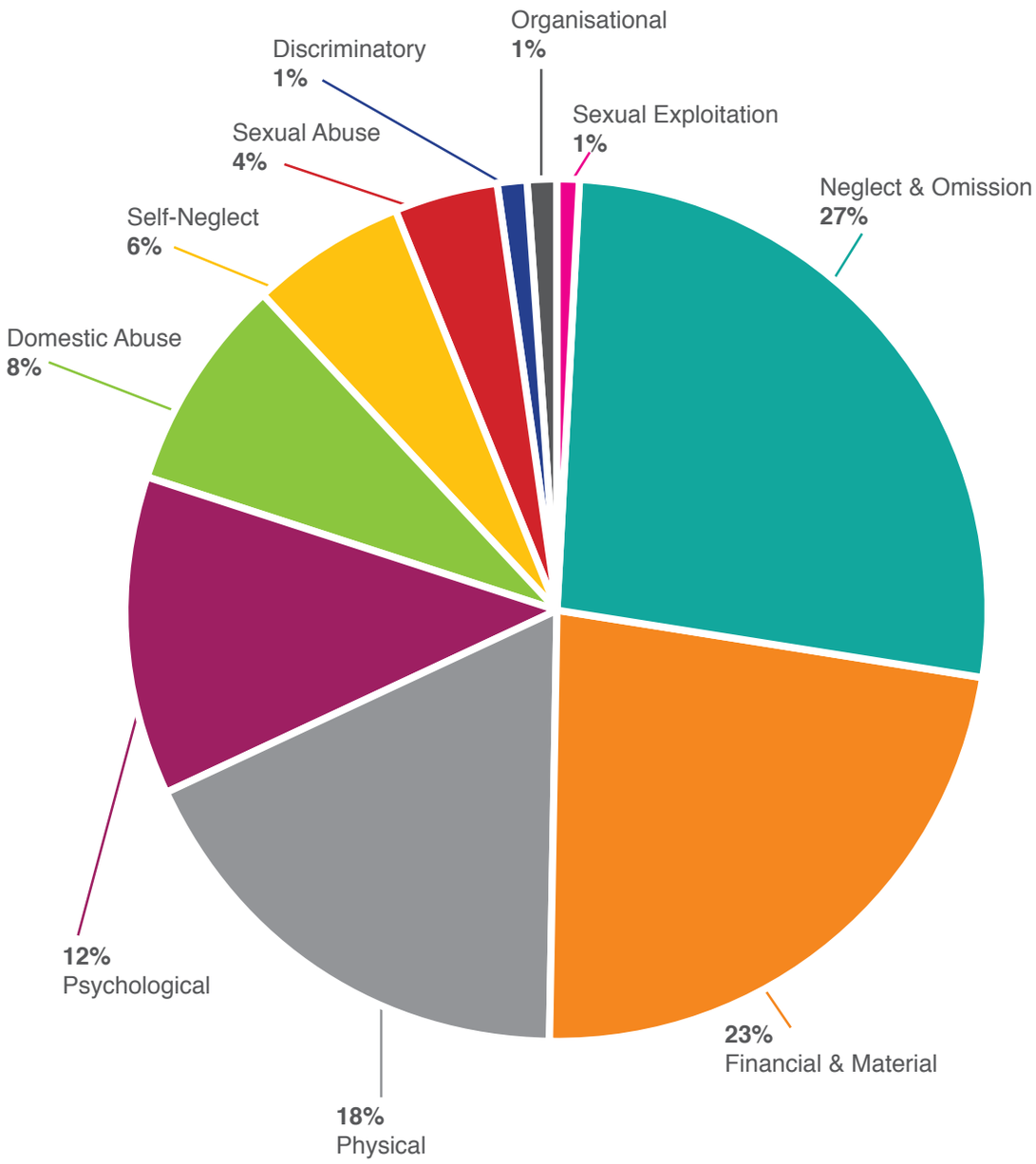
The data shows that most of the abuse happened in people's own homes. That most abuse happens in people's homes is in line with what is happening generally in similar authorities, as demonstrated by the comparator. (This comparator is a measure used by NHS Digital to report analysis data from

[1]A s42 enquiry is undertaken according to Chapter 14 of the Care and Support Statutory Guidance (Department of Health, updated February 2016), sometimes referred to as 'a formal safeguarding enquiry'. 'section 42' or a 's.42'.

the Safeguarding Adults Collection. Comparator groups are a selection of 15 councils considered to be similar to the chosen council. They are selected according to the Chartered Institute of Public Finance and Accountancy (CIPFA) Nearest Neighbour Model, which identifies similarities between councils based on a range of socio-economic indicators). But abuse in the

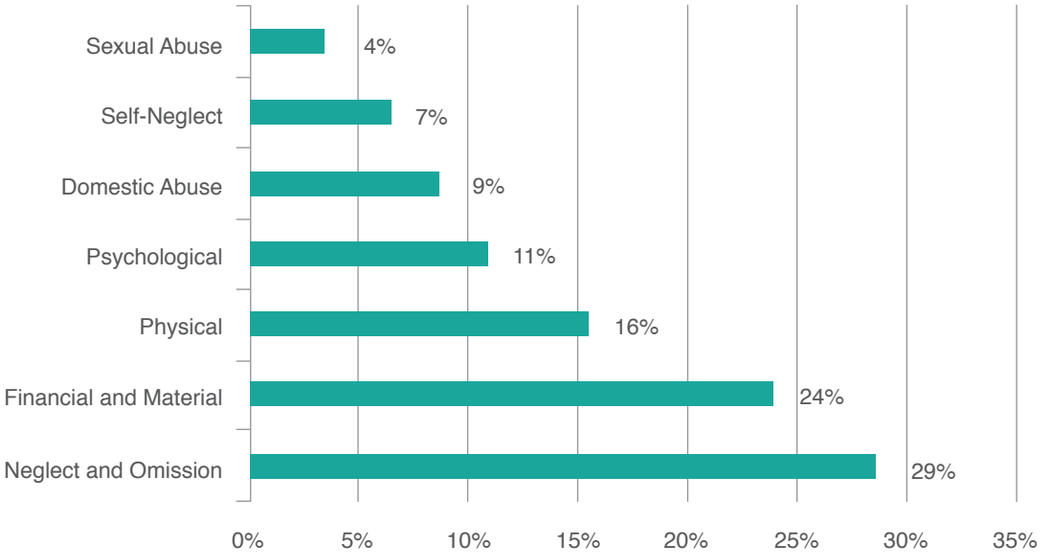
person's own home was 23% higher in Hackney than the other boroughs in the comparator in 2015/16. Whereas it looks like there has been a drop to less than 50% for enquiries in hospitals in 2016/17, the actual reduction in cases is 2. The levels of abuse in care homes is low due to the fact that there are a very small number of care homes in Hackney.

S42 by types of abuse

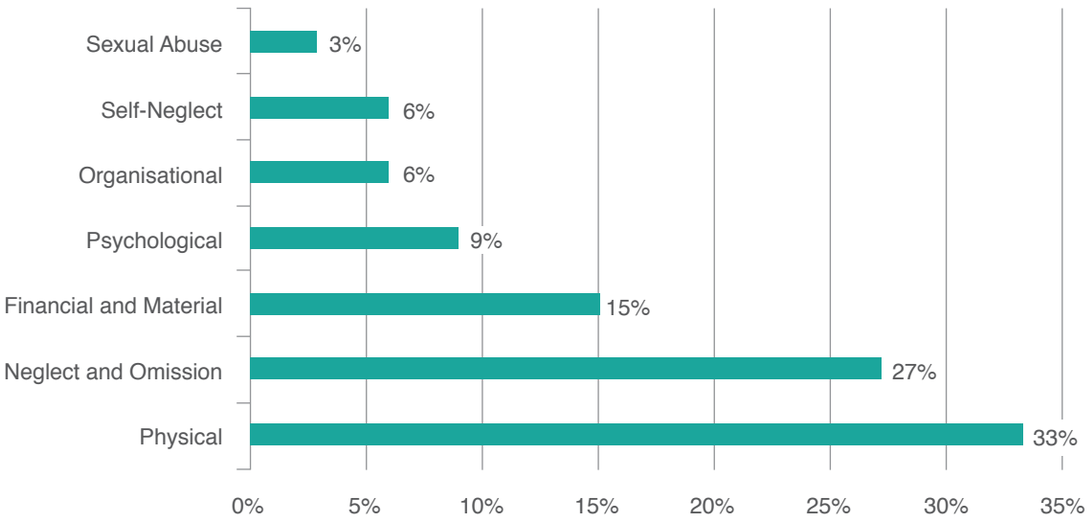


The biggest category of abuse remains neglect and acts of omission, this compares with other comparator authorities in 2015/16. This category is followed closely by financial and material abuse, then by physical abuse. Physical abuse rather than financial and material abuse was the second largest category in other comparator authorities.

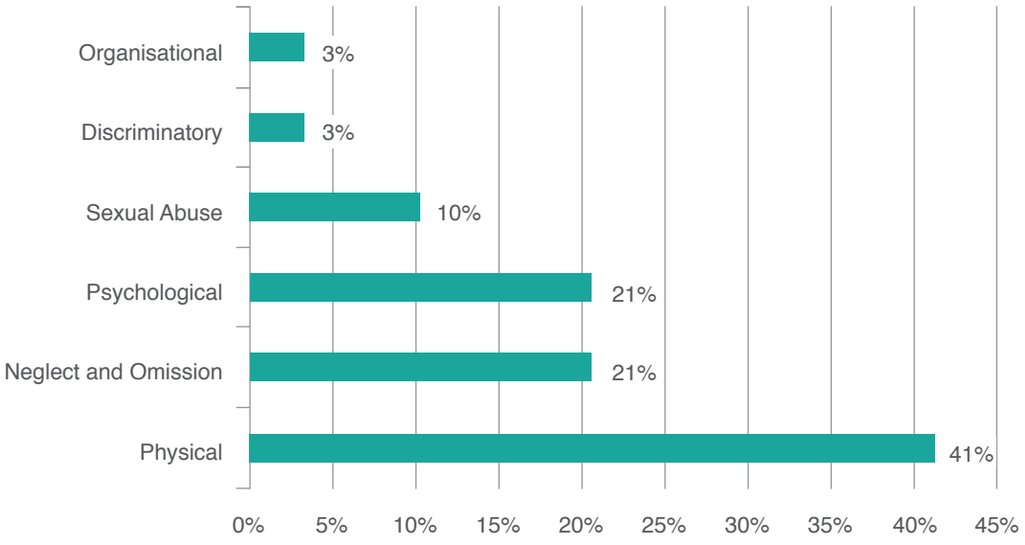
Proportion of types of abuse in own home 2016/17



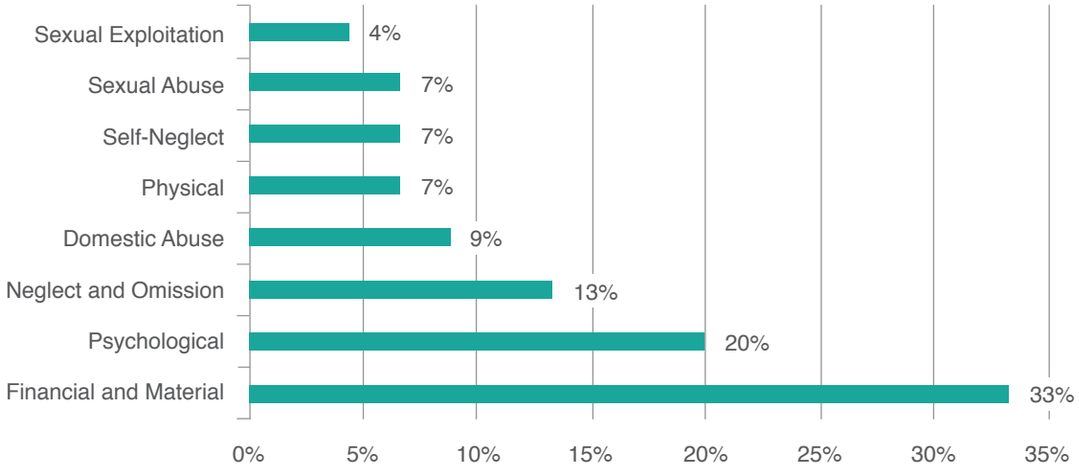
Proportion of types of abuse in care homes 2016/17



Proportion of types of abuse in hospitals 2016/17

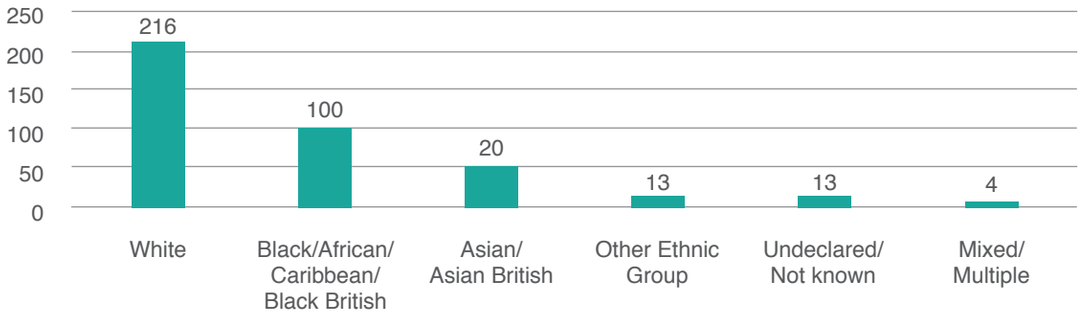


Proportion of types of abuse in other locations 2016/17



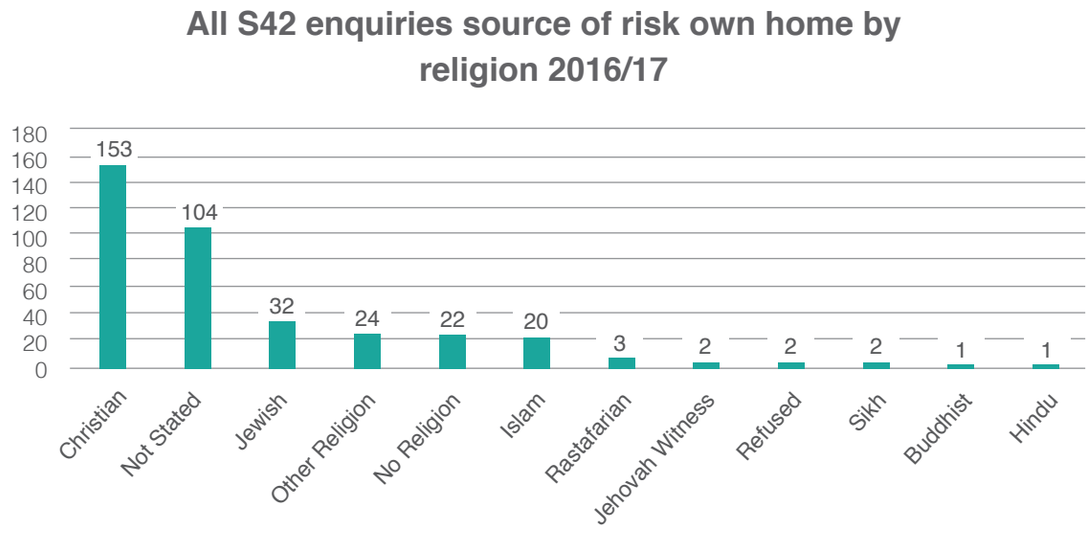
Neglect and omission was the largest category of abuse in people's own home, while physical abuse was the highest category in hospitals and care homes. Financial and material abuse was the main category in other settings.

All S42 enquiries source of risk own home by ethnicity 2016/17



	White	Black/ African/ Caribbean/ Black British	Asian/ Asian British	Other Ethnic Group	Undeclared/ Not known	Mixed/ Multiple
Source of Risk in Own Home	56%	28%	6%	4%	4%	1%
Hackney Population (ONS 2015)	55%	23%	11%	5%		6%

The table above shows the ethnicity of people who were subject to S42 enquiries. Asian/Asian British is under represented in safeguarding where cases progressed to S42 enquiries. As per the Office of National Statistics Asian/Asian British Population makes up 11% of the population of Hackney and have had 5% of cases taken forward to S42 Enquiries. In relation to all other ethnic groups, S42 enquiries have been in line or above the average as per the population profile of Hackney residents.



	Christian	Not started	Jewish	Other Religion	No Religion	Islam
Source of Risk in Own Home	42%	28%	9%	7%	6%	5%
Hackney Population (ONS 2015)	39%	10%	6%	1%	28%	14%

The tables above shows the religion, where available, of people who were involved in S42 enquiries. People of Islamic faith are under represented i.e. whereas 14% of the population of Hackney are people of this faith, only 5% of people involved in the S42 enquiries were people of Islamic faith. Taking into account that Asian/Asian British have low representation (as stated earlier), it is worth noting that there were very low level of S42 enquiries involving people of Sikh, Buddhist and Hindu faith.

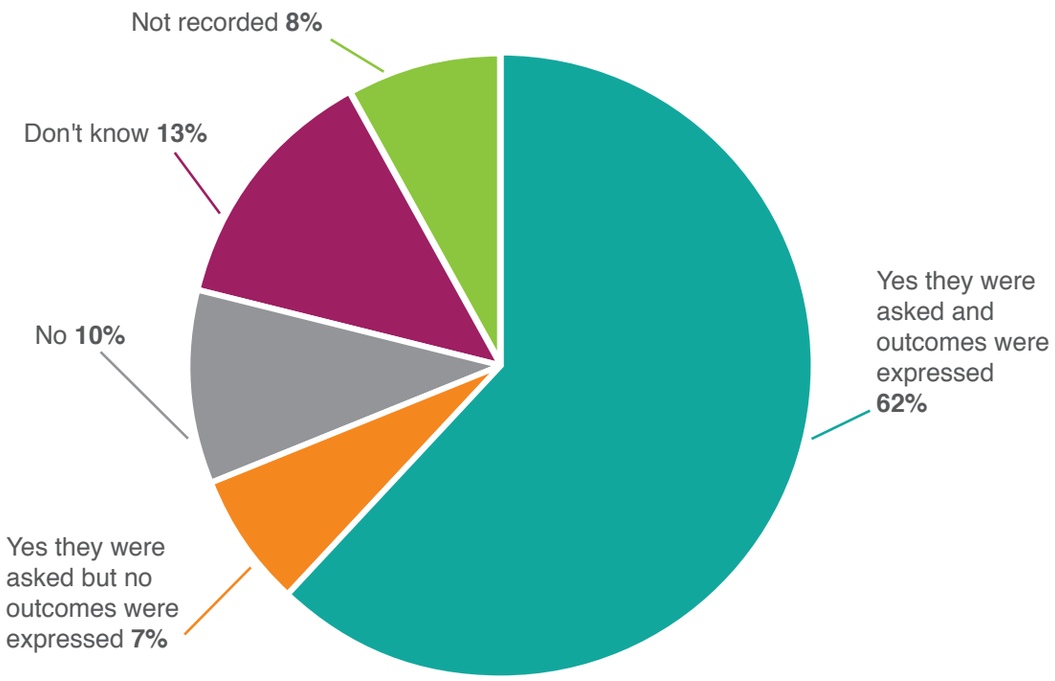
Repeated S42 Enquiries

The data showed that 1 person was subject to 4 Section 42 enquiries, 13 were subject to 3 such enquiries and 45 people had had 2 Section 42 enquiries during 2016/17. This data where more than two Section 42 enquiries were pursued warrants further investigation to understand the reasons for repeat enquiries in order to refine practice and this will be undertaken.

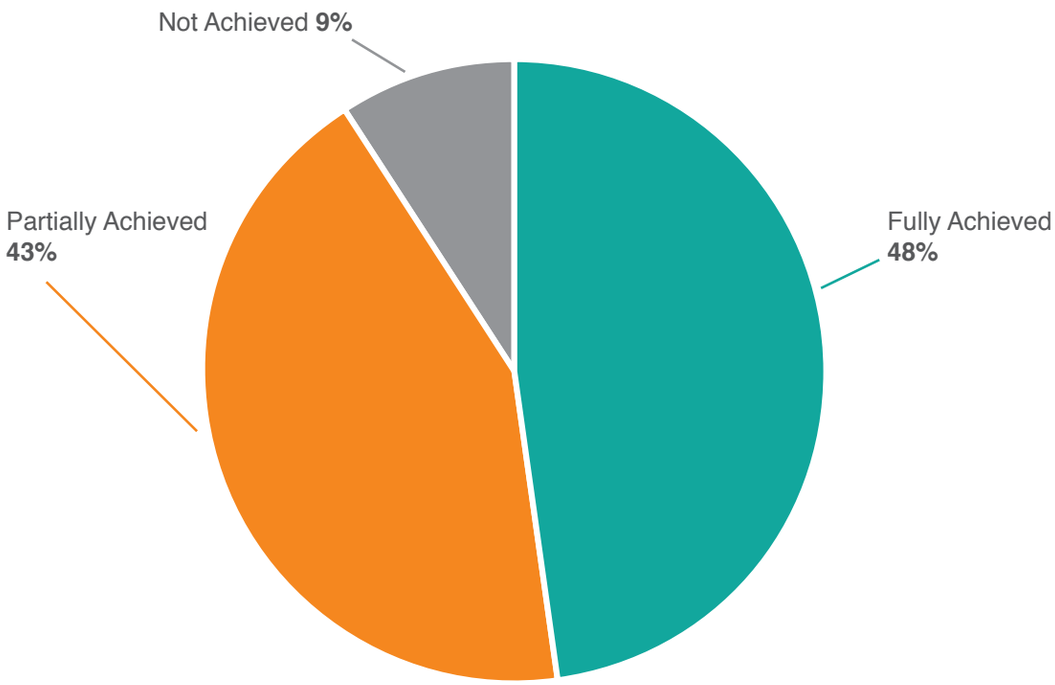
Making Safeguarding Personal

During 2016/17, 62% of people were asked about their desired outcomes and their outcomes were expressed where 'other safeguarding enquiries' were progressed. 91% of those who were asked had their outcomes achieved or partially achieved .

Making safeguarding personal outcomes for other safeguarding enquiries

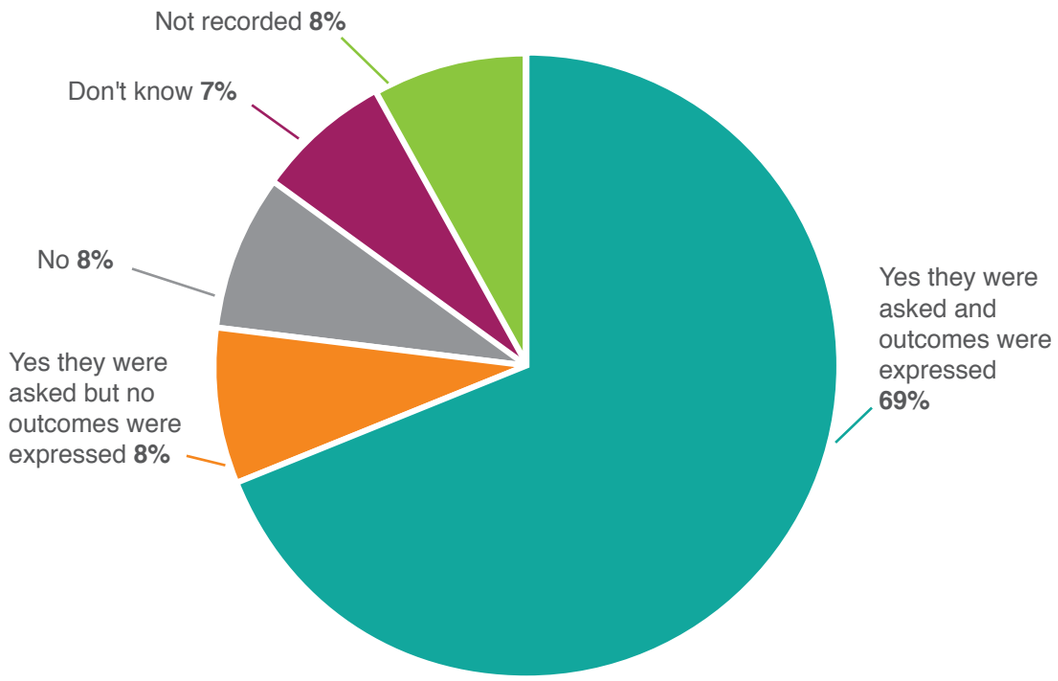


Desired outcomes of other enquries where outcomes were asked and achieved

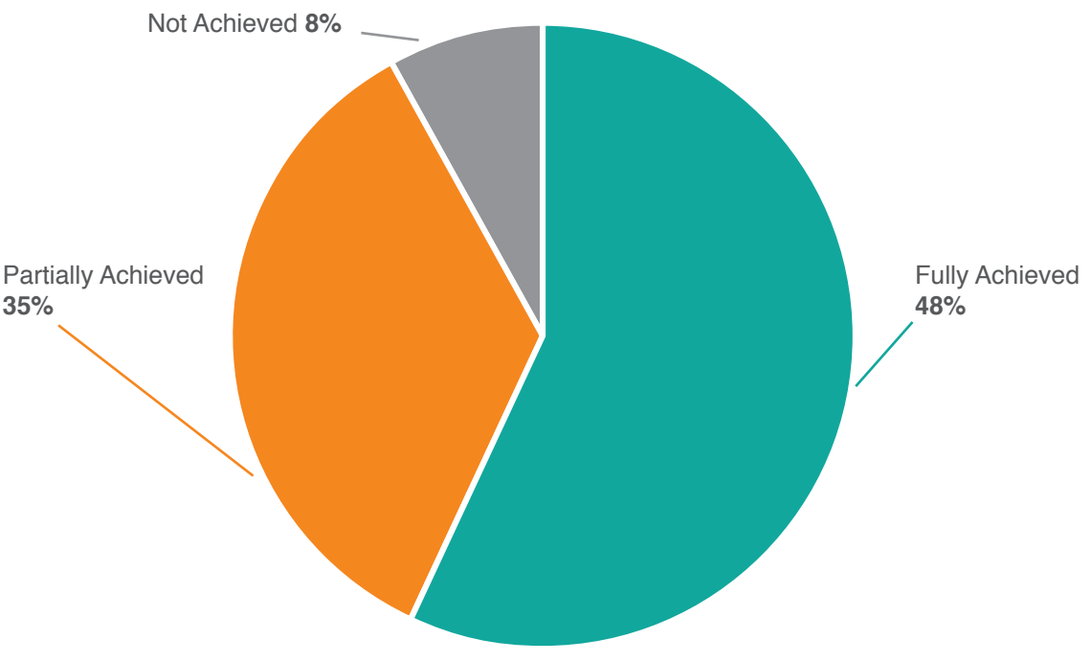


During 2016/17, 69% of people whose safeguarding concerns were progressed as S42 safeguarding enquiries were asked and expressed their desired outcomes. 92% had their outcomes fully or partially achieved.

Making Safeguarding personal outcomes for concluded S42 Safeguarding enquiries



Desired outcomes of concluded S42 enquiries where outcomes were asked and achieved



Other Key Improvements

Referrers informed us that we were not getting back to them to tell them what happened to the referrals they made. Due to additions to our data recording systems we are able to report on this item. The data shows that we have got back to 80% of referrers. This issue is being auditted as part of the multi-agency file audit and we will be able to report more fully in the Annual Report for 2017/18

It had been highlighted that in Hackney there was a low usage of advocacy. In an audit of 20 cases where a person lacked capacity and was subject to safeguarding procedures, in 80% of cases the person had appropriate representation. Work is being carried out to improve the forms to prompt and ensure clarity for practitioners to report appropriately on advocacy.

Deprivation of Liberty Safeguards (DoLS)

In 2016/17 there were 804 applications for DoLS, an increase from 682 applications in 2015/16, and 344 in 2014/15. This continues the pattern of a radically increased DoLS workload each year since the Supreme Court's judgment in the "Cheshire West" case in March 2014. By comparison, there were only 23 applications for DoLS 2013/14, of which 13 were approved.

However, given the significantly broader awareness of the Deprivation of Liberty Safeguards amongst providers, including hospitals and residential homes, this is likely to be a plateau for the borough and creates the opportunity to devise a permanent approach to responding to the applications, whilst also increasing the number of applications made to the Court of Protection where a deprivation of liberty is occurring for somebody in a community setting, i.e. supported living, sheltered accommodation, shared lives, etc.

Safeguarding Data – City of London

The number of safeguarding concerns received from April 2016 to March 2017 was 29: 25 were within the City of London and 4 were outside the City. There has been a slight decrease in alerts raised this year: in comparison there were 34 alerts raised in 2015-2016, with 3 alerts regarding residents placed outside the City. Of the 25 City of London concerns, 13 were progressed to a S42 enquiry. The other concerns were diverted from the formal safeguarding process but support and care was provided in all cases. The highest category of risk was neglect and omission, followed by physical abuse and closely followed by financial abuse. 1 person was subject to domestic abuse. All people subject to the safeguarding process had their desired outcomes met.

Deprivation of Liberty Safeguards (DoLS)

The requests for authorisations for the Deprivation of Liberty Safeguards in the City of London has continually increased following the 'Cheshire West' judgement in 2014. However, it appears that they have begun to plateau. The

demand for DoLS is unpredictable as there can be an increase in the number of applications received if people are admitted to hospital.

There have been two DOLS cases in the Court of Protection this year, which illustrate the complexities of the Mental Capacity Act and Mental Health Act and the skilled management of rights and risks.

Reporting Period	Number of DOLS Requested	Number of DOLS Granted
2013 – 2014	Less than 5	Less than 5
2014 – 2015	13	12
2015 – 2016	34	29
2016 – 2017	39	29

Safeguarding Adults Reviews (SARs)

The SAR & Case Review subgroup received three case referrals this year. One was deemed not to require a SAR, for another, Ms Q, a SAR was instigated and the group is waiting on further information on the third. All 4 SARs from the previous years were completed during this year and published, not always in their entirety, depending on sensitivities or wishes of family (short summaries follow below). 2 Independent Practice Reviews from the previous year were also completed during 2016/17.

Mrs A & Mr B SAR

Mrs A and Mr B were residents in a supported housing with care complex. There were concerns that Mr B posed a fire risk to the other residents and that he allegedly sexually assaulted Mrs A in her flat. The Review has been necessarily drawn out, being mindful both of working with the families of those involved and that it was running in parallel with other reviews or investigations. The CHSAB followed the Social Care Institute for Excellence's Learning Together model for this SAR. An executive summary of the SAR has been published and is available on the CHSAB webpage to view (http://www.hackney.gov.uk/safeguarding-adults-board#sar).

As a result of this SAR, an independent report and guidance were commissioned on consent, sexuality and sexual relations when working with older people living in supported housing. This guidance was developed with relevant staff, and, following training, is now available to all staff. Risk assessment and risk management training has been provided to staff. The full range of improvement actions from this SAR are monitored by the SAR subgroup and reported to the Board.

Mr BC SAR

Mr BC was an older person living in a sheltered housing scheme, who died in a fire at his home in 2014. He was a heavy smoker who routinely drank large amounts of alcohol and was using a number of services at the time of his death. This SAR adopted a more traditional approach set out by other SARs and Serious Case Reviews, establishing a SAR Panel, with an independent Panel Chair and an independent lead reviewer, which commissioned Individual Management Reports (IMRs) and further evidence from the agencies involved.

During the course of this Review, the Panel advised the CHSAB Chair that it was necessary to seek from the housing provider involved further assurance, beyond and complementary to the scope of the SAR, that it had taken sufficient

action to reduce the likelihood of serious injury due to fire to vulnerable individuals in their properties. The provider gave this assurance satisfactorily before the SAR completed. The SAR report is available on the CHSAB webpage to view (http://www.hackney.gov.uk/safeguarding-adults-board#sar).

Actions taken so far as a consequence of this SAR include:

- Housing services are represented on the CHSAB, and a representative of Care and Support services has been invited to join the Board.
- The Self-Neglect protocol has been reviewed and a multi-agency case file audit based on cases where self-neglect occurred, is being conducted
- Safeguarding processes have been reviewed in Hackney and new forms are being used
- An escalation policy is in place for all Board partners
- Shared ownership of risk is facilitated through the High Risk Panel
- Risk Assessment and risk management training, training on relationship based approaches and MCA training has been arranged
- Fire safety visits are recorded on the LBH dashboard. Since February 2015, 98 visits were carried out to tenancies in housing where care is also provided.

The improvement actions from this SAR are being monitored by the SAR & Case Review subgroup and are reported to the Board.

Mr GH SAR

Mr GH was also an older person living in a sheltered housing scheme. Mr GH passed away in 2015 while experiencing a number of health issues and using a range of services. This SAR followed the same methodology as is described above for Mr BC. The CHSAB funded specific IMR training for the contributing agencies and SAR panel members involved, to help ensure that the process was well supported to deliver effective evidence-based learning. This is an example of how the CHSAB is continually working to evaluate and develop its practices. The report of this SAR is available on the CHSAB webpage to view (http://www.hackney.gov.uk/safeguarding-adults-board#sar).

The action plan is being compiled and will be reported on in the annual report for 2017/18.

Mrs Y SAR

Mrs Y was 85-years-old at the time of her death. She was known to have a history of history of strokes, cognitive impairment and visual impairment.

She was living at home with her daughters. There are concerns that neglect may have contributed to her death and a number of different agencies had concerns about Mrs Y, but there was limited evidence on file of any concerted action to establish her needs and assess risk. The report of this SAR has been published and is available to view on the CHSAB webpage (http://www.hackney.gov.uk/safeguarding-adults-board#sar).

The action plan is being updated and will be reported on in the annual report for 2017/18.

Key Cross-cutting Themes from the SARs

While each SAR has identified specific issues for learning, there are some shared themes for learning i.e. the need for:

1) Effective working together arrangements across agencies
2) Coordinated working together on a case with one agency taking the lead, including effective communication between all parties
3) Thorough risk assessment and risk management
4) Shared ownership of risk
5) Understanding of the Mental Capacity Act and its application

SAR Learning Events

All four SARs from previous years were completed during 2016/17. The Board noted that these have taken some time to complete. Various processes were used to complete the SARs and it is becoming clearer about the way forward to ensure timely completion of SARs to improve learning and impact.

The Board has agreed a series of events during 2017/18 to promote learning from the SARs that include:

- A conference
- Workshops
- A Leaders' Symposium

A SAR Communication Plan has been produced to disseminate learning for staff and volunteers across services in the City of London and Hackney.

Evidencing Good Practice – Case Studies

Homerton University Hospital NHS Foundation Trust

Case Study: Modern Slavery

The following case study describes a patient who was subject to Modern Slavery.

A patient arrived in A&E at the Homerton. He reported the following that:

- He came to the UK by "car", driving from Poland with "friends"
- He was told he would come to work in construction in London for £6-7/hr
- He was told not to bring his own money
- He was in fact taken to an industrial area "an hour from London"
- He discovered that the job he was to be given was to sort recycling for £1.50/hour
- He was told that he had to pay them back for his travel and accommodation, and that his wages would be put towards that
- He was told he would not be paid until the end of the week
- He did not want to work under such conditions and so left by foot
- He reported he walked for 3 hours to reach London
- He went to the Polish embassy, and could not find anyone to speak to
- He had no money
- He was sleeping rough, and woke up in hospital

The ward staff contacted the Modern Slavery Helpline and the Salvation Army.

The person on the Modern Slavery helpline spoke to the patient in his own language and reassured him that steps could be taken to support him to return to Poland.

The Salvation Army reported they would be able to help. They requested a National Referral Mechanism' form, which was completed by a social worker. The patient was picked up from the hospital by the Salvation Army and taken to a hostel in Cardiff. The Lead for Adult Safeguarding established, during a follow up conversation, that the patient has returned to Poland.

Good practice

The ward team, particularly the junior doctor involved, pursued the case until a positive outcome was achieved for the patient. They addressed his social needs, as well as his health needs, diligently.

Metropolitan Police Service – Hackney

Case Study 1: Domestic Violence

Police were alerted to this situation following a victim disclosure made during a safeguarding adults meeting where the victim disclosed physical abuse to a professional by her elderly and unwell husband. The victim herself was elderly with some disabilities together with early onset of dementia. She was dependant on her husband and scared to report him but wanted the violence to stop.

Police and Adult Safeguarding staff worked closely together to implement a safeguarding strategy; it included the arrest of the perpetrator. The husband was charged with assault and remanded to court where he was convicted of assault. He was unwell himself and this impacted on the family and the victim's engagement with police as all sought to have the perpetrator released and for him to return to the family home.

Rehousing was offered but declined. Safeguarding the victim continued beyond the conviction with support from an Independent Domestic Violence Advocate and a MARAC referral was made. Follow up visits were undertaken. Re-housing was offered to the victim. The suspect had a firearms licence to hold guns at his address – by revoking a firearm licence it removes firearms from the environment and prevents them being used in anger or as part of domestic abuse.

The person's desired outcomes were met as we worked with her and it wasn't just about a criminal justice outcome. We put her at the centre of the process.

Case Study 2: Conviction for Carer Abuse

Hackney MPS has a dedicated Vulnerable Adult team with Detectives located within our Community Safety Unit who lead on Vulnerable Adult and Carer abuse through a multi-agency approach. This is historically an investigation area where due to the vulnerability of our victims it is difficult to secure evidence to meet the thresholds required for any prosecution. We have however through our dedicated officers and our multi-agency engagement with partners recently secured a conviction in court for Adult Abuse by a Carer. In this case the victim was a 52-year-old lady with Alzheimer's with no ability to communicate pain or concerns whether by speech, sign, writing or other method. She had been scalded (21% burns) by willful negligence after being placed in a hot bath by her carer. Her family reported the incident to police. The carer was arrested and received a six month suspended prison sentence.

London Borough of Hackney – Adult Social Care

Case Study: Hoarding, Think Family & Making Safeguarding Personal

An older woman and her adult son, who had never lived apart came to the attention of Hackney Adult Social Care (ASC) services following a referral from a local Housing Association. The Housing Association raised safeguarding concerns about their verbally aggressive relationship that had been reported to them by neighbours, in addition to a self-neglect concern for the mother in relation to hoarding, as they were in the process of progressing eviction proceedings.

This was a complex case, as the family were initially reluctant to accept any input from the council despite both telephone calls and letters being sent. However, they had a positive relationship with the local Housing Officer, despite the threat of eviction. The Housing Officer eventually managed to negotiate an agreed time for a joint visit along with a social worker. The visit identified that there were significant hoarding issues, which had resulted in the couple using a small proportion of their available space. During the visit it became very apparent that both mother and son were extremely attached, and would often conclude each other's sentences whilst also shouting at each other. It was also clear that the mother had poor mobility and some medical concerns that required addressing, e.g. swollen legs. The son was becoming increasingly agitated at the thought of people getting involved in his and his mother's life and was not able to accept that the environment was becoming a concern.

Through discussion and several visits, the family outlined their desired outcomes, in keeping with the principles of Making Safeguarding Personal, which initially centred upon addressing the possibility of eviction, and some support to the mother and for professionals to not become too involved in their life. In view of this they agreed to a number of actions, which included a request that the GP undertake a home visit, a full assessment of the mothers needs and a carer's assessment was completed for the son.

The GP visit a few days later led to the mother being admitted to hospital in order to address her serious health deterioration. The son became extremely anxious that his mother would not return home, although he struggled to accept that she may require space to be made in the home. His reaction to this was regarded as concerning as he was not able to acknowledge his mother's needs.

Hospital staff noted that the mother was becoming increasingly anxious about her son's wellbeing and although she was extremely keen to get back home, she was also not able to appreciate that she now had her own care needs which could not be met in the current home environment. A mental capacity assessment was completed which indicated that she did not have full capacity to make a decision about her complex health needs. However, she was very

clear in relation to wishes and feelings about where she wanted to reside, which was at home with her son.

Through negotiation with the mother and son at a number of meetings at the hospital, it was agreed that she could go home once her son was able to create a micro-environment in one room, whilst also engaging with mental health services to address his anxiety and hoarding, in order to prevent eviction.

The mother subsequently returned home with a support package and an agreement from the son to ensure the space was maintained. He attended a number of appointments with mental health services but then dis-engaged. ASC continued to maintain contact and in concluding the safeguarding work they were able to identify that the families desired outcomes had been met for the most part, in that a care package had been provided and the Housing Association had suspended any eviction proceedings. However, due to the remaining risks, it was not possible to meet their desired outcome of little involvement from Social Services, although they were less reluctant than at the onset of the safeguarding concern being instigated.

City of London Corporation – Adult Social Care

Case Study: Working Together

Brenda is a 75 year old woman who lives in her own flat with her son, David, and 14 year old grand-daughter, Betty. Her daughter, Sherrie lives locally but Brenda has not seen much of her recently due to a disagreement between Sherrie and David. Brenda was previously a carer to her elderly husband, Joe, who now lives in residential care. Social care became involved when the care for Joe started to break down and the family could no longer care for Joe, who has dementia. The admission had been traumatic for both husband and wife who wanted to be together. On Joe's admission it was discovered that the family were in substantial debt due to various speculative loans and that tensions remained.

The social worker described the flat as being very cluttered and unhygienic, without hot water or working lights. Every room was full of "rubbish" that David said should be kept. The social worker noted that Brenda seemed very anxious and timid.

On visiting Brenda while she was on her own Brenda said that whereas she used to like being with her family, now she would like them to leave. She felt that they placed her under financial pressure because David demanded money of her. She felt threatened by him albeit, not at serious risk. She worried that the debts would lead to her losing her home. The social worker felt she had capacity to make the decision not to refer this to the police and to keep herself safe at home until a solution could be found. .

There were referrals to adult safeguarding, David was referred for a social work

assessment, and Betty was referred to children's services. A housing referral was made for David as well as benefits advice. Legal referral was made about the housing situation and Brenda was advised that she could evict them from her home. A letter was written to the son giving a time limit to leave once it was clear that a place could be found. They were supported with removal costs to ensure that they moved. Lasting power of attorney was applied for by Sherrie, the daughter, so that no more money could be given to David. Although there did appear to be financial irregularities in the account Brenda and Sherrie did not want this to be formally pursued as it would only inflame the situation.

Making Safeguarding Personal

The social worker worked with Brenda to achieve the outcome that she wanted and respected her decision not to report the 'abuse' to the police.

Outcomes

Brenda was pleased that the family left and, supported by her daughter, she enjoyed some months in her own home including regular visits to her husband before being moved to the same residential home as her husband when her mental state deteriorated.

City of London Police

Case Study: Benefits of Community MARAC

Mr G was identified by the City of London Police (COLP) as a vulnerable 55 year old man with mental health issues. He had come to the notice of police notice 11 times in the City since May 2016. His behaviour and mental health was deteriorating, causing him to become increasingly aggressive and unstable. He had threatened to kill officers as well as take his own life. Police attended his house following several reports of loud music and anti-social behaviour which was particularly directed towards his neighbours. He kept a screw driver, chisel and hammer by a chair and repeatedly made threats towards City of London Police. Numerous 'adult to notice' reports were submitted to the Public Protection Unit and referred to Adult Social Care as Mr G was identified as vulnerable. He previously told a Nurse that he was hearing voices to kill a City of London Police officer. Efforts had been made to engage with him but he refused support from all services and was not receiving treatment.

The Case was referred to the Community MARAC in December 2016 and a full multiagency assessment was undertaken at his premises.

As a result of multi-agency intervention:

- Mr G was assessed by a mental health team and deemed to have capacity. He was offered support.
- As a result of the MARAC, a multi-agency plan was put in to place in order

to manage his vulnerabilities whilst protecting the community from anti-social behaviour related to the presentation of his mental health issues.

As a result, Mr G was made aware that his behaviour was unacceptable and was given the opportunity to engage to change his pattern of behaviour. The pattern of calls regarding anti-social behaviour stopped immediately and a civil injunction meant that the community tensions caused by Mr G's anti-social behaviour were quelled, and the community was protected.

Partner Contributions

In the next section CHSAB partners set out how they have contributed to the work of the CHSAB and to the ongoing improvement of local safeguarding adults arrangements.

London Borough of Hackney – Adult Social Care

Hackney Adult Social Care (HASC) is a statutory member of the CHSAB and is represented at all relevant sub-groups. This assists in ensuring that HASC are actively involved in the majority of aspects of the strategic development of adult safeguarding in City and Hackney.

HASC participated in the completion of the annual Safeguarding Adults at Risk Self-Audit and the associated peer challenge event. The self-audit provided an opportunity to highlight good practice and identify areas for further development. The audit outcome was largely positive in that it identified a wide range of systems, policies and protocols that inform and support adult safeguarding within Hackney. There was evidence of good inter-agency working and consistent engagement with the CHSAB.

The positive examples of the promotion of adult safeguarding included the strengthened alignment of a workforce development team which has provided an opportunity to work with the CHSAB to create and implement a training programme that provides safeguarding related training to all CHSAB partners, including Making Safeguarding Personal, general safeguarding awareness, etc. This will be further developed upon for 2017/18 and will focus upon the findings from the Safeguarding Adults Reviews commissioned by the CHSAB.

Another example of good practice that seeks to promote adult safeguarding across the partnership has been the decision to create a distinct Principal Social Worker role, and separate this function from the Head of Safeguarding Adults, creating more capacity for strategic safeguarding development as well as best practice models.

The role of Principal Social Worker will build upon the quality assurance framework that has been implemented by ASC which includes quarterly audits of cases against good practice principles. Findings from the most recent audit identified that whilst most areas are of a good standard, there are some that require more focus to provide assurance that safeguarding practice is consistent in capturing the voice and desired outcomes of the adult at risk, better recording of risk analysis and how we work with the person to recognise and manage risks collaboratively.

Both of these new posts will be instrumental in progressing a ‘Think Family’ approach to the work that we undertake in HASC.

HASC continue to chair and co-ordinate the Community MARAC (High Risk)

panel which has led to improved outcomes for some Hackney residents whilst promoting a multi-agency approach to risk management. This has included the use of monies secured from London Fire Brigade to purchase fire prevention equipment. This is now being provided to residents who are regarded as being at a high risk of fire following Home Fire Safety Checks, i.e. poor mobility, smoker, etc.

Areas where we are seeking to develop practice includes the creation of a robust data set, which when combined with data from partners will be amalgamated to construct a "live" dashboard that assists in supporting the work of the CHSAB and demonstrating achievements, i.e. Making Safeguarding Personal outcomes, etc.

Linked to this is the need to better understand the national benchmarking data which suggests that the number of people receiving advocacy services in the borough is below the average. As the commissioner for this service, we will seek to better understand this data and locally ensure the need for advocacy is identified and available in all its forms.

The Safeguarding Adults Team continues to promote understanding of the Care Act 2014, particularly safeguarding domains of domestic harm, sexual exploitation and modern day slavery via its continued engagement with Community Safety Partnership initiatives, and has seen a steady increase in referral figures although these areas of work require further promotion.

City of London – Adult Social Care

Top 3 successes as identified in the self-audit were:

1. The development of the multi-agency self-neglect, hoarding and fire risk panel.

   The panel has met bi-monthly and continued to engage housing estate managers from all estates, environmental health, London Fire Brigade, alongside adult social care. Grant money from the Community Fire Safety investment fund will be administered through the panel. Learning from SAR Fire deaths has been fully disseminated to partners.

2. Learning from SARs within the ASC and Commissioning.

   ASC and Commissioning have been briefed as to outcomes of SARs particularly where contractual matters around housing with support have been highlighted.

3. Strengthening work within MCA/DOLS and use of advocates in safeguarding adults work.

   This has been a key area of strength this year with the use of advocates being fully embedded into all safeguarding work and being able to be evidenced through the reporting process.

Top 2 things to work on:

1. Working more fully to an enhanced Making Safeguarding Personal (MSP) approach within the safeguarding process in ASC.
2. Enhancing public awareness and understanding of MSP through a communications campaign aimed at City residents.

As part of the CHSAB QA sub group and work on enhancing performance practice standards in the City, MSP outcomes are now fully reportable on in line with the CHSAB performance dashboard

There have been no safeguarding concerns raised through the complaints process this year.

Both Children's and Adults Social Care services have worked on developing a 'Think Family' approach and the cross cutting themes that arise particularly in relation to safeguarding. The City of London Domestic Abuse & Sexual Violence Forum has representation from both Adults and Children's services, and the directorate work to the Joint service protocol to meet the needs of children where adults or carers have additional needs.

There has been an Adult Safeguarding case that was investigated as a s42 enquiry and involved domestic abuse in relation to an adult with an additional needs, whose son is known to the children's team because of his physical and learning needs. A successful 'Think Family' approach was evidenced through strategy meetings that involved the Adults and Children's service as well as adhering to MSP principles.

NHS City and Hackney Clinical Commissioning Group

Adult safeguarding performance in 2016/17

The Clinical Commissioning Group (CCG) has continued to perform well this year with a number of actions completed following an audit by NHS England of our safeguarding arrangements in 2015/6, which gave an overall rating of "assured as good" with some areas for further development. No areas were rated as "unassured". The CCG has implemented most recommendations from the resulting action plan and will be implementing the outstanding actions in 2017/18.

Our successes for the year include: a working party looking at actions required to improve the safety, and care of patients for whom we commission continuing care support; agreeing a safeguarding through commissioning policy; and the use of a safeguarding dashboard which we have developed and agreed with Newham and Tower Hamlets CCGs and is used by all the main NHS providers from which we commission acute and mental health care.

Key actions for 2017/18 are:

- Produce a safeguarding strategy for the CCG
- Agreeing a supervision policy
- Reviewing our adult safeguarding role and recruiting to that revised job role
- Work with our GP practices and our GP out of hours provider to support them to adopt and deliver best practice safeguarding work.

Making Safeguarding Personal

As a commissioner of health services our role is to ensure our providers of NHS funded care deliver best practice in terms of their safeguarding duties. In 2017/18 we will be reviewing providers' annual safeguarding reports and will be asking questions about how they ensure they make safeguarding personal in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

Safeguarding concerns that have been raised with the CCG through the complaints processes. In 2016/17 the CCG did not receive any complaints that raised safeguarding issues: we do not provide any services directly to patients or carers so we don't get very many complaints.

How we have supported the implementation of Think Family approaches locally

The CCG has been promoting the 'Think Family' approach within health services, particularly mental health, for many years including:

- In 2016/17 the CCG commissioned the Homerton hospital to improve the identification of pregnant women and new mothers with emotional and mental health needs. It aimed to bring together Homerton Community Mental Health Services and Maternity Services (along with ELFT Mental Health Services) to improve the local service offer to pregnant women and new mothers (and their partners and babies) with low-level emotional wellbeing concerns and mild, moderate and severe mental health needs. The scheme also ensured a strengthened mental health message in Homerton antenatal education for all women and partners and enhanced training for Midwives and Obstetricians on perinatal and infant mental health. New mothers and partners were also consulted about their experience including those with lived experience.
- In 2016 we provided training for GPs on safeguarding which included elements of 'Think Family', concentrating on when adults present with mental health issues and the impact on the child. This will be repeated in 2017/18.

City of London Police

The City of London Police (COLP) has continued its' positive work to promote adults safeguarding. This can be demonstrated in a number of ways.

The development of the COLP Vulnerability Working Group, a monthly meeting between representatives of different operational units where different aspects of vulnerability and safeguarding are discussed to ensure joined up working and capture of activities across the force. The meeting is also driven by HMIC and other recommendations. The VAWG reports in to the Vulnerability Steering Group for strategic oversight.

Inclusion of Vulnerability in the Policing Plan

There is now a specific area in the policing plan around vulnerability which utilises the 4P approach. This ensures that vulnerability (including adult safeguarding) remains on the radar at strategic level, and demonstrates the force commitment in this area. It drives the operational activity below and ensures a problem solving approach. Departments are required to report on specific areas within this plan.

Roll out of a Vulnerability Training Package

This specifically covers mental health, suicide, adults at risk (reporting concerns and the Vulnerability Assessment framework). It covers the ideas around 'Making Safeguarding Personal' to ensure officers understand the issues of gaining consent from individuals to share information with partners and discussing with individuals the outcomes they would like. Additionally the training is delivered by an officer who talks of his own struggles with mental health and provides a first-hand perspective to staff. This training is in addition to mandatory Domestic Abuse training for officers.

Development of Community MARAC

This has been developed with partners to consider cases of vulnerable persons in the community to deal with issues around anti-social behaviour and hate crime. It has already had success to put in place multi-agency plans and used civil injunctions to protect vulnerable persons in our force area, and take a problem solving approach to community issues. This multi-agency approach allows COL to consider both Making Safeguarding Personal, and the think family approach due to the representation from agencies.

As per the multi-agency audit, the external COLP website has been updated to include an area around Adults at Risk, to signpost individuals where to report concerns and link to the Corporation of London site for help and advice.

Specialist Investigation and Safeguarding

The Public Protection Unit continue to promote messages around adult safeguarding, supporting national awareness weeks on Domestic Abuse, honour based violence and Stalking and Harassment.As the main referral unit,

they assess all reports of adult safeguarding concerns and work closely with adult and children's social care, along with other agencies to ensure a joined up and multi-faceted approach. Senior managers continue to engage with both the adult and children's Safeguarding Boards with a high level of attendance at meetings.

Economic Crime have begun the task of adopting Operation Signature, a National procedure, to ensure that vulnerable victims of fraud are identified and safeguarded by the City of London Police. This will be an on-going piece of work in to the next year.

Complaints involving Adult Safeguarding Concerns

There have been no adult safeguarding concerns that have been raised through the complaints process within COLP. The Professional Standards Department will raise these directly with PPU if they arise.

Metropolitan Police Service (MPS) – Hackney

Hackney MPS continue to work hard to ensure that Vulnerable Adults within our community are safe and protected with those who offend against them being brought to justice. We seek to ensure that our police policies and procedures are fit for purpose with escalation mechanisms and officer expectations clearly demonstrated.

Hackney MPS recognises the importance of the Hackney & City Safeguarding Adults Board and the strategic work it does. We show our commitment through our attendance at the board, sub groups and linked events where we seek to work closely and collaboratively with our partners to ensure safeguarding.

Some notable Adult Safeguarding successes this year for MPS Hackney Safeguarding include:

Acquisition of the first Criminal Behaviour Order for Domestic Abuse

Hackney police sit on and work closely with MARAC and the VAWG strategic & operational groups, both of which are closely aligned to Adult Safeguarding. Our Community Safety Unit at Hackney MPS recently secured a Criminal Behaviour Order for domestic abuse against a violent DA perpetrator. The order, believed to be the first of its kind to be imposed in England and Wales requires the perpetrator to inform police if he is in a relationship for more than 14 days and it also allows police to inform the woman of his previous violence against women under the Domestic Violence Disclosure Scheme. The victim in this case was vulnerable through her immigration status and had been subjected to a horrendous ordeal by the perpetrator following a sustained campaign of domestic violence. The court heard that he banged his victim's head on the floor and strangled her, inflicting blunt force trauma injuries to her head. Following his arrest and while in custody the suspect continued

to intimidate the victim and whilst on bail before his court appearance, he assaulted another woman he was in a relationship with. The suspect admitted to two counts of actual bodily harm, perverting the course of justice and witness intimidation and on 14 February 2017, he was sentenced to 46 months in prison.

Reflection & Improvement

Hackney MPS has been more reflective this year with regards to the role we play in adult safeguarding. Through this self-reflection, evaluation and by listening to our partners Hackney MPS has identified areas where we can change, improve and better understand our role within the adult safeguarding arena:

We recognise the need to embed Making Safeguarding Personal and Think Family into the way we work - We need to improve the confidence and satisfaction of our service users with their police interactions. We will do this through increased targeted and forward planning of attendance by front line staff at Multi-agency training and our interactions with service users will be monitored through our monthly Borough satisfaction meetings in conjunction with customer call backs and reflection.

Between March 2016 & April 2017 police generated 4349 Adult Come to Notice (ACN) Merlins for Vulnerable Adults within our community of which 49% (2107) were referred to Adult Safeguarding.

For the same period, April 2015/6 police raised 3697 ACNs with 1904 (52%) being referred to Adult Safeguarding. This has seen an overall 3% drop in police ACN referrals.

This year we are working closely with our Adult Safeguarding Partners at Hackney to ensure that our Adult Come to Notice referrals to Hackney Adult Safeguarding meet the thresholds and referral expectations of our partners. We will do this through single and joint dip sampling of those referred and those not referred together with comparison data against other Boroughs and Safeguarding Adults capacity.

We recognise the need to provide Adult Safeguarding with reassurance that our custody procedures ensure that persons who work with vulnerable adults, if arrested, are properly referred in accordance with the Notifiable Occupation Scheme. We are currently working with our internal Met Detention alongside Adult Safeguarding to ensure robust processes and pathways are in place.

Healthwatch Hackney

Local Healthwatch services share a common purpose to ensure the voices of people who use services are listened to and responded to. We provide unique insight into people's experiences of health and social care issues across in our area of operation; we seek to be the eyes and ears on the ground telling us what matters to our local communities.

In this context our work with the City and Hackney Safeguarding Adult Board is to support its agenda by promoting safeguarding training, act as a 'critical friend' to the Board, advise on public engagement and report safeguard incidents appropriately where we come across them.

This year we have trained our board, staff and volunteers to identify safeguarding incidents and how to report them. In the last year none of the complaints we dealt with raised safeguarding issues.

Healthwatch City of London

All Board Members, volunteers and staff have attended safeguarding training. Safeguarding is an agenda item at all Board and Team meetings. Safeguarding questions have been brought up at external meetings such as with the London Ambulance Service.

Staff have participated in the City & Hackney Safeguarding Adults Board and its sub-committee on engagement and communication. City of London Healthwatch also attends the City of London Adult Safeguarding Sub Committee.

There have been no complaints relating to safeguarding or safeguarding issues during this period.

Homerton University Hospital NHS Foundation Trust

Top 3 successes:

- Safeguarding Adults Levels 1 and 2 training are mandatory and emphasise staff members' responsibilities in regard to Safeguarding Adults.
- There is a Safeguarding Module on the 'Datix' clinical incident reporting system. This specifies the nature of the abuse and the desired outcomes of the adult at risk. The Homerton Safeguarding Adults Team (HSAT) review these forms weekly to check Safeguarding referrals have been sent, if appropriate, and give advice to the staff who raised the concern.
- The Lead for Adult Safeguarding chairs the MCA/DoLS group, which is attended by neuropsychologists, psychiatrists and the LBH Adult Safeguarding Lead. This acts as an expert resource for queries arising about MCA and DoLS, e.g. arranging for the MCA assessment form to be a template on the Electronic Patient Record (EPR), updating the MCA/DoLS policy and delivering training.

Top 3 things to work on:

- Compliance with completion of Level 2 Safeguarding Adults training needs to increase from 74% to 90%.

- The terms of reference of the Homerton Safeguarding Adults Committee need to be reviewed and embedded, to check the appropriate reporting structures are in place for safeguarding issues.
- The MCA/DoLS policy and procedures need to be updated to reflect the current legal position on DoLS and the Trust responsibilities in this regard.

Making Safeguarding Personal

- One of the questions in the Safeguarding Module on the 'Datix' clinical incident reporting system is, 'What outcome does the adult at risk want from the safeguarding process?'
- Safeguarding training Level's 1 and 2 make reference to Making Safeguarding Personal.

Adult safeguarding concerns raised through our complaints processes

The HSAT monitor feedback from complaints in two ways:

- A member of the team attends the weekly Complaints, Litigation, Incidents and PALS (CLIP) meeting for Integrated Medicine and Rehabilitation Services (IMRS), which is the largest directorate in the Homerton. To date, none of the complaints discussed in that forum have had a safeguarding component.
- The HSAT shares an office with the Head of Patient Experience and any feedback from patients that may constitute a safeguarding issue is discussed informally, to see if further action should be taken. To date, no safeguarding referrals have arisen via this route.

Supporting the implementation of Think Family

The HSAT work closely with the Homerton Children's Safeguarding Team, to ensure that the needs of children and families are considered and addressed in all safeguarding concerns, as follows:

- A joint committee meeting is held quarterly, at which issues related to adults and children are discussed.
- The lead nurse for adult safeguarding attends the Children's Team's psychosocial Meeting on a weekly basis, to oversee the transition of any children from Children's to Adult Services.
- The HSAT attended a Domestic Abuse Study Day, convened by the Children's Safeguarding Team, on 3.11.16, and uses the information gained there to refer families to appropriate services.
- The Adult and Children's Safeguarding Teams are working together on a project to highlight FGM on the Homerton's Electronic Patient Record system

St Barts Health

Top 3 areas of good practice

- The safeguarding principles set out in the Care Act (2014) have been incorporated into the Trust policies, processes and training materials this year. One of the most important changes to the work is the emphasis that is now placed on the needs and wishes of the person experiencing the abuse or neglect. 'Think family' has been signposted in the nursing admission assessment tool that has been implemented across the Trust this year.
- There is clear evidence that people with learning disabilities have greater levels of health need, unequal access to health care and poorer health outcomes including premature death. The Trust has undertaken a number of initiatives to meet Healthcare for All, (DH, 2008). This includes to flag all patients known to the local learning disability teams in the 3 boroughs (Newham Hospital remains an exception until IT system is merged). Reasonably adjusted care pathways in place supported by the use of the Hospital Passports and easy read materials. St Barts was part of the national pilot of the mortality review and will use early findings from this project to influence health care that improves the outcomes for people with learning disabilities.
- Initiatives undertaken to raise awareness of the Mental Capacity Act and Deprivation of Liberty Safeguards, include

  a) A programme of face-to-face training which covered all adult in-patient and community teams across the Trust, at all levels up to and including the Trust Board. 242 training sessions on DoLS and Mental Capacity Act were held in the 12 months to August 2016, with almost 2,500 staff attending one or more of these.

  b) An MCA / DoLS awareness week was held, with stalls, awareness raising events and circulation of relevant materials on each Trust site.

  c) MCA-DoLS champions were recruited in all in-patient areas and have all received additional training.

  d) An audit conducted at the beginning and end of the Commissioning for Quality and Innovation (CQuIN) period showed that by the end of the period (April 2016) there had been an increase of 52% in the number of capacity assessments undertaken across the organisation and DoLS applications were made for 97% of eligible patients.

  e) The administrative systems have continued to be developed to meet the increased volume of DoLS applications. These will be reviewed following in light the recommendations from the Law Commission consultation

Priorities for the next 12 months

Following a period of change and consultation we will publish our joint adult and children safeguarding strategy this year. The strategy will focus on work to develop safeguarding leadership, governance and investment in our workforce.

The top 3 priorities will be

1. Agree a training strategy in line with the new intercollegiate document, the STP and other partners

- To work collaboratively with the others to create multi-agency accessible training
- To develop a range of training options including inter-professional team simulation training events, scenario based interactive learning/e-learning and attendance at multi-agency safeguarding strategy meetings and conferences.
- To align safeguarding adult competency assessment and compliance to appraisal and clinical/case supervision

2. To agree a process to strengthen shared learning from incidents

- Monitor's framework for governance reviews (2015) recommend that there is a culture of continuous learning so our aim for this year is that learning reviews and dissemination are integrated into the governance and assurance framework for safeguarding adults

3. To strengthen practice around personalisation and advocacy

- We will work more closely with local authorities to ensure that the patient focussed outcomes are shared and direct the safeguarding work
- We will establish a system to monitor IMCA and other advocacy referrals where indicated

East London Foundation Trust

Top 3 Successes:

- Improved involvement with the CHSAB Board and sub groups
- Last year's CQC inspection, in which the Trust achieved Outstanding, acknowledged that the Trust is good at keeping people safe
- Introduction of online Level 1 and Level 2 Adult Safeguarding

Top 3 Things to Work on in Coming Year:

- Improving the level of Adult Safeguarding training compliance of staff throughout the City & Hackney Directorate

- Working with the LBH Adult Safeguarding Lead to clarify the threshold and improve reporting of Safeguarding concerns, especially from the inpatient wards
- To clarify and streamline reporting processes between ELFT and LBH

Making Safeguarding Personal (MSP) in our adult safeguarding practice

There is work going on across the Trust with the Trust's Head of People Participation (Service User involvement) to ensure that we have systems in place that ensure that MSP is a core component for individuals who are subject to safeguarding adults process. This includes considering how we might use focus groups with service users to get feedback.

Report on how your agency has supported the implementation of Think Family approaches locally

We are taking a number of steps to imbed the principles of "Think Family" into practice. It is an important element of our on-going staff training. In our local C&H level 3 Safeguarding refresher training, one of the sessions is facilitated by Tom Richardson, from Hackney CSC Troubled Families team. The title of the session is 'The Whole Family Approach.' Dr Lenny Fagan is also running a session on parental mental health and children. We will also be undertaking a local audit looking at practitioners recording of family demographics on RiO.

Housing Providers

Housing providers from Hackney and City of London are represented on the CHSAB by Genesis Housing Association. This is a new arrangement that commenced during 2016/17. It does this through linking with the London Housing and Safeguarding Group, the Hackney Better Housing Partnership and City of London Housing Department.

The role of Housing Providers in safeguarding was formalised by the Care Act 2014. Since these changes came into force in April 2015. Housing Providers operating across Hackney and City of London have been implementing changes to strengthen their approach to safeguarding

Key achievements have included:

Training:

- Classroom-based training focussed on ensuring staff gain skills and awareness appropriate to their role. For example, Genesis has sessions for Operatives, all staff in Look Ahead have received classroom-based training on safeguarding adults in the last 2 years
- E learning on Adult Safeguarding. For example all staff at Genesis have completed this

- Housing providers have engaged with the training provided by the Board and found this a useful forum to engage with partners as well as develop understanding, skills and awareness.

Governance:

Housing Associations have developed robust governance structures ensuring there is appropriate scrutiny and assurance around safeguarding. Examples include:

- Genesis has a Safeguarding Committee chaired by the Director of Care and Support, a Safeguarding Operational Group and an internal case review group to ensure that all learning is embedded and processes are improved to avoid cases escalating and a situation arising in which a customer is harmed. Regular reports are provided to these groups, managers, the Executive and the Board.
- Look Ahead have a Safeguarding and Serious Incident Group which is led by the Director of Care and Director of Quality & Performance. This group provides assurance and ensures compliance; including but not limited to commissioning deep dives into serious incidents, reviewing KPIs, monitoring data and identifying trends and ensuring an appropriate culture is in place to support effective safeguarding.

Leadership commitment to Safeguarding. Examples include:

- A Head of Safeguarding post in Genesis to lead the safeguarding agenda.
- Training for the Genesis Board, Executive, Directors and Heads of Service.
- Southern Housing Group has delivered safeguarding adults training to their Directors and Heads of Service.

This work will continue throughout 2017/18 with Housing Providers continuing to strengthen their approach to safeguarding adults. Examples of work to be delivered include: Southern Housing Group rolling out a new training programme to all staff; and Genesis developing a new safeguarding system to support better quality case management. There will also be continuing work to establish better links between the Board and Housing Providers, ensuring that learning is shared with and embedded within organisations.

Hackney Council for Voluntary Services

Top 10 highlights to Safeguard Adults 2016-2017

1. Enabled the VCS to directly contribute to the CHSAB strategic plan 2017 - 2018

2. Over 252 members of the VCS accessed learning opportunities on adult safeguarding
3. Facilitated a discussion about hidden challenges when making referrals with Adult Social Care Team Managers. This led to revising the referrals systems
4. Assisted user stakeholders to share their views on the style and content of the new City and Hackney website
5. Participated in the Training and Development Sub Group and Serious Adult Review (SAR)Sub groups
6. Improved safeguarding awareness amongst LBH grant applicant and grant holders supported the grants team to roll out the safeguarding tool kit
7. Proactively supported work to eliminate violence against women and girls and FGM at policy level and at community level with a range of communities
8. Embedded Safeguarding in Hackney CVS and continued to host the Training teams safeguarding offer at Hackney CVS
9. Delivered a key training session with the Social Care Institute for Excellence - Writing a Better Safeguarding Adults policy
10. Adopted a new networks based approach to embed safeguarding in key networks such as Hackney Refugee Forum and updated the adult safeguarding Health check

Over the last year Hackney CVS has played an ambassador role in safeguarding adults' key safeguarding messages across the Community and Voluntary sector in City and Hackney. The following is a summary of our top 10 highlights for the year. The adult VCS workforce comprises funded and commissioned organisations that provide a range of services to adults aged 18 years and over in Hackney. Overall many more VCs organisations and residents talk about safeguarding and understand its relevance to their service users, staff and volunteers.

The following achievements stand out

- Participation in policy and planning of CHSAB
- Our safeguarding focus with organisations that support migrant and refugee communities
- Awareness of the safeguarding needs affecting older people.
- Work with LBH Grants Team to meet the Adult Safeguarding Audit and compliance requirements

Participation in Subgroups

- Communication and Engagement Hackney CVS actively contributed to the strategic plan and actively encouraged VCS organisations and their service users to share their views on the ideal CHSAB website.
- Jackie Brett has attended the SAR sub groups and gained an insight to key messages for professionals and practitioners within health and social care.
- Kristine Wellington attended the Training and Development Subgroup. The learning and development courses have been identified that will boost VCS workforce skills. Safeguarding Leads training, Advocacy and in-house courses on Mental Capacity Act 2005

Being on the CHSAB has been very informative for the wider transformation work that we are involved in as it highlights the issues that recur. It has been good that the Board now has a Housing Association representative on the board.

During this period we have engaged Hackney Refugee Forum, a network comprising of migrant and refugee organisations in Hackney. The members add one hour of safeguarding to their network meeting and address key concerns such as; violence and domestic abuse, Mental capacity issues, the role of advocates, making referrals, increased awareness of financial abuse and promotion of the CHSSB Adult workforce training. We have also engaged with more organisations that raise concerns about the threshold requirement and needs of older people, particularly VCS organisations that do not speak English as their first language or groups that have less understanding of their safeguarding rights and hesitate to blow the whistle.

Hackney CVS has worked closely with the CHSAB to support the VCS to understand and meet its safeguarding compliance requirement. In particular to ensure the sector has a working knowledge of the principles outlined in the Care Act 2014. Particularly frontline organisations working with refugee and migrant communities, faith, tenants groups, and family support organisations.

This year we worked closely with the Council officers to ensure that grant holders met the safeguarding requirements outlined by the Place for Everyone Grants Team. In addition we have supported organisations in how to meet key public sector stakeholders that work on safeguarding.

Conclusion

We look forward to the development of a website that can be accessible to the people of Hackney as well as professionals. I would like to acknowledge key community stakeholders. Safeguarding leads from the VCS, Health Watch City and Hackney, One Hackney, Connect Hackney, Hive / POhWER, User Led training team and the Health and Social Care Forum members.

City of London - Trading Standards

The City of London Trading Standards Service receives around 2000 complaints and enquiries from consumers living in the City and across the UK every year. These relate to problems with businesses primarily linked to the Square Mile that may have treated consumers unfairly, supplied unsafe goods, failed to provide services using reasonable care and skill or simply defrauded them of money. There is a particular emphasis on investment fraud within the City and Trading Standards are a key partner of Operation Broadway. This is a multi-agency project that has been operational since 2014 and partners include the City of London Police, Metropolitan Police, the Financial Conduct Authority, Action Fraud and HMRC. The Trading Standards team speak to many victims of investment fraud and make safeguarding referrals to Adults Services where vulnerability is an issue. The team also offer to talk to local resident groups with a view to target hardening and preventing financial abuse in the future.

London Borough of Hackney - Trading Standards

Hackney Trading Standards treat doorstep crime and scams as a service priority. We refer any victim of financial abuse to Adult Care Services. We will liaise with the Adult Safeguarding Section together with other agencies such as The Police, Age Concern and London Fire Brigade to put together action plans and to carry out joint visits. Hackney Trading Standards cannot prevent every resident from becoming a victim of doorstep crime or scams but we are working towards the elimination of repeat victimisation.

In the first quarter of 2017 we carried our two direct interventions as a result of live doorstep crime reports that resulted in saving the two residents in question a combined total of £22,000.Both residents were extremely vulnerable with one suffering from dementia and the other suffering from mobility problems and anxiety. We subsequently identified evidence of further cross border offending and associated money laundering. The case is still under investigation but the residents have had substantial support and target hardening from Trained Officers and referrals have been made to safeguarding in order to get them the support they require.

Plans for 2017/18

We will build on what we did in 2016-2017, under the 4 agreed aims of the CHSAB strategy:

Our aim is to raise awareness of adult safeguarding and together learn from experience

- We want to be in a place where we have identified the gaps where safeguarding adults needs should be promoted and raise awareness of safeguarding adults in the community
- We want to engage with people who use safeguarding services and include their feedback into our plans
- We want to promote safeguarding either through a conference or themed week/month so that we reach the widest audience
- We will ascertain whether staff and volunteers have learnt from the SARs, that actions from the SARs are delivered, and the impact of learning is evaluated
- We will continue to evaluate everyday practice through multi-agency audit of individual cases

Our aim is to promote an open culture

- We want to ensure that people who need advocacy during safeguarding activity receive it
- We want to be proactive in preventing risks to socially isolated residents
- We will keep abreast of the impact of resource reductions and service redesign in the public sector on vulnerable adults in respect of adult safeguarding i.e. Local authorities, Police, CCG etc.
- Members of the CHSAB regularly will demonstrate that they hold each other to account

Our aim is to improve the competency of all those involved in safeguarding activity

- We will continue to work to embed the Making Safeguarding Personal approach to safeguarding adults in practice across the partnership
- Common principles for supervision of safeguarding adults practice will be agreed and adopted across the partnership
- We want the CHSAB to have a set of shared resources/tools to use in training and briefings that supports consistency in the approach to and practice of adult safeguarding

- We will continue to learn about new themes/emerging concerns/ issues in adult safeguarding in order to be effective as a CHSAB partnership (including cross cutting issues with the City and Hackney Safeguarding Children's Board and local Community Partnerships)

Our aim is to understand how effective adult safeguarding is across the communities we work with

- We will agree a set of safeguarding data, in order to inform and improve services
- We will establish an agreed format for presenting this data which is understandable to all agencies and is regularly reported/ presented to the CHSAB
- We want to improve communication between those involved in safeguarding adults and improve the appropriateness and proportionality of referrals (concerns)
- The data set, which will include data from partners will be a 'live' dashboard that assists in supporting the work of the CHSAB and demonstrating achievements i.e. Making Safeguarding Personal outcomes etc.
- We will benchmark safeguarding data against similar boroughs

(For Full Information of our plan for 2017-2018 – Please see Appendix A

Appendix A:

CHSAB Annual Strategic Plan 2017-2018

City and Hackney
Safeguarding Adults Board

The CHSAB Plan addresses the Six Principles of Adult Safeguarding: Empowerment, Protection, Prevention, Partnership, Proportionality and Accountability.

Partner	Lead
London Fire Brigade Hackney (LFBH)	Stephen Dudeney
City of London Corporation (CoL)	Chris Pelham
Homerton Hospital (HUHFT)	Lesley Rogers
City & Hackney CCG (CHCCG)	Jenny Singleton
Hackney CVS (HCVS)	Kristine Wellington
Hackney Met. Police (HMPS)	Catherine Edgington
City of London Police (CoLP)	Alexander Hayman
Barts Health NHS Trust (BHHNST)	Jane Callaghan
London Borough of Hackney (LBH)	Simon Galczynski

Partner	Lead
London Fire Brigade City of London (LFBCoL)	Jon Simpson
London Ambulance Service (LAS)	tbc
East London NHS Trust (ELFT)	Dean Henderson
Public Health (PH)	Nicole Klynman
Healthwatch City of London (HWCoL)	Lynn Strother
Healthwatch Hackney (HWH)	Jon Williams
National Probationary Service (NPS)	Stuart Webber
Care Quality Commission (CQC)	Paula Eaton
City & Hackney Safeguarding Children Board (CHSCB)	Rory McCullum

Sub-group	Chair
Quality Assurance	Dean Henderson
SAR & Case Review	Chris Pelham
Training & Development	Simon Richardson
Communication & Engagement	Kristine Wellington

Sub-Committee	Chair
City of London	Dr Adi Cooper

Principle 1: We will raise awareness of adult safeguarding and together will learn from experience

Priority	Action	Lead Individual, sub-group chair, or agencies	Outcome(s)	Target Date
1. Awareness Raising Ensure awareness of adult safeguarding is raised across all communities in City and Hackney, particularly to reach 'hard to hear' / 'hard to reach' communities, groups and individuals	1. Identify and report on where there are gaps in awareness of 1safeguarding from demographic data, based upon referral data / benchmarking, in order to target awareness raising.	QA sub group	Clear and helpful information and communication channels so that awareness of adult safeguarding is increased across all communities in Hackney and feedback encouraged on experience of adult safeguarding	Dec 2017 Dec 2017
	1.2 Identify support for communicating messages (e.g. through Advocacy and Hospital Patient Representatives) and co-produce/develop appropriate forms of communication	C & E subgroup	VCS groups are able to raise awareness of adult safeguarding, support people to prevent risks of abuse or neglect and inform the CHSAB how satisfied people are with the safeguarding services they receive in order to improve services	Jan 2018
	1.3 Collate a SA Lead toolkit / resource list / training access support for VCS.	C&E Subgroup	VCS groups are able to raise awareness of adult safeguarding, support people to prevent risks of abuse or neglect and inform the CHSAB how satisfied people are with the safeguarding services they receive in order to improve services	Feb 2018
	1.4 Foster capacity building initiatives to support community groups to extend awareness of adult safeguarding and provide feedback to CHSAB on experience of adult safeguarding	SG/HASC	Communicate key messages through Working Together Adult Safeguarding Conference 2017 (Carried forward from previous plan) or, alternatively through a safeguarding themed week / month with agreed messages, themes, venues, etc.	Feb 2018
	1.5 Consider an approach of a "safeguarding week / month" with a series of events / awareness raising opportunities, with CHSAB partners highlighting what they are able to offer	Task & Finish Group to be convened	That the CHSAB is able to populate a week / month of safeguarding awareness raising across the borough which seeks to include input from all partner agencies. For the CHSAB to monitor increases in	

	to promote this within the timeframe.		safeguarding concerns being generated in focused areas.	
2. Service user feedback Develop and establish a model for ongoing service user and carer feedback on safeguarding services to, and engagement with the CHSAB (includes service user feedback about the safeguarding service informs the work of the CHSAB)	2.1 Set up a reference group of people who have experience of safeguarding or input into safeguarding processes to work with the CHSAB ('experts by experience'), nominated by Members of the CHSAB, to regularly provide feedback to the CHSAB	Adult safeguarding leads in HASC & CoL	CHAB is informed about service user experience of safeguarding and their satisfaction in order to improve services	Jan 2018
	2.2 Consider how service user feedback could be incorporated into the safeguarding process, recommend to the CHSAB if feasible/ achievable (e.g. use survey monkey for commissioned services), and report to the CHSAB	QA sub group	People who have experienced safeguarding processes influence improvement in practice and identify areas for co-production	Jan 2018
	2.3 Produce an options paper on service user feedback for the CHSAB which outlines the pros & cons of each option, whilst capturing an overview of all current forums.	John Binding / Chris Pelham / Cynthia Davies (LBH Commissioning)	The CHSAB has a clear strategy for ensuring that the user experience is gathered and is reflected in its work and subsequent business plan.	Jan 2018
3. Safeguarding Adult Reviews (SARs) SAR action plans are implemented, the learning disseminated and the CHSAB monitors the impact of learning, with a view towards this being an integral "business as usual" approach amongst partners.	3.1 The Communication Plan regarding lessons from SARs is implemented (includes feedback to staff, volunteers and community on lessons from the SARs bitesize learning, bespoke events, presentations, targeted training)	SAR & CR L & D C & E sub groups	Staff and volunteers know the lessons from the SARs Actions arising from SARs are delivered Impact of the learning the lessons from SARs in understood (through an evaluation framework)	Dec 2017 March 2018 Dec 2017
	3.2 Delivery of Action Plans monitored and organisations held to account by the SAR & CR sub group on behalf of the CHSAB	SAR & CR subgroup	Safeguarding risks are mitigated because recommendations from SARs for improvement and development are addressed	March 18

Principle 1: We will raise awareness of adult safeguarding and together will learn from experience				
Priority	Action	Lead Individual, sub-group chair, or agencies	Outcome(s)	Target Date
	3.3. Develop mechanisms to assess the impact of learning from SARs on improving safeguarding practice	SAR & CR subgroup	As above	
4. Multi - Agency Case File Audit (MACFA) Promote learning from everyday practice through multi-agency review of individual cases	4.1.Develop and test a model of Multi-Agency Case File audit 4.2 Establish a programme for MACFA audit to assess multi-agency safeguarding practice, and identify areas for improvement, (including core elements – MSP; plus issues agreed by the CHSAB – e.g. lessons from SARs, and focus on key themes e.g. self-neglect)	CHSAB Chair & Task & Finish group	The CHSAB is assured that practice is improving, people are receiving appropriate help and support that prevents harm, lessons from SARs are having an impact, and areas for further improvement are identified	Completed and ongoing
Progress and Impact				

Principle 2: "We will promote a fair and open culture"

Priority	Action	Lead Individual, sub-group chair, or agencies	Outcome(s)	Target Date
5. Advocacy Ensure that access to advocacy is supported for those who need it	5.1 Analyse current low take up of advocacy in Hackney, based upon benchmarking data, and provide narrative and action plan if appropriate to address.	QA Sub-group	The CHSAB is able to evidence that advocacy services are being appropriately promoted to and accessed by Hackney / City of London residents.	Nov 2017
	5.2 Improve recording and monitoring of use of advocates in safeguarding cases through promotion of appropriate use of advocates to front line staff across relevant service areas (include in safeguarding training and briefings)	HASC T & D Subgroup	Increased use of advocates (Hackney) 90% of service users who lack capacity have an IMCA	
	5.3 HASC ensures that sufficient advocacy services are commissioned to meet demand (LBH) and report to CHSAB on use of advocacy	HASC	To see an increase in the Hackney / City of London residents receiving Care Act advocacy in safeguarding cases	Nov 2017
	5.4 Connect the 'informal' and registered advocates with front line staff in statutory services to improve sign posting and communication	C & E sub group	Professionals and safeguarding champions in the CVS know how to access advocates for service users who need them	Completed
6. Prevention and Early Intervention Develop proactive prevention approaches for socially isolated residents	6.1. Develop a local "Early Help" protocol and overview of services to support socially isolated individuals who lack support and may be at risk of safeguarding concerns, e.g. 'silent patients' in Barts, and provide sign posting to find support	Task and Finish Group Barts lead City sub-group	Socially isolated residents are supported via a range of statutory and voluntary services and provision of information in order to maintain and develop self-esteem so that safeguarding risks are prevented.	March 2017

Principle 2: "We will promote a fair and open culture"				
Priority	Action	Lead Individual, sub-group chair, or agencies	Outcome(s)	Target Date
	6.2 Consider development of a "safer places scheme" where people are able to inform "trusted partners" of concerns in a safe environment, and are helped to make contact with respective agencies for support. 6.3 Identify the safeguarding issues for those people who don't have s.42 enquiries to see how their safeguarding risks and needs can be prevented	Task and Finish Group (JB) C&E sub group	Agencies, including social and private housing, are able to identify support from their respective infrastructures to establish what their support "offer" is and what ability there is to identify socially isolated residents. CHSAB partners are able to demonstrate knowledge of signposting options.	
7. Impact of change Understand the impact of resource reductions and service re-design in the public sector on vulnerable adults in respect of adult safeguarding, ie Local Authorities, Police, CCG, etc.	7.1. Provide the CHSAB with information about plans, risks and assurance that impact will be mitigated and the controls put in place. These would acknowledge the impact of resource reductions and service re-design in the public sector on vulnerable adults in respect of adult safeguarding. Consider updating as required, with contributions from CHSAB partners to highlight areas of concern.	HASC / CoL/CCG/ Police	Assurance to the CHSAB that mitigation of negative risks effectively reduces any potential for adult safeguarding activity	Ongoing
8. CHSAB assurance Members of the CHSAB regularly hold each other to account and review progress	8.1Share annual self-audits of safeguarding responsibilities (to review at an Awayday) 8.2 Regular Agency updates to the CHSAB to provide assurance that		CHSAB can demonstrate ongoing improvement in the Annual Report Poor quality issues are being addressed to prevent escalation to safeguarding	April 2018 April 2018

concerns and safeguarding issues are addressed by commissioners in provider services			
adult safeguarding is embedded in contracting and monitoring arrangement; quality is managed to prevent safeguarding risks; and that provider concerns are being addressed.			
	Progress and Impact		

Principle 3: "We want to improve the competency of all those involved in adult safeguarding activities"

Priority	Action	Lead Individual, sub-group chair, or agencies	Outcome(s)	Target Date
9. Making Safeguarding Personal (MSP) Ensure that the MSP approach to safeguarding is embedded in practice across the partnership	9.1 Each partner organisation assures the CHSAB of the measures it is taking to adopt the MSP approach to safeguarding through updates to the CHSAB.	All	Making Safeguarding Personal is embedded in front line practice across all partners: adult safeguarding services are person led and outcome focused because people are supported to make their own decisions about their safety and wellbeing	
	9.2. Gap analysis of MSP training needs undertaken to inform the annual training programme – and targeted workshops are delivered for each sector on what MSP means in practice (Care Providers, Housing Providers, VCS, Health, LA, Police etc) e.g. practice workshops rerun by Ripfa to support front line staff to change their practice and implement MSP	T&D sub group	70% of service users express their desired outcomes from safeguarding (included in CHSAB Dashboard)	
	9.3 Assess the current key safeguarding forms and linked data capture to ensure this is fit for purpose and performance is regularly reported to the CHSAB.	ASC	To ensure that respective SA forms / processes are able to provide required assurance of MSP approach and performance on achieving outcomes.	
	9.4 Safeguarding leads and champions in the CVS promote an MSP approach and MSP is embedded in their policies and practice	QA Sub-group C&E sub-group	CVS consistently promotes person centred and outcome focused approach in safeguarding practice	
10. Supervision Good practice principles of supervision of	10.1Commission (Bournemouth University) to develop and provide proposal alongside the BU competency standards)		Staff are supported by effective supervision in delivering adult safeguarding services which enhances their confidence and competence in working with risk and	

safeguarding practice are agreed and adopted across the partnership (including debriefing and support from complex/ traumatic cases)	10.2Newly appointed Hackney Principal Social Worker to liaise with PSW network to establish if this proposal has been progressed in other places	H PSW	decision making Learn from other areas applied in City and Hackney	
11. Training & communication resources CHSAB has a set of shared resources / tools to use in training and briefings that supports consistency in the approach to and practice of adult safeguarding.	11. 1.Collate and disseminate shared resources etc including: simulation exercises; YouTube videos; table top exercises (MDS) 11.2 Identify and share / promote good practice, e.g. on Mental Capacity Act (MCA)	T & D sub-Group C&E Sub-group T & D Sub-group	Staff across the partnership have a shared understanding and approach to adult safeguarding Communication is varied in approach and appropriate for different audiences and staff groups CHSAB partners are familiar with resources promoted via the MCA Forum, including the MCA Competencies.	
12. CHSAB Learning Improve understanding of new themes/ emerging concerns/ issues in adult safeguarding in order to be effective as a CHSAB partnership (including cross cutting issues with the City and Hackney Safeguarding Children's Board and local Community Safety Partnerships	12.1 CHSAB seeks to keep itself aware of key subject areas via other general agencies and identifies areas where it could assist in the promotion of good practice, via briefings and presentations to the CHSAB on: Law Commission Review; Child Sexual Exploitation County Lines Modern Day Slavery (with annual review of CHSAB protocol) Homelessness/ Rough Sleepers Sex Working Domestic Violence Financial abuse, including scamming	ALL AS Leads C&F leads Police Chris Pelham	Increase awareness of CHSAB Members on new themes/ emerging concerns/ issues in order to identify any areas of shared development and planning Increased referrals linked to subject areas.	
Progress and Impact				

Principle 4: "We will understand how effective adult safeguarding is across the communities we work with"

Priority	Action	Lead Individual, sub-group chair, or agencies	Outcome(s)	Target Date
13. Dashboard development Collect agreed safeguarding data, including a reflection of the service user's journey, in order to inform and improve services. Establish an agreed format for presenting this data which is understandable to all agencies and is regularly reported / presented to the CHSAB	13.1 Clarify and agree a consistency of reporting and responses to safeguarding concerns across the partnership 13.2 Agree how vulnerability is recognised and managed within the respective CHSAB partner services.	QA Sub-group QA Sub-group	CHSAB is provided with adult safeguarding data that can inform development priorities and show the impact of changes in practice Consistency of approach to delivering adult safeguarding services across the partnership	
14. Feedback mechanisms Improve communication between those involved in safeguarding adults and improve the appropriateness and proportionality of referrals (concerns)	14.1 Agree a protocol for feedback/ communication between partners 14.2 Report/monitor the response rates back to referrers and analyse by source, feedback on appropriateness and actions taken	QA Sub-group QA Sub0group	Improve communication between partners Improve appropriateness of referrals for safeguarding enquiries	
Progress and Impact				

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City and Hackney
Safeguarding Adults Board

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Committee:	Dated:
Safeguarding Sub Committee	06/02/2018
Subject: Independent Reviewing Officer (IRO), Annual Report for 2016 to 2017	**Public**
Report of: Andrew Carter, Director of Community and Children's Services	**For Information**
Report author: Pat Dixon, Safeguarding and Quality Assurance Service Manager	

Summary

This report gives Members an overview of the Independent Review Service in the City of London covered in the IRO annual report for 2016 to 2017. During this time period there has been a change of IRO, which had an impact on the development of the service while interim arrangements were in place. In July 2016, the Independent Review Service was subject of the Ofsted inspection of local authority children's services. During this inspection, looked-after children spoke about their experiences, which they described as being very positive in relation to services and help.

This report summarises the statutory requirements of the IRO service and how the City of London has performed in this regard. There is an overview of the IRO role and their performance in ensuring that children's key needs are met. Strengths of last year's practice and areas of development for 2017/18 are identified.

Recommendation

Members are asked to:

• Note the report.

Main Report

Background

1. The Independent Reviewing Officers (IRO) service is set within the framework of the updated *IRO Handbook*, linked to the revised *Care Planning Regulations and Guidance* introduced in April 2011. The responsibility of the IRO has changed from the management of the review process to a wider overview of the case, including regular monitoring and follow-up between reviews. The IRO has a key role in relation to the improvement of care planning for children in care and for challenging drift and delay.

   Specifically, the statutory duties of the IRO are to:
   - monitor the performance by the local authority of their functions in relation to the child's case

- participate in any review of the child's case

- ensure that any ascertained wishes and feelings of the child concerning the case are given due consideration by the authority.

2. The IRO's primary task is to ensure that the care plan for the child fully reflects the child's current needs and that the actions set out in the plan are consistent with the local authority's legal responsibilities towards the child. As 'corporate parents', each local authority should look after the children in their care as a responsible and conscientious parent.

Current Position

3. The Independent Review Service was brought in-house in 2015 and, between April 2015 and February 2016, the City of London employed an agency IRO to support the development of this service. The IRO developed strong relationships with the young people and considerably improved the quality of service, which was evidenced through the judgement of "good" given in the service's Ofsted inspection in 2016. In February 2017 the IRO left and interim arrangements were in place while the post was advertised for permanent recruitment. Young people had the opportunity to say goodbye to their IRO and were introduced to the new IRO, who covered the service part-time.

4. In August 2017 a permanent IRO was appointed. There was no change in IRO for the young people as the interim IRO applied for the permanent post and was successful. However, while the interim IRO was in place, there was limited capacity to develop the service.

The achievements identified within the annual report for 2016 to 2017 are:

- all statutory reviews are held within timescales
- increased participation of children in their review meetings
- all children seen alone by the IRO outside of review meetings
- active monitoring of children's care plans and needs between review periods
- review minutes, contacts and alerts recorded on children's files within the Integrated Children's System workflow
- the development of the permanency tracking and approval process
- the development and promotion of the Children's Rights service
- the development of a local dispute resolution process.

In addition to direct work with children and the local authority, the IRO takes part in the London IRO Practitioner Network and serves as a practitioner representative to the London IRO Managers' Group. Engagement in these pan-London groups facilitates the IRO's access to information and the experience of colleagues from larger authorities. It also ensures that the experience and needs of the City's children in care are represented in forums that have the potential to

influence the direction of practice and statutory guidance about the services and support they receive.

The IRO service has been alert to safeguarding issues for children in care and will continue to monitor care plans closely to include actions that address the known risks of all forms of exploitation. The service aims to build safety and stability according to the needs of each child.

5. The IRO service acknowledges the need for improvement in the following areas:

- distribution of review meeting records within timescales
- developing more innovative ways of consulting with children and young people
- exploring different ways of engaging children and young people in their reviews
- developing performance indicators that will evidence the quality of practice and engagement of children and young people
- ensuring that all review participants are able to contribute to discussions in meetings.

Conclusion

6. The IRO service has made significant contributions to quality assuring and improving services for children in care throughout 2016/17. The monitoring and challenge functions of the role have been strengthened, and the IRO's knowledge of and relationship with the children in care is a positive feature of the service. This was recognised in July 2016 when the Independent Review Service was subject to Ofsted's Single Inspection Framework for children's services. The judgement of the impact of the IRO role was "good ".

7. A key priority for 2017/18 will be to look at more innovative ways of engaging young people in the consultation and the direct impact of their views in influencing change within children's services. The children who received the *Have Your Say* consultation booklet ahead of their reviews and chose not to use it shared that they did not find the document useful and preferred to express their views verbally during their review meetings.

Appendices

- Appendix 1 – City of London Independent Reviewing Officer Annual Report for 2016 to 2017

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Appendix

City of London Corporation
Department of Community and Children's Services

Independent Reviewing Officer (IRO)
Annual Report 2016/2017

August 2017

CONTENTS PAGES

1. PURPOSE OF SERVICE & LEGAL CONTEXT

The Independent Reviewing Officers' (IRO) service is set within the framework of the updated IRO Handbook, linked to the revised Care Planning Regulations and Guidance that were introduced in April 2011. The responsibility of the IRO has changed from the management of the review process to a wider overview of the case including regular monitoring and follow-up between reviews. The IRO has a key role in relation to the improvement of care planning for children in care and for challenging drift and delay.

Specifically, the statutory duties of the IRO are to:

- Monitor the performance by the local authority of their functions in relation to the child's case
- Participate in any review of the child's case
- Ensure that any ascertained wishes and feelings of the child concerning the case are given due consideration by the authority

The IRO's primary task is to ensure that the care plan for the child fully reflects the child's current needs and that the actions set out in the plan are consistent with the local authority's legal responsibilities towards the child. As corporate parents, each local authority should act for the children they look after how a responsible and conscientious parent would act.

In carrying out the monitoring function, the IRO's duty extends beyond the focus on individual cases to include the collective experience of and services to looked after children. Where concerns about the local authority's services to its children in care are identified, the IRO is obligated to immediately alert senior managers.

The National Children's Bureau research 'The Role of the Independent Reviewing Officers in England' (March 2014) provides a wealth of information and findings regarding the efficacy of IRO services. Mr Justice Peter Jackson, the author of the foreword in the research report, makes the following comment about the significance of the IRO function:

> The Independent Reviewing Officer must be the visible embodiment of our commitment to meet our legal obligations to this special group of children. The health and effectiveness of the IRO service is a direct reflection of whether we are meeting that commitment, or whether we are failing.

This annual report provides evidence of the effectiveness of IRO services provided to and on behalf of the City of London's children in care between April 2016 and March 2017

2. THE IRO SERVICE

2.1. Local Arrangements

The City of London has provided an in-house Independent reviewing service since April 2015 and there is one full time IRO who is responsible for carrying out the functions of the role to all children in the care of the City. The IRO service sits within the Safeguarding and Quality Assurance (S&QA) Service and is managed by the S&QA Service Manager who reports directly to the Assistant Director of the People's Division.

The IRO's independence is assured by the fact that the position is held by someone who is not involved in the preparation of the child's care plan, management of the child's case, or the control over resources allocated to or required by the child. The IRO sits away from the Children's Social Care Team, which serves to reinforce the independence of the role.

In order to ensure that the needs of children in care are being met at all times, the City has engaged an external provider to give cover for the service should the in-house IRO be unavailable. The arrangements in place are for the external provider to offer cover should it be required. This will be on a spot purchase when required. Since this agreement has been in place the in-house IRO has not had any periods of unplanned absence and therefore there has not been a necessity to use the external provider.

This has enabled consistency for children and young people in the City of London, whereby they have had the same IRO from April 2015 to February 2017, when a new IRO was appointed to take over. Every effort was made during this period of transition to ensure that children and young people had the opportunity to say their goodbyes to their IRO and be introduced to the new IRO.

The Children and Families Team ensure that the IRO is notified of all children received into care within 72hrs and the IRO assumes immediate responsibility for monitoring the child's care planning and ensuring the statutory reviews takes place within timescales from the point of allocation onwards.

Where relevant, the IRO service would be guided by the CAFCASS and Independent Reviewing Officer Good Practice for Public Law Work protocol to ensure cases in proceedings are subject to robust analysis and challenge about the matters of critical importance to children's safety, wellbeing and permanency needs. This is further monitored within the permanency panel meetings chaired by the Assistant Director of People.

In July 2016, the Independent Reviewing Service was subject to the Ofsted "Single Inspection Framework" of services for children in need of help and protection, children looked after and care leavers. During this inspection children looked after and care leavers were spoken to about their

experience of being cared for by the City of London Corporation and they described their experience as being very positive in relation to services and help.

2.2. Professional Profile

There has been a change of IRO in 2016 to 2017; the IRO in place up until February 2017 was a qualified social worker, experienced practitioner and manager who had the requisite expertise for the role. The IRO who is currently in place has a background in child protection, with previous managerial and IRO experience. Both IRO's were registered with the Health and Care Professions Council (HCPC) as well as being DBS checked on an annual basis.

The IRO in place up until February 2017 was a black African female of dual Canadian and British nationality, whereas the new IRO is white British and female, both IRO's have considerable experience in working with children and young people from culturally diverse backgrounds. However, given that the vast majority of the children in the City of London's care population are male Unaccompanied Asylum Seeking Children (UASC), whose nationality, language, ethnic, religious and cultural identities within the population are diverse. It would be difficult to reflect this diversity across the workforce; however every effort is made to ensure that their needs are represented in where they are placed and how they are supported.

The IRO is committed to understanding the identity needs of individual children through her direct contact with them, independent study, and care reviews with their allocated social workers and foster carers.

The IRO adopts and advocates Anti Oppressive Practice as part of all aspects of service delivery including direct contact with children, foster carers, and the Children's Social Care Team.

2.3. Scope of the Service

The IRO service fulfils its statutory duties by:

- Charing and co-chairing statutory Reviews
- Visiting children in care
- Case discussions with allocated social workers and the management team
- Consulting with foster carers and parents
- Reviewing case file records
- Participating in any additional meeting required by the needs of the child
- Maintaining up to date knowledge of relevant legislation and practice developments

Additionally, the scope of the IRO service includes:

- Chairing Child Protection Case Conferences
- Core Membership in Permanency Tracking Meetings
- Core Membership in Permanency Panels
- Core Membership in the Children Looked After & Care Leavers Service Improvement Group

- Core Membership in the early years and social care Service Improvement Board
- Core Membership in Quality Assurance Review Meetings
- Core Membership in the commissioning and review of all Children's Rights Services
- Management of the Annual Consultation of Children and Young People
- Participant in the quality assurance process of Independent Fostering Agencies
- Core Membership in ICS – Framework I – Sub Group
- Training delivery

3. SERVICE ACTIVITY

3.1. Children in Care

During 2016/2017 a total of 17 young people were children looked after, of which 16 were UASC, this included one female. During the year, six young people became children looked after, all of these six children were UASC. Within this time period five young people progressed from being a child looked after to a care leaver.

One young person who became a child looked after within 2016/2017, also transitioned to being a care leaver in the year, whilst another young person who became a care leaver in 2016/2017 also became a mother, two months after becoming a care leaver. Throughout the year there have been three young people who would be classed as being in long term care, which is over 2.5 years, out of these three young people two are UASC and one is a City of London resident.

Figure 1.0

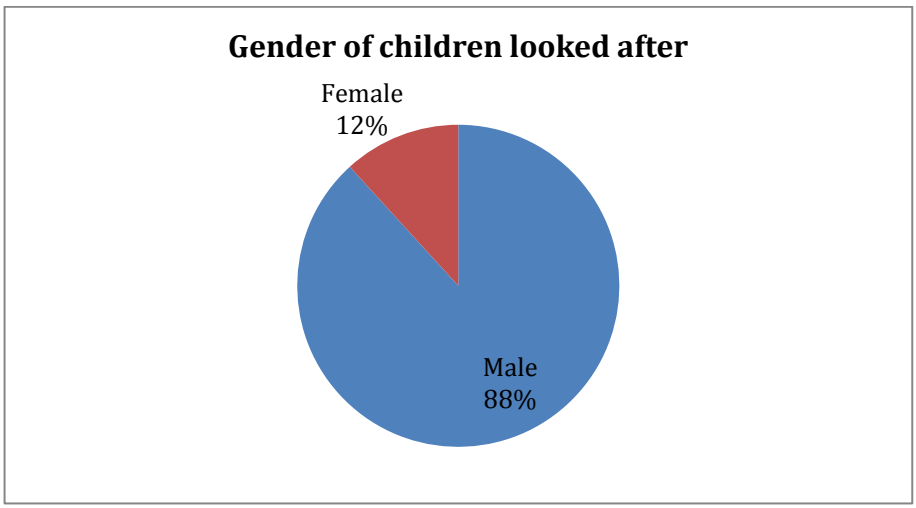
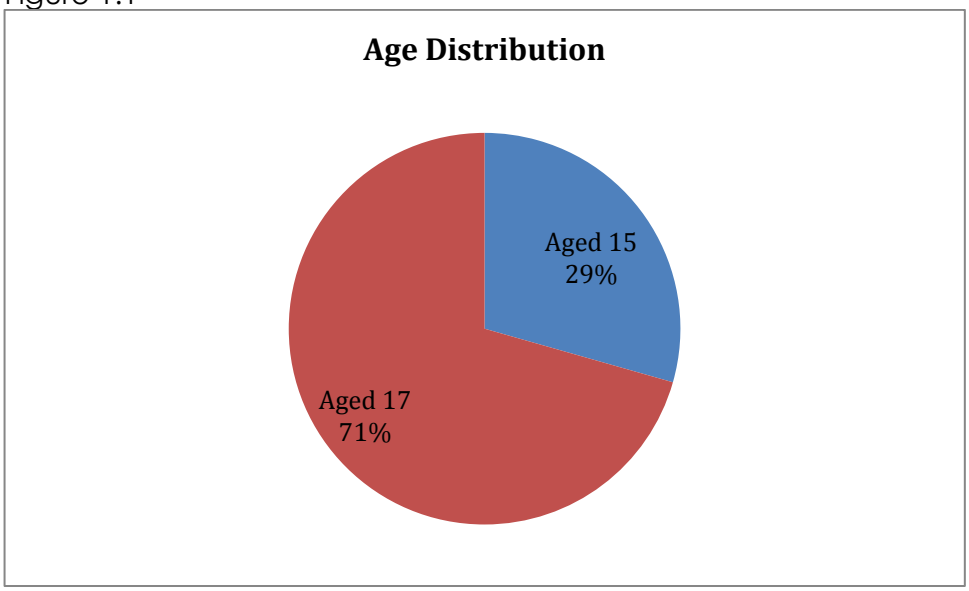


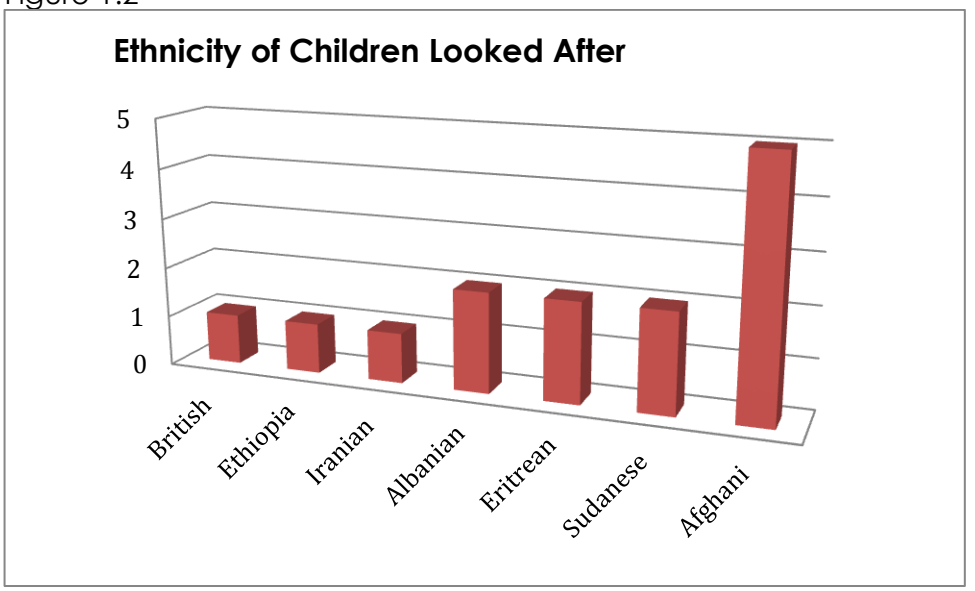
Figure 1.1



The ages reflected in Figure 1.1 show that a significant proportion of the children looked after population will soon be transitioning into being care leavers. As the City of London Corporation has one generic Children's Team this will not mean that the young people will necessarily need to change their social worker. This gives young people the continuity of care they require in a period of their life where they are moving from adolescence to adulthood. The City of London Corporation takes its role as a corporate parent seriously and this is demonstrated through the staying put policy, whereby young people are supported and encouraged to stay put in their foster placement until they feel able to take the next step towards independent living. The IRO service plays an integral part in supporting the young person in expressing their wishes and feelings through the children looked after reviews, ensuring that young people know and can have access to advocacy and independent visitors.

As previously identified within this annual report, a significant proportion of the children looked after population are UASC. As can be seen by figure 1.2 the young people come from diverse ethnic backgrounds. The City of London Corporation does not have a fostering service and therefore children and young people coming into care are placed in foster placement's across London, these placements are provide by Independent Fostering Agencies. Key to the stability of the placement is ensuring that young people are placed with carers who closely match their cultural and ethnic background. In 2016/2017 the IRO visited young people in their placements between reviews, advocating on their behalf at monitoring meetings with the Independent Fostering Agencies.

Figure 1.2



The 94% of the children looked after population are UASC and therefore are accommodated under Section 20 of the Children Act 1989. One young person is subject to a Full Care Order.

Children Missing From Placement

If a child or young person goes missing from care the IRO is notified by the Children and Families team. On the child or young person's return the IRO will support plans to prevent further episodes of the child missing from care.

In the time period between April 2016 and March 2017 there were two young people who went missing from placements. One young person went missing on four occasions and was aged 16 to 17; none of the missing episodes lasted more than 24 hours. The second young person aged 17 went missing from care on three occasions, two of the missing episodes lasted more than three days and children missing from care procedures were complied with, on the third occasion the young person missed his curfew after an evening, but later returned to his placement.

Action for Children have been commissioned to facilitate the return to placement interviews, audits on cases where children went missing did identify that there had been some delay on some of these interviews.

3.3. Consultation and Participation in Reviews

The IRO service is committed to and guided by the duty to ascertain the wishes and feelings of children in care and to ensure that these are given due consideration by the local authority.

Children's views about all aspects of their care planning and review processes are sought after by the IRO during Pre Review and Midway Visits, by reviewing completed Have Your Say consultation booklets, and during review meetings where children are given the space to express their wishes and feelings, encouraged to ask questions, and supported to raise issues when needed.

The IRO also ensures that the views of the children's foster carers are established during placement visits, through consultation forms and during review meetings.

Where possible, the IRO contacts and consults directly with the parents of children whose parents' whereabouts are known, however this is not always possible especially with our UASC young people, due to either the children indicating that this is not possible or social workers' reporting that they have not been able to reach the parents for whom they had been given contact details. The IRO service acknowledges the complicated nature of family relationships for UASC and is sensitive to the safety considerations required as a result.

There is evidence of the young person's voice in reviews and care planning; however consultation documents sent out to young people prior to their review are not always returned, or completed. As the majority of the young people are UASC it is likely that they may have difficulty in writing their views due to their level of understanding of English. A key priority for 2017/2018 will be to look at more innovative ways of engaging young people in the consultation and the direct impact of their views in influencing change within children's services. The children who received the Have Your Say consultation booklet ahead of their reviews and chose not to use it shared that they did not find the document useful and preferred to express their views verbally during their review meetings.

3.4. Children's Rights

Action For Children provide the full range of children's rights services for the City's children in care.

The IRO works hard to ensure that children in care understand, have access to, and make use of their right to independent advocacy, independent visiting services (IV), and the complaints process by maintaining this topic as a standing agenda item for each review meeting and through the contact the IRO has with children.

While there hasn't been any use of the independent advocacy service or the complaints process during this reporting period, there have been examples of children escalating their concerns to the IRO, to their Independent Return Interviewers, and directly with their social workers.

Every child in care has a copy of the City's Pledge in English and in their native language. The IRO ensures that all children's rights information is routinely shared with foster carers specifically so that they are equipped to support the children in their care to exercise their rights.

4. QUALITY ASSURANCE OF SERVICES TO CHILDREN IN CARE

4.1. Care Planning

Services and support provided to looked after children in the City is good and in some cases outstanding. The size of the looked after population is such that each child in care is known to all members of the team and senior management group and there is clear time and resource commitments made to ensuring their needs are met. Care plans when children and young people first come into care are of a good quality and overall reflect the needs of the young person, however there is evidence through reviews that plans do not show the changing needs of the child, young person.

In 2015/2016 the IRO service identified transition planning to be a challenging area of work due to the quality and the timeliness of pathway plans. In 2016/2017 the IRO service expanded its remit to include independent reviews of pathway plans for care leavers, whereby there is now an Independent Reviewing Protocol for Care Leavers and Child in Need (CIN) cases, whereby young people can have a review of their pathway plan. (Appendix 1). This has seen a marked improvement in the quality and timeliness of the majority of the pathway plans.

4.2. Placement Stability

As previously identified, during 2016 / 2017 there were 17 young people who were children looked after, five of those young people had moved to a third placement within 12 rolling months, giving an annual rate of 29.4% . The national comparator for those in care at the 31st March, which reduces the City of London rate to 16.7%, is still above the 2016 national rate of 10%, with our statistical neighbours coming in at 11.7%, however consideration does need to be given to our small cohort on percentage rates.

Given the City's care population of predominately UASC and there being no planned accommodations throughout this year, the initial placement of children is either an emergency arrangement or through London Asylum Seekers Consortium duty rota system. This means that all placement searching activity is done with little information about the child, is always time pressured, and significantly limited by the shortage of foster carers experienced in looking after the needs of UASC in this current climate of increased migration.

Where the social work team have had the opportunity to plan placement moves, the quality of the search and matching process is good. Children are involved in the process, the application of

learning from the breakdown is evident, and the search is informed by the child's short and long term care needs.

4.3. Health

At the end of March 2017 all children looked after, including new children and young people, had received a health check. Achieving 100% compliance, in comparison to the national average of 90%. Although this is a positive, the City does have problems around delivering initial health assessments within 20 working days, between 2016/2017 three initial health checks were out or timescale bringing down the City's compliance in this area to 82%.

The IRO service has developed a quarterly review meeting process with the designated CLA nurse to improve the independent monitoring of the care and health services needed by and provided to children in care. Findings from these meetings are fed back to the local authority in the form of recommendations or notifications of agreements reached. An example of the effectiveness of this arrangement is that health assessment reports that were once taking months to be returned to children, foster carers and social workers, are now largely being returned within weeks of the assessment, thereby facilitating information sharing and follow through with recommended actions.

4.4. Education

Children and young people looked after in the City of London are supported in accessing education with support from their social worker and virtual school head. Those young people who require additional support with English are given access to English for Speakers of Other Languages, (ESOL) classes, which is taught at different levels. Those young people who have no understanding of English attend ESOL classes prior to going into mainstream education. As the majority of the City of London's children looked after population are UASC they usually require support with ESOL when they first arrive as English isn't their first language.

All young people in education up until the age of 18 are required to have a personal education plan (PEP), however some colleges will not engage with the process if the young person is above 16 years. The PEP is undertaken with the young person, foster carer, social worker and school on a six monthly basis and is a statutory requirement. In the City of London,compliance in regard to PEP's is good. The quality of PEP's has also significantly improved due to the input of the support from the Virtual School Head. The regularity and quality of the PEP's is obtained through performance data, audits and oversight from the IRO.

4.5. Practice Recognition and Dispute Resolution

One of the key functions of the IRO is to identify and resolve issues arising from the care planning process. In the City of London this is the called the Dispute Resolution Process for Independent Reviewing Officers (DRP). The DRP is a 6stage process that begins with the team manager and

ends with a referral to CAFCASS but it encourages resolution at the lowest appropriate level and anticipates that in the vast majority of cases, issues can be resolved through discussion between professionals.

In 2016/2017 all concerns have been resolved through informal challenge within the service and during quality assurance monitoring meetings. In no particular order, the tables below provide samples of the good practice recognised and the issues of concern identified throughout 2016/2017.

Table1.0

Good Practice Identified 2016 to 2017	
All children placed in foster families to 18	Involvement of children in placement changes
Young people are supported by their SW	Quality of SW/CLA relationships in most cases
SW Support to UASC with immigration process	Evidenced through audits, review reports and feedback from young people.
SW reports prepared for review meetings	Support for children to engage in CiCC
SW and VSH support with education	No unnecessary Age Assessments initiated
Quality and timeliness of statutory visits	Children supported to develop talents/interests
Transfer of learning between reviews leading to improved practice	SW efforts to consult and engage parents and significant family members

Table 1.1

Issues of Concerns Identified in 2015/2016	Current Status
Visiting timescales during initial 4 weeks in care	Children looked after reviews and audits completed throughout 2016 to 2017 have identified that this has now been resolved.
Children's preparation for review meetings	The need to improve children's involvement in planning their review and the support offered to complete consultation documents remains. This remains an issue, as a priority the current IRO is exploring more innovative approaches in engaging with young people, which will take into consideration our demographic children looked after population.
Care Plan document	This is expected to be ready for use 1st July 2016. This has now been completed.
Quality and timeliness of most Pathway Plans	There have been some improvements and most pathway plans are being completed within timescales.
Life story work	Audits and the Ofsted Single Inspection Framework in 2016 identified that there had been significant improvements in this area.
Delay in arranging leisure activities	SW's attention to the extra-curricular needs of

	children in care has improved throughout this year. At year end, all children who were still in care were engaged in at least one activity reflective of their interests.
Disparity in financial allowances between IFAs	This has improved as contracts are clear around financial arrangements.
Staying Put planning	This remains an area where timely arrangements need to be made with IFA's prior to young people being placed, to ensure that young people have the opportunity to stay in placement post 18.
Delegated Authority re: parental responsibility and young people's right of consent	On-going
Health Assessments out of timescales	They have improved over 2016 to 2017

5. QUALITY ASSURANCE Of THE IRO SERVICE

5.1. Supervision and Management Oversight

The Safeguarding and Quality Assurance Service Manager supervises the IRO once every 4weeks. These sessions focus on practice issues as well as service development needs.

The revised statutory guidance states that designated senior managers must consider the decisions from reviews. This is in part due to the need to monitor and account for any decisions with resource implications. Any disagreements with the decisions made are required to be sent to the IRO in writing within 5 days for resolution and where this is not possible through informal means, the DRP will need to be used. In the City the social work team and service managers are the designated seniors responsible for considering review decisions. The fact that there haven't been any disagreements raised indicates that managers are overall satisfied with the recommendations and decisions made by the IRO.

The Assistant Director (AD) has oversight of the impact and effectiveness of the IRO service through performance management and permanency planning meetings. Through his visits to children young people in placement and his contact with the Children in Care Council he has a good understanding and oversight of children looked after in the City of London.

5.2. Performance Monitoring

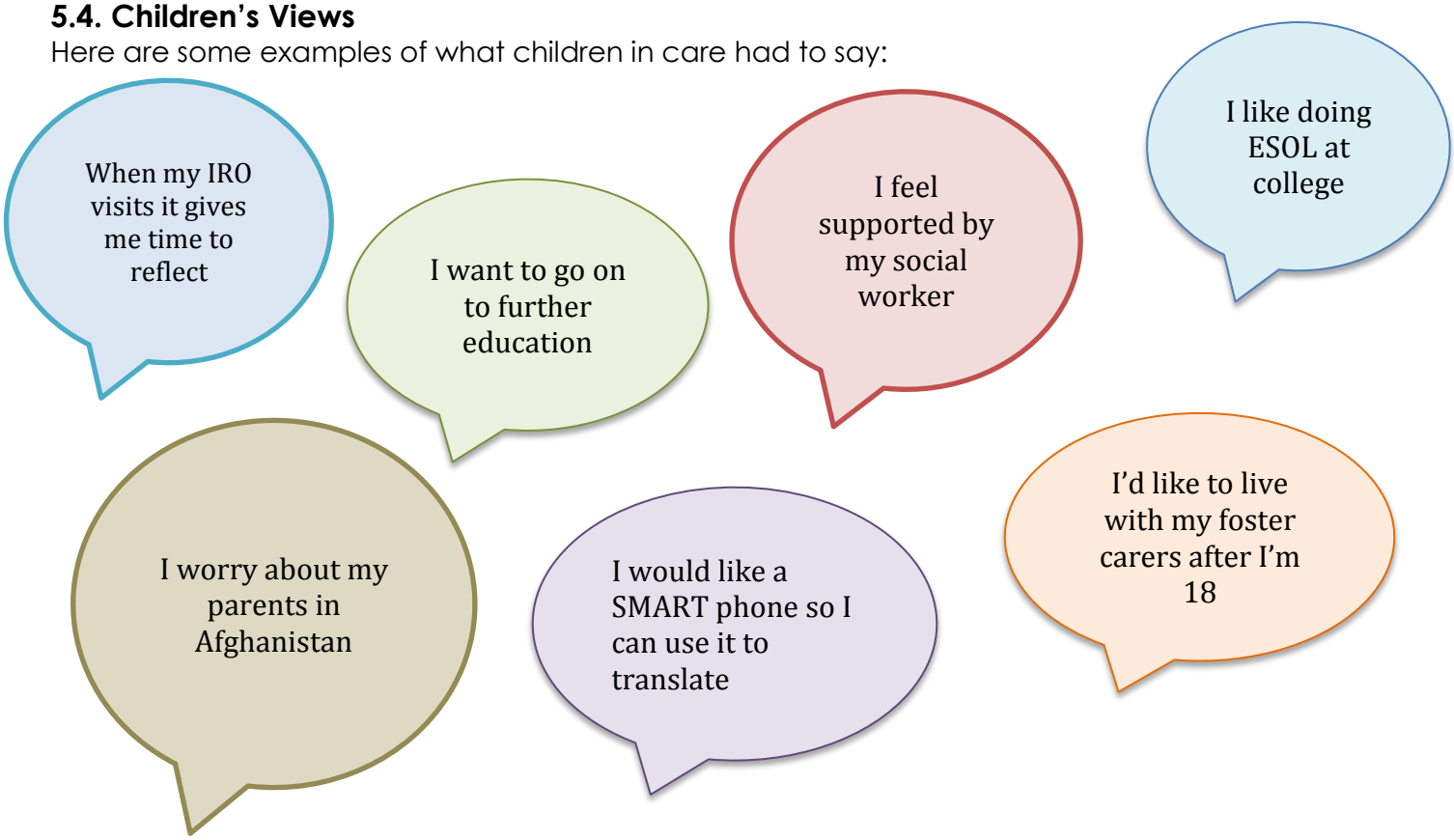
The IRO meets with the Performance Analyst twice a month to monitor compliance with statutory review timescales and the degree to which the IRO is 'keeping in touch' with children in care. There have been no issues of non-compliance identified as part of this process. The IRO's performance is reported into the People's Directorate Senior Management Team, the Safeguarding Sub Committee, and the City and Hackney Safeguarding Children Board's Quality Assurance Sub Committee.

5.3. Case File Auditing

The IRO's footprint and the quality of the service provided are considered as part of all formal case file audits. There has a full-scale audit across the children's social care service in November 2016 and as part of the Ofsted "Single Inspection Framework" of Local Authorities children's services in all cases, the IRO's footprint was found to be evident with the quality of the IRO's involvement being recognised as positive in the majority of cases

5.4. Children's Views

Here are some examples of what children in care had to say:



5.5. Social Works' Views

The social work team were invited to give their views on our children looked after;

"It's sometimes very difficult for our young people who are UASC to adjust to the boundaries of their placement. We often forget that during their journey to Britain they have had to be self-sufficient."

"During the referendum to come out of the EU some young people felt they weren't wanted and that they would be sent back home"

"Young people are worried that they won't get leave to remain and the process can be a slow and worrying time for them"

6. Overview

6.1 Achievements

There continues to be a positive impact from the IRO service in 2016/2017 which is evident in the following list of achievements:

- All statutory reviews are held within timescales
- Increased participation of children in their review meetings
- All children seen alone by the IRO outside of review meetings
- Active monitoring of children's care plans and needs between review periods
- Review minutes, contacts and alerts recorded on children's files within the ICS workflow
- The development of the permanency tracking and approval process
- The development and promotion of the Children's Right services
- The development of a local Dispute Resolution Process.

In addition to direct work with children and the local authority, the IRO takes part in the London IRO Practitioner Network and serves as a practitioner representative to the London IRO Managers' Group. Engagement in these pan-London groups facilitates the IRO's access to information and the experience of colleagues from larger authorities. It also ensures that the experience and needs of the City's children in care are represented in forums that have the potential to influence the direction of practice and statutory guidance about the services and supports they receive.

The IRO service has been alert to safeguarding issues for children in care and will continue to monitor care plans closely to include actions that address the known risks of all forms of exploitation and aims to build safety and stability according to the needs of each child.

6.2 Areas for Improvement

The IRO service acknowledges the need for improvement in the following areas:

- Distribution of review meeting records within timescales
- Developing more innovative ways of consulting with children and young people.
- Exploring different ways of engaging children and young them in their review.
- Develop performance indicators that will evidence the quality of practice and engagement of children and young people.
- Ensuring all review participants are able to contribute to discussions in meetings

6.3 Conclusion

The IRO service has made significant contributions to quality assuring and improving services for children in care throughout 2015/2016. The monitoring and challenge functions of the role have been strengthened and the IRO's knowledge of and relationship with the children in care is a positive feature of the service and this was recognised in July 2016 the Independent Reviewing Service was subject to the Ofsted "Single Inspection Framework" of services for children. The judgement of the impact of the IRO role was "good ".

7. Planned & Recommended Improvements For 2016/2017

The Safeguarding and Quality Assurance Service will continue to develop the IRO service across the full range of its roles and functions. Since February 2017 there has been a permanent IRO in post.
The following table outlines the key practice priorities planned for the IRO service in the coming year.

Table 3.0

Objective	Actions
To look at more innovative ways of engaging with young people in the engagement of their reviews and hearing their voice.	1. Look at different mediums to use to consult with young people. 2. Look at the different models currently being used in other LA's. 3. Consult with the CiCC to ascertain their views about the models reviewed. 4. Consult with the Children and Families and SMT. 5. Trail new model and evaluate impact.
Improve the quality of reviews and child protection conferences.	1. By setting clear expectation that; • Reports are shared with young people, parents/ carers in adequate time before reviews and conferences. • That all professionals who attend the children's looked after review and child protection conferences provide a written report. • If reports are not provided contact will be made with the professionals line manager to ascertain why. • That any meeting involving children and families involves their views in the first person. • That monitoring forms are completed at

	each review/ conference and this performance data is reviewed within SMT and QA Meeting

Appendix 1

Independent Reviewing Protocol for Care Leavers and Child in Need (CIN) cases – Reviewed May 2017.

Introduction
The Safeguarding and Quality Assurance Service presents this protocol for how independent reviews for Care Leavers (CL) could be arranged to offer external scrutiny and support to Pathway Planning for our young people post 18. Further to these arrangements and additionally to the function of the Independent Reviewing Service there will be oversight on some CIN cases to ensure that planning is outcome focused and timely.

Protocol

Care Leavers

1. All young people in care will continue to have their last CLA statutory review held 4-6 weeks before their 18th birthday.

2. All CL will be offered an independent review of their Pathway Plan before their 19th birthday. The review will be chaired by the Independent Reviewing Officer (IRO) and will aim to track the progress and planning for the CL during this initial stage of their transition into adulthood.

3. Post 19, independent reviews for CL can be requested by the young person themselves, the allocated social worker, personal advisor, Virtual School Head Teacher, and/or management based on need. Examples of need include: CL who are NEET for extended periods of time (+6 months); CL who are experiencing significant immigration difficulties; and/or CL who are unhappy with the quality of the support they are receiving.

4. Any CL with a Pathway Plan out of timescale by 3 months or more will also be offered an independent review meeting.

5. Independent Reviews for CL will be documented in the young person's Framework file by the IRO in case notes under the type: Record of Meeting. The meeting record will be shared with all meeting participants as well as the Children's Social Care Team and Service Manager.

6. Independent reviews for CL can only take place if the young person provides their consent/agreement.

7. Independent reviews will be arranged within 4 weeks of the request/need for a review is made.

8. The IRO will be responsible for tracking and arranging the initial post 18 review but identifying the need for all future reviews will be the responsibility of Children's Social Care service.

9. The IRO will follow the existing Dispute Resolution Protocol for any concerns that arise.

Child in Need

1. When a decision has been made that a child is a "Child in Need" the Team Manager/ Social Worker will inform the IRO.

2. The Social Worker will make arrangements with the IRO to chair the first CIN review for the child.

3. At the first review a multi-agency CIN plan will be formulated in partnership with the family, which is outcome focused and timely.

4. Subsequent CIN reviews will then be chaired by the Social Worker.

5. If there are concerns around the progress of the plan then the Team Manager can request that the Independent Reviewing Service review the plan and /or chair a CIN review meeting.

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Committees	**Dated:**
Safeguarding Sub Committee	06/02/2018
Subject: Report on an Exploration of How Social Workers Engage Neglectful Parents from Affluent Backgrounds in the Child Protection System	**Public**
Report of: Director Community and Children's Services	**For Information**
Report author: Chris Pelham Assistant Director of People	

Summary

This report informs Members of the findings of research into neglect linked to affluence, carried out by Goldsmiths, University of London as part of the Knowledge Transfer Programme, a partnership between Goldsmiths and the Department of Community and Children's Services. The main purpose of the study was to understand the issues that arise for social workers around discovering and confronting parental neglect in affluent families, and to identify and develop potential practice interventions when working with this issue.

An initial literature review carried out by Goldsmiths identified that there was a significant lack of research carried out in the UK, although there was more evidence from overseas. As a result of this, coupled with evidence of practice issues identified via City & Hackney Safeguarding Children Board audits, this detailed research was commissioned with the aim of seeking to better understand and assist social work practice in this area.

The research did not draw solely on the City of London experiences but on direct evidence and experiences from social workers who worked in 12 local authority areas, county councils and unitary authorities across England. Indices of deprivation (income, health, education, housing, crime, and so on) by geographical areas were used to select five counties and seven local authorities that represented a geographical mix and a range of socio-economic divisions.

The research was overseen by an expert panel made up of representatives from Goldsmiths University, City of London Children's Social Care, City & Hackney Safeguarding Children Board and, for its final meeting, representatives from the City's independent schools.

The research identified a number of key findings including;

- The vast majority of the cases described by the participants concerned emotional neglect, although other forms of maltreatment, such as sexual abuse, child sexual exploitation and emotional abuse, were also identified.

- Commonly encountered cases involved struggling teenagers in private fee-paying and boarding schools, who were often isolated from their parents physically and emotionally, and had complex safeguarding needs.

- Participants consistently cited that highly resistant parents were more likely to use legal advocates or the complaints procedures to challenge social workers.

- Considerable experience, practice wisdom and knowledge of neglect were essential in relation to working with highly resistant parents who had the resources to challenge social workers' decision-making.

This report will be presented to practitioners from all the local authorities, county councils and unitary areas involved in the research at a seminar event at Goldsmiths University at the end of January 2018.

At a local level, the learning from the research will be built into the Children's Social Care Service Improvement Plan and will link directly back into local practice.

Recommendation

Members are asked to:

- Note the report.

Main Report

Background

1. This exploratory research was commissioned by the City of London and was developed from a scoping review that sought to find out what is known about child neglect in affluent families.

2. The scoping review identified that there is a paucity of research in the UK looking at how social workers engage parents from affluent backgrounds in the child protection system to address the issue of child neglect. This study therefore investigated what factors arise for social workers in responding to this type of child maltreatment in affluent families.

3. The main purpose of the study was to understand the issues that arise for social workers around discovering and confronting parental neglect in affluent families and to identify and develop successful intervention practice.

4. Three specific research questions guided this inquiry:

- How do social workers identify risk factors for vulnerable children in affluent circumstances?

- Which factors inhibit or enable social workers' engagement with affluent parents when there are child protection concerns?

- What kind of skills, knowledge and experience is necessary for frontline social workers to effectively assert their professional authority with affluent parents when there are concerns about abuse and neglect?

5. Participants were recruited from 12 local authorities, county councils and unitary authorities in England. The research sites were selected using the Ministry of Housing, Communities and Local Government's Open Data Communities data platform. Indices of deprivation (income, health, education, housing, crime, and so on) by geographical areas were used to select five counties and seven local authorities that represented a geographical mix and a range of socio-economic divisions. Therefore, some of the authorities in the sample were characterised by extremes of wealth and deprivation.

6. The sample consisted of professional stakeholders from across children's services and included;

- frontline social workers
- team managers
- an early help team manager
- principal social workers
- designated safeguarding leads
- service managers
- a head of service for safeguarding standards
- a local authority designated officer.

7. The goal was to include a diverse representation of professionals with particular experiences of child protection who were either active in frontline practice, and/or learning and development in the same organisation.

8. A semi-structured topic guide was used in interviews and focus groups with a total of 30 participants. The interview questions explored aspects of the practitioners' experiences of how they engage affluent parents when there were safeguarding concerns. The interviews and focus groups lasted, on average, one hour and were audio-recorded, transcribed in full, and anonymised. The Research Ethics and Integrity Committee, Goldsmiths, University of London, granted ethical approval for the study.

Current Position

9. The research identified four overarching themes from the data analysis:

- recognising and addressing neglect
- privilege and entitlement
- barriers to escalating concerns
- factors that make a difference for authoritative practice.

Recognising and addressing neglect

10. Issues highlighted by participants included:

- difficulty in interpreting and assessing emotional neglect, especially when parenting for children from affluent backgrounds might come from paid carers
- challenges of parents recognising emotional neglect that can be linked to the home environment
- high levels of domestic abuse, drug and alcohol abuse and mental health issues
- hidden issues because families are able to access privately funded resources
- participants' comments that public schools would deal with safeguarding concerns in-house, making it difficult to develop a shared understanding of neglect.

Privilege and entitlement

11. Issues highlighted by participants included:

- Parents had access to powerful social networks which some used to resist social work intervention.
- Practitioners felt belittled with threats of complaints and legal intervention and also felt that their involvement was regarded as an unwarranted intrusion.
- Some participants commented that parents would only deal with managers if there had to be involvement.
- All participants felt that the parents' socio-economic status gave them a sense of privilege that encouraged them to subject the social work practice to a level of scrutiny in a way that families from lower socio-economic backgrounds did not.
- Significantly, the challenge was then to ensure the focus remained on the needs of the child.

Barriers to escalating concerns

12. Issues highlighted by participants included:

- challenges in gathering information as part of the escalation to a child protection assessment
- non-compliance was a feature of this type of casework
- involvement of lawyers and use of the complaints process when escalating to a child protection assessment
- challenges of accessing direct observation of children and their relationship with parents
- practitioners who had contact with children, especially older children, were able to achieve good outcomes when the children were able to engage in the assessment process.

Factors that make a difference for authoritative practice

13. Issues highlighted by participants included that practitioners needed:

- personal qualities in assertiveness, confidence and being self-assured
- a good understanding of the threshold of emotional neglect and a good level of legal literacy
- to pay more attention to how they presented themselves as an expert and authority figure, including how they dressed and spoke
- good support and supervision from their manager.

Key messages

14. The research identified the following key messages:

- The findings revealed that thresholds for neglect are not always understood, which posed challenges for effectively safeguarding children at risk of significant harm in privileged families.
- The vast majority of the cases described by the participants concerned emotional neglect, although other forms of maltreatment, such as sexual abuse, child sexual exploitation and emotional abuse, were also identified.
- Commonly encountered cases involved struggling teenagers in private fee-paying and boarding schools, who were often isolated from their parents physically and emotionally, and had complex safeguarding needs.
- Participants gave many examples to show how parents had the financial resources to access psychological support through private care providers to address their children's emotional and behavioural problems. Some practitioners viewed this as a positive outcome for the child, but some saw this as a way for the parents to opt out of the statutory child protection system, and to thus slip under the radar of children's services.
- All of the participants described difficulties in maintaining focus on the child because of the way that parents used their status and social capital to resist child protection intervention. Many also displayed a sense of entitlement to do as they pleased and an attitude that 'they know best'.
- Participants consistently cited that highly resistant parents were more likely to use legal advocates or the complaints procedures to challenge social workers.
- All of the participants also experienced the challenges of inter-agency working with private fee-paying and boarding schools when child protection concerns were raised.

- Considerable experience, practice wisdom and knowledge of neglect were essential in relation to working with highly resistant parents who had the resources to challenge social workers' decision-making.

- Skills, knowledge and competence: all of the participants highlighted the important role that supportive managers and good supervision played in helping them to effectively intervene in affluent families.

- Key to their ability to work in this complex field, participants cite the organisational culture of support, purposeful informal conversations about the case with colleagues, good supervision, knowledge, confidence, responsive managers, and themed learning activities.

Next Steps

15. This report will be presented at a seminar at Goldsmiths University on 31 January 2018 to more than 100 participants from all the local areas who were involved in the research, academics from Goldsmiths and other Higher Education Institutions, and representatives from the Department for Education.

16. A City of London learning session will be held with the City of London Children and Families Service to consider the learning opportunities and how these can inform local practice.

17. The agreed actions from the City learning event will be included in the Children and Families Service Improvement Plan which is subject to ongoing monitoring via the Service Improvement Board and the Safeguarding Sub Committee.

18. Future audits will consider the implementation of learning from this research.

Corporate & Strategic Implications

19. The findings of the research and the learning that will feed back into practice will support the City's ambition , thorough its Children and Young People's Plan, to ensure children are safe and feel safe

Financial Implications

20. There are no financial implications associated with this report.

Health Implications

21. There are no health risks that would require Public Health engagement

Conclusion

22. This report has highlighted the findings of research into issues associated with identifying child abuse linked to parents from affluent backgrounds. The research identified four thematic areas from data analysis which have captured the learning and the report sets out a number of points of learning.

23. These learning points will form part of the City of London Children's Services Improvement Plan that will help to inform social work practice. The Improvement Plan will be monitored by the Service Improvement Board and the Safeguarding Sub Committee.

Appendices

- Appendix 1 – *An Exploration of How Social Workers Engage Neglectful Parents from Affluent Backgrounds in the Child Protection System*, Professor Claudia Bernard, Goldsmiths, University of London

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Appendix 1

An Exploration of How Social Workers Engage Neglectful Parents from Affluent Backgrounds in the Child Protection System

Professor Claudia Bernard

Goldsmiths, University of London

Acknowledgements
This research would not have been possible without the input of a number of individuals. I would like to thank all the staff across the organisations, who worked with us in helpful ways to make this research happen. A special thank you to the City and Hackney Safeguarding Children Board (CHSCB) whose audits provided the stimulus for this research. I would also like to thank Chris Pelham and, Richard Banks for their invaluable feedback on the design of the study. The project has benefited greatly from the support and guidance provided by Rachel Green. My thanks also go to the Expert Panel members, Angela Bent, the CHSCB Board Manager and the Safeguarding Leads, Coco Stevenson, City of London School for Boys and Katherine Brice, City of London School for Girls for their guidance into how to translate the findings into practice tools. I would particularly like to extend my thanks to Tom Greenwood for providing the research assistance and support throughout. Finally, and not least, I am particularly grateful to all the social workers and managers in this study who gave up their time so generously to take part and who were very open and honest about their practice. It was a privilege to be able to talk with all of them.

Introduction

This exploratory research was commissioned by the City of London and was developed out of a scoping review, which sought to find out what is known about child neglect in affluent families. The scoping review identified that there is a paucity of research in the UK looking at how social workers engage parents from affluent backgrounds in the child protection system to address the issue of child neglect. This study therefore investigated what factors arise for social workers in responding to this type of child maltreatment in affluent families.

Background

Child neglect is the most prevalent type of maltreatment in the UK, and is the largest category of abuse for children subject to a child protection plan (Action for Children 2014; Brandon *et al*. 2014a: Daniel *et al*. 2010; NSPCC 2014; Ofsted 2014; Taylor *et al*. 2012). There is strong evidence that children living in environments of deprivation and social inequalities are at higher risk for neglect than children from more privileged backgrounds (Burgess *et al*. 2014; Bywaters *et al*. 2014; Bywaters *et al*. 2016; Daniel *et al*. 2011; May-Chahal and Cawson 2005; Sidebotham *et al*. 2002; Sidebotham *et al*. 2016). It is important to note that social class as a category is not routinely recorded when collecting child abuse and neglect data for the Department for Education's children in need census in the UK, which tells us little about the specific demographic characteristics of children. Additionally, there is currently little empirical research focusing directly on the experiences of children in affluent families, with the great majority of research having largely focused on

the relationship between childhood neglect and poverty. It would seem, therefore, that when socio-economic factors are addressed in the research literature, the focus is almost exclusively on neglect in poor families. One obvious reason for this is that the majority of studies examining neglect have used samples that are largely drawn from families that are known to the authorities, and by and large these families tend to be from lower socio-economic backgrounds (Burgess *et al*. 2014; Bywaters *et al*. 2014; Daniel *et al*. 2011; May-Chahal and Cawson 2005). Furthermore, most studies generally show that neglect is more likely to come to the attention of the authorities when it involves families from lower socio-economic groups, and that middleclass and affluent families are not subjected to the same amount of state scrutiny (Corby 2006; Radford *et al*. 2011). The literature thus suggests that there may be biases in the reporting of maltreatment by higher social classes (Sidebotham *et al*. 2002). There are therefore biases inherent in using samples largely drawn from official records.

While recognising the significance of poverty and disadvantage, there is growing evidence to show that child neglect also occurs in significant amounts in families from the highest social class (Bellis *et al*. 2014). Other research has found that neglectful parents in affluent circumstances rarely come under the radar of child protection services, so they do not show up in official reported statistics (Watson, 2005). Thus, it has been suggested that socio-economic biases play a crucial role in determining which families come under the scrutiny of the child protection services (Burgess *et al*. 2014; Daniel *et al*. 2011). Even so, there are preliminary suggestions that child abuse and

neglect in affluent families may be much more widespread than is currently thought and that recognising neglect and its impacts for affluent children is a significant challenge (Asthon *et al*. 2016; Bellis *et al*. 2014a; Hughes *et al*. 2014).

Research on neglect in affluent families in the USA and Australia has pointed to the particular risks and problems facing children in affluent families (Felitti *et al*. 1998; Luthar *et al*. 2002; Watson 2005). Luthar and Becker (2003) maintain that parental emotional neglect is often the cause of psychological problems suffered throughout adulthood by children from affluent families. For example, the UK Adverse Childhood Experiences (ACE) research (Bellis *et al*. 2014b) and retrospective studies on childhood experiences of abuse and neglect (Bifulco and Moran 1998), highlight that children from middleclass and affluent families suffer childhood neglect in less visible ways. Additionally, researchers in the USA have commented on the disconnect between some affluent parents and their children (Luthar and Becker, 2002; Luthar and Crossman 2013). The claim is made that many affluent parents do not spend enough quality time with their children, and put excessive pressure on their children to be high achievers, and that such factors create psychological and emotional problems for the children in adulthood (Luthar and Becker 2002).

It has been suggested that the issue of neglect in affluent families is made more complex because of differing values. For example, Luthar and Crossman (2013) noted that affluent parents have a more relaxed attitude to drug use, sexual activity and sexuality, and as a consequence their children

are exposed to more risks. Furthermore, although children may be living in affluent households, they may also be affected by parental alcohol and substance abuse, and domestic violence. It tends to be assumed that such problems only occur in poor families. However, there is a growing body of evidence that these same issues are also found in affluent families. Typically, it is thought that some affluent parents are often emotionally disconnected from their children because they work very long hours, which means that their children are often left alone, or with a range of paid carers (Luthar and Latendresse 2006). Such situations raise complex questions about how to assess the psychological and emotional availability of parents. Furthermore, the notion is supported by evidence from ACE studies, which drew their sample from the general population to look at associations between childhood trauma and long-term health consequences (Bellis *et al.* 2014; Hughes *et al*. 2016). Adverse childhood experiences refer to physical and emotional abuse, sexual abuse and neglect, being exposed to domestic violence, substance abuse, and other early life stressors (Felitti *et al*. 1998). While many ACEs are disproportionately found in economically disadvantaged communities, it is important to note that research has identified that ACEs are far from absent in more affluent families (Bellis *et al*. 2014). For example, data from ACE cross-sectional studies, which draws on a representative sample of the population to look at associations between childhood trauma and long-term health consequences, reports evidence of abuse and neglect in the higher socio-economic strata (Bellis *et al*. 2013; Bellis *et al.* 2014a; Bellis *et al.* 2014b). Additionally, Watson (2005) asserts that wealthier families may have the material resources to hide physical and supervisory neglect while being

psychologically or emotionally neglectful. This point is key to understanding why neglect may go undetected in affluent families.

Defining Neglect

The definition of neglect used in this study was the *Working Together to Safeguard Children* (2015) definition of neglect is used:

> *"The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health and development"* (DfE 2015).

It is important to note that there are variations in how neglect is defined across the different jurisdictions in the UK. For example, the devolved governments of Wales and Northern Ireland have removed any reference to persistence in their definitions of neglect (Flood and Holmes 2016).

It is also important to note that there are different sub-categories of neglect ***(see appendix 1)***; these include educational, emotional, medical, nutritional, physical, and supervisory neglect (Flood and Holmes 2016). Additionally, there are, major challenges in quantifying psychological and emotional neglect. As Daniel (2015) observes, the range of ways that neglect can be defined contributes to confusion about what actually constitutes neglect.

Aims

The main purpose of this study is to understand the issues that arise for social workers around discovering and confronting parental neglect in affluent families and to identify and develop intervention practice that is successful.

Three specific research questions guided this inquiry: (1) How do social workers identify risk factors for vulnerable children in affluent circumstances? (2) Which factors inhibit or enable social workers' engagement with affluent parents when there are child protection concerns? (3) What kind of skills, knowledge and experience is necessary for frontline social workers to effectively assert their professional authority with affluent parents when there are concerns about abuse and neglect?

Methodology

Participants were recruited from twelve local authorities, county councils and unitary authorities in England. The research sites were selected using The Department for Communities and Local Government, *Open Data Communities* data platform. Indices of deprivation (*Income, Health, Education, Housing, Crime etc.*) by geographical areas were used to select five Counties and seven local authorities, which represented a geographical mix and a range of socioeconomic divisions. Therefore, some of the authorities in the sample were characterised by extremes of wealth and deprivation. The sample consisted of professional stakeholders from across children services and included frontline social workers, team managers, an Early Help team manager; principal social workers; designated safeguarding leads; service managers; a Head of Service for Safeguarding Standards and a Local

Authority Designated Officer. The goal was to include a diverse representation of professionals with particular experiences of child protection who were either active in frontline practice, and/or learning and development in the same organisation. A semi-structured topic guide was used in interviews and focus groups with a total of 30 participants. Focus groups in each research site afforded the opportunity to gather a group of practitioners situated at different levels in their organisation to reflect on neglect from their particular vantage point. Overall, a very diverse group of children services practitioners were interviewed. The interview questions explored aspects of the practitioners' experiences of how they engage affluent parents when there were safeguarding concerns. The interviews and focus groups lasted on average one hour and were audio-recorded, transcribed in full, and anonymised. The Research Ethics and Integrity Committee, Goldsmiths, University of London, granted ethical approval for the study.

A thematic analysis approach was used to analyse the data (Braun and Clark 2006). The central research questions were used as a guide to an initial reading of the transcripts to generate a coding scheme. Each interview was carefully read and re-read and a line-by-line coding of the interview transcripts was conducted. During this stage, new codes were added and initial codes were merged or removed. The final stage of analysis involved more detailed selective coding and breaking down the codes into several subthemes, which were then placed into broad categories, to analyse the relationships between them (Braun and Clark 2006). NVivo, the qualitative data analysis software program, was used to organise and group segments of the data. NVivo

supported searching for themes and identifying common patterns that were consistent in the data. To establish a degree of coding reliability, the research assistant audited the documentation for four interviews as a validity check on the analysis.

Key Messages from the Research

- ***The findings revealed that thresholds for neglect are not always understood, which posed challenges for effectively safeguarding children at risk of significant harm in privileged families.***

- ***The vast majority of the cases described by the participants concerned emotional neglect, although other forms of maltreatment, such as sexual abuse, child sexual exploitation and emotional abuse, were also identified.***

- ***Commonly-encountered cases involved struggling teenagers in private fee-paying and boarding schools, who were often isolated from their parents physically and emotionally, and had complex safeguarding needs.***

- ***Participants gave many examples to show how parents had the financial resources to access psychological support through private care providers to address their children's emotional and behavioural problems; some practitioners viewed this as a positive outcome for the child, but some saw this as a way for the parents to opt out of the statutory child protection system, and to thus slip under the radar of children's services.***

- ***All of the participants described difficulties in maintaining focus on the child because of the way that parents used their status and social capital to resist child protection intervention, and many also displayed a sense of entitlement to do as they pleased and that they know best.***

- ***Participants consistently cited that highly resistant parents were more likely to use legal advocates or the complaints procedures to challenge social workers.***

- ***All of the participants also experienced the challenges of inter-agency working with private fee-paying and boarding schools when child protection concerns were raised.***

- ***Considerable experience, practice wisdom and knowledge of neglect were essential in relation to working with highly resistant parents who had the resources to challenge social workers' decision-making.***

- ***Skills, knowledge and competence: all of the participants highlighted the important role that supportive managers and good supervision played in helping them to effectively intervene in affluent families.***

- ***Participants cite the organisational cultures of support, purposeful informal conversations about the case with colleagues, good supervision, knowledge and confidence and responsive managers, themed learning activities, as key to their ability to work in this complex field.***

Four overarching themes emerged from the data analysis: Recognising and addressing neglect, the parents' sense of privilege and entitlement, barriers to escalating concerns, and factors that make a difference for authoritative practice.

THEME 1: Recognising and Addressing Neglect

All of the participants described the challenges in recognising and naming neglect in affluent families, and the factors that might indicate that emotional neglect is not well understood by practitioners. Participants stressed that the vague and ambiguous nature of emotional neglect was one possible factor making it difficult to interpret and assess indicators of emotional neglect. They also reported that because of preconceived ideas that stereotypically associate neglect with poverty, the parents' (and indeed, some professionals in public schools') perceptions were, that neglect is about the failure to provide for a child's basic physical needs.

One participant remarked:

> *"Those children are quite hidden, because parents know their rights, they are articulate, and they can be quite avoiding. I would say that social workers are quite often concerned that working with affluent parents rather than with other parents because they are educated and they are very challenging".*

Because the children who come to their attention have affluent home environments including: excellent housing, a nutritious diet, first-class educational opportunities and access to a range of enrichment opportunities, it was often difficult to differentiate when their home environment lacked emotionally-nurturing parenting behaviours. The families were often involved with private providers, such as GPs, therapists, nurseries, and schools, and there are often difficulties in getting private health care providers to understand emotional neglect. These children largely experienced inadequate parenting from emotionally unavailable parents, as their mothers and fathers were not investing parental time in them. It was clear in some cases children experienced the majority of their "parenting" came from carers who were paid to look after them. Some participants expressed that the parents' detachment from their children were often a contributory factor in the emotional and behavioural difficulties that brought them to the attention of children social care, and that parents were often affronted that the quality of their parenting were being questioned, or that they were being accused of neglecting their children. What remained consistent in participants' accounts is that it is a challenge to get these parents to understand the issues pertaining to their children's relational attachments and their emotional experiences of care. Thus, any questions about their parenting and the emotional home environment were often met with hostility and conflict, and parents strongly resisted any intervention, in some cases, their obstruction towards social workers manifested in formal complaints to senior managers and elected councillors and the threat of legal action.

A key finding concerned the high levels of domestic violence, drug and alcohol abuse, and parental mental ill-health issues, that were a feature of a number of cases of neglect that social workers interviewed dealt with. Often these issues were hidden and only came to light when parents were going through acrimonious separations and needed a Section 7 Report. Getting parents to understand the adverse effects on the children was often very difficult when they did not acknowledge that the negative family dynamics placed their children in a vulnerable position.

One participant made the following point:

> *"Yes especially with domestic violence we have had some cases where parents have said they are having couples therapy which means the risks are higher but they have been able to pay for that, and if we can't influence the impact on that child right now, we can't be involved and that's really difficult".*

A number of participants reported that an obvious advantage of affluent parents is that they could purchase goods and services such as nannies, and other forms of help to "do their parenting for them" – and the hired help was doing a lot of the day-to-day interacting with children's private health care providers and public schools, and nurseries, so it is easier for parenting-capacity problems to be masked and for issues of neglect to not be picked up by practitioners.

A team manager commented:

> *"Actually when we are talking about affluent families they are not the people who can't afford to clothe their children, they're not the people who can't afford to feed their children, so quite often those basic care needs are being met even if*

> *you've got an alcoholic parent, for example. Um, they may be quite high functioning, may be still be working, and childcare comes into that quite a bit too. The children are picked up from school, their attendance is still good, it might be somebody else actually meeting the child's needs, so it might be more difficult to find out what's really going on in the family, but that child's needs are being met".*

Some of the cases described in the interviews indicated that parents had the financial resources to purchase private substance or alcohol abuse services to address their problems if it was flagged up as an issue by practitioners, so they therefore removed themselves from the spotlight of social services through private means.

As this participant noted:

> "*The child had been seriously neglected because of alcohol misuse. That's another area which is hidden in a different way because sometimes in affluent families misuse of alcohol there is an acceptance of its a thing that they do, and if it becomes a problem they refer themselves to a clinic and deal with it and then come out and then the cycle starts again. And then the children may well be in private schools or boarding schools and then maybe some sort of positive figure out there that keeps it ticking over but the neglect that the child is suffering remains, and it almost comes out by the second time they came to our attention".*

All of the children's social care departments that participated in the research had high numbers of fee-paying and independent boarding schools in their geographical area attended by children whose family homes were out of the authority areas, and in some cases, the parents lived overseas. This added to the complexity of safeguarding children when concerns about child abuse and neglect were flagged up. Practitioners describe the difficulties in getting

schools to acknowledge and take seriously their safeguarding responsibilities to ensure that all safeguarding allegations were handled appropriately.

Participants consistently reported that the independent boarding schools struggled to see these children as being in need or at risk of significant harm as a consequence of neglect. Participants described that, in their dealings with boarding schools, staff were not always clear about signs and symptoms of neglect, and their awareness that neglect may be an indicator that other forms of abuse may be taking place was very limited.

For example, one participant had this to say:

> "*The school nurse would have a conversation and say 'look there's no physical evidence she was sexually abused', and this is 6 months down the line when these parents have really been difficult with us, avoiding, making several complaints and change of social workers because they refuse to work with people. You feel, how many times do I need to explain what their basic techniques are, to close the door to us. And they are still saying 'look there's no physical evidence' and school says 'look she is a great Mum, there is no way she would ignore the child being abused'. And you have to keep repeating that 'this is the disclosure that this child made', she is a very articulate lovely little girl, she has not retracted anything, those are harsh cases for the social worker because you feel like you are holding, umm not managing the risk because that is what we do but emotionally you are really feeling that this is not good enough for this child and it really helps when you've got other people around the table that are on the same page and it's really hard when they're not".*

Participants reported that, in some cases, the designated safeguarding leads in fee-paying and boarding schools were often very reluctant to raise concerns with parents and to report safeguarding concerns about neglect to children's social care. They were also resistant to joint-working. A number of

participants also stated that some schools' reluctance to report signs of abuse stemmed from the parents' transactional arrangements with the schools, thus there is hesitancy from schools to pass judgement on parenting behaviours and confront the problem of child neglect. Interview participants raised questions about whether the schools prioritised their relationship with the parents over the needs of the child as a consequence. Some participants expressed the view that boarding schools foster what they refer to as "normalised parental deprivation" and that this idea is not widely talked about. Thus, a number of public schools dealt with any safeguarding concerns in-house and participants stated that developing a shared understanding of neglect was often very challenging and highlighted that effective joint work to build a picture of children's experiences were often very difficult.

THEME 2: Privilege and Entitlement

All of the participants recounted that affluent parents' social class placed them at an advantage over the social workers and formed a major barrier to the level and depth of potential intervention. The common view expressed was that socially-privileged parents had access to powerful social networks, which some used to resist social work interventions.

> *"They know where to go with complaints, they know people within the council because the place is so small as well, they'll get on to their local councillor, someone who they go hunting or shooting with or playing golf, that's the reality of working in a very small place like this (and affluent) they know people in high places and they threaten you with people as well. So you've got to be confident when you arrive and know what you're talking about".*

For example, in one of the smaller counties in the sample one of the cases that came to child protection workers' attention involved a child whose parents were well established members of the community with high status in the county, the parents therefore called on various members in the community to give personal testimonies attesting to how upstanding they were and therefore good parents. On the other hand, the main concern of other parents were to do with shame and the stigma associated with social work involvement, and were therefore fearful that knowledge or suspicion of neglect of the children might spread to their social networks. Participants elaborated the ways that the parents' class backgrounds gave them an unspoken advantage, which meant that they were generally knowledgeable about the workings of organisations such as children's social care and the safeguarding process; perhaps more crucially, their sense of entitlement, brought a greater confidence to challenge the child protection decision-making processes. A number of participants expressed that because of parents' social status, income, and educational backgrounds they looked down on social workers, who they considered were beneath them, thus their intervention was often seen as an unwarranted intrusion. Such class elements formed a major barrier to developing constructive relationships with parents. Some participants also gave detailed examples of the various ways parents exercised class-based privilege to deliberately undermine their professional authority. For example, some participants spoke of being belittled and humiliated by parents in meetings, leaving them feeling as if they had to prove themselves and establish their credibility. Some reflected the view that, from the perspective of affluent parents, being told what is in their children's best

interests by social workers was not an experience they welcomed, resulting in the wishes and feelings of the parents taking precedence over the needs of the children. Some also pointed out that certain parents felt that, if they had to have any social work involvement at all, they should only have to deal with managers.

The following observation was made:

> *"You will get affluent families who will come and stand in reception and even though the social worker has gone down, they will demand to see the team manager or they will ring the director and it's not just an empty threat, they will ring the director. Whereas with our less affluent families they may standing reception and shout and get kicked out, and they might make threats to go to the newspaper but actually it's not going to happen. With affluent families what they want they want the manager and then they want the director and then they go to the MP. I have had a number of letters from MPs saying 'what are we doing with these certain cases?', certain low level cases, why we haven't responded to somebody as they would want you to. With our usual families that doesn't happen, once they have got the assistant manager there, they are quite happy to work with them".*

One of the biggest challenges described by participants was that parents with abundant financial resources used their privileged position to hire legal advocates to help them resist social work interventions, and were therefore more likely to either make threats to complain, and/or unjustified complaints, thus attempting to dilute the assessment of risk that social workers undertook.

In one research site the participant had this to say:

> *"When you go into an affluent area what you find is that was asking people who are more articulate and better educated you find that they are more likely to use the complaints processes. So a lot of time and energy is spent trying to unpick what has and what has not happened. and it makes*

social workers worried about actually getting to the hub of the issue, because they know a complaint will follow".

According to participants power is exercised through their use of solicitors and lawyers and they described what they referred to as the "scattergun approach": affluent parents were more likely to write long letters or emails quoting the relevant passages from The Children Act (1989), Working Together to Safeguard Children, or to directly contact senior managers, elected council members and MPs, with their vexatious complaints**.**

"I had found that families who are more affluent, we communicate with them in a different way. They send emails, they write to us formally, whereas the other families that we work with, they don't. Do they? They come in the office, or they phone. But the affluent families we get a long list, almost to the point where it becomes almost harassing, you know I don't want to be seen as if we don't communicate with families, but it is almost like they want a response and they want it immediately. They have sent you an email half an hour ago and they want a response to it. They are much more articulate, they are much more able to challenge, which is not a bad thing. And because of that, I sometimes wonder whether they do get a different service than a family who are less articulate".

All participants felt that the parents' socio-economic status privileged them to subject their practice to a level of scrutiny in a way that families from lower-socio-economic backgrounds did not. In part, responding to the demands that were made meant it was sometimes difficult to retain a focus on the child's needs. Participants spoke of the extra effort, skill, and time they had to dedicate to cases involving affluent parents, due to this extra scrutiny from parents' which raises questions about fairness and quality of provision to non-affluent families.

Put briefly**,** affluent families who came to children's social care's notice were more likely to have the resources and capabilities to resist social workers' intervention. There was often a great concern that the parents would make a formal complaint; thus, the subtleties and nuances of class privilege had a key role to play in parents' ability to resist child protection investigations.

Theme 3: Barriers to Escalating Concerns

A recurring theme that permeated through the participants' accounts was the challenging behaviours they encountered when attempting to escalate concerns for a section 47 investigation. Specific barriers included difficulties engaging parents, and the gathering of information to build up a picture for the assessment of the safety needs of children. Participants noted it was a considerable challenge to gain knowledge of families' histories and functioning for assessing emotional neglect, or its severity and its chronicity.

Participants also discussed the ways that parents resisted the level of probing and questioning that is required, and in some cases their non-compliance made it significantly more challenging to make the children the subject of a child protection plan. Other factors influencing this process included the parents' use of lawyers and solicitors to challenge the decisions of social workers, or to avoid social work intervention. Overall, participants consistently cited that highly resistant parents were more likely to use legal advocates or the complaints procedures to challenge social workers when they attempted to escalate their concerns to child protection, which could have considerable influence on the outcomes of the case. Some practitioners reported being put

under a lot of pressure to respond to the demands of the parents which made it difficult to maintain a child-focus approach. Some participants reported feeling intimidated by parents and needing good support from their managers in order to carry out a robust risk assessment as parents did not often engage with social workers and actively resisted their intervention. They expressed the importance of being able to focus on the child but highlighted that there were very few opportunities for direct observation of the child's relationship with the parents; particularly, in situations where children were in schools that were failing to recognise child neglect, leaving the children at risk of significant harm.

One participant said:

> *"I think it is very important to build that rapport with the child because once they trust you they will tell you about the daily routine. What they don't like Mum and Dad doing. In that particular case we got lots of evidence from the older brother who just reached a point where he had had enough and told the social worker everything. And on that occasion they had both been neglected, it was emotional neglect and they were both very overweight. Mum had an argument with every professional involved so it was constant drama. Relatives were cut off from them, so the neglect in that case was overwhelming but pulling the evidence together was very difficult to reach the threshold. But actually when he reached and said he had had enough the evidence was brilliant because although he was raised in an environment with two parents with massive egos and limited emotional intelligence, he was one of the most emotionally articulate children I have ever met, and he could put himself in his brother's shoes and he saved him and his brother really and they went to live with his granny".*

In one site it was highlighted that there were some differences in how social workers engaged with affluent families from minority ethnic backgrounds. For

example, it was noted that social workers were much more likely to draw on cultural explanations to make sense of risks to the children concerned, which resulted added difficulties in keeping a focus on the child.

A participant commented:

> *"What happens is that social workers get worn down by these cases, and we let go of them without actually achieving the outcomes we want to. With affluent families from minority ethnic backgrounds, social workers can react the other way because they are different, they are constantly looking for other things which are not always rooted in the cause. So it plays out in a different way. You have perhaps got English as a second language and the interplay can be different. And you know you could swing the other way and not let go when you should".*

More often than not, parents prevented practitioners from seeing and listening to the child. Therefore, practitioners were often left with insufficient evidence to progress to a section 47 investigation, resulting in drift and delay in some cases. Findings suggest that when the social workers were able to get good outcomes for the children this stemmed from their direct contact with them especially with older children who, had a greater ability to express themselves and discuss what it is like for them living in that household.

Here is what one practitioner had to say:

> *On the surface there was nothing wrong with the care, the presentation of these children, but it was more about their experience of being in a very hostile home and it impacted on them and the parents' ability to understand how their behaviour impacted on the children. Because you know they had a holiday twice a year, they had their iPhones, they had this, and also I think the hardest bit was for Mum to accept that actually the relationship between her and her husband was causing the*

> *children more damage than if she separated and they lost all that materialistic side of things. And actually that's what the children wanted. It was easier in that particular case too, because if you've got a good social worker, the social worker was able to get the voice of the child in that, and that's something we really do focus on in about, what does the child want? These children were very able because they were older, to express what it was like living in that home, how the tension in the home changes as soon as Dad walked in the door, and actually living with two parents that actually didn't communicate with each other. You know, so in that respect I think it is about social worker skills in actually engaging that child, but they were teenagers so when you've got a younger one I think it is much harder".*

There was widespread agreement among participants about the tensions inherent in having to devote a great deal of time to responding to the demands and complaints of affluent parents while keeping focus on the safeguarding needs of the child. In order to persevere and not be intimidated by the parents, the social workers needed to have good knowledge of child neglect, good communication skills and confidence in their ability to navigate the complexities and dynamics that arise in such cases.

Theme 4: Factors that make a difference for Authoritative Practice

Being skilled and knowledgeable in relation to working with neglect was identified by all participants as critically important. For timely and skilled intervention, participants stressed that skills such as assertiveness, confidence, and being self-assured were key as well as the personal qualities and relational approach of the worker. Considerable experience, practice wisdom and knowledge of neglect were essential in relation to working with highly resistant parents who had the resources to challenge social work decisions. Knowledge about child development was necessary in order to understand the impact of child neglect, but a very good understanding of the

threshold for emotional neglect was also considered as essential as a high level of judgment and assessment ability is needed. Participants spoke of the spectrum of skills that social workers need to have because affluent parents are highly litigious, and have the material resources and the machinery behind them. Practitioners thus needed to be skilled in communicating with difficult-to-engage and highly-resistant parents from affluent backgrounds.

A participant made this observation:

> *"I think it takes a really skilled practitioner, because you have to acknowledge, hear and listen to what parents are saying. You need to give them sufficient attention so they feel what they have said has been heard, whilst at the same time just keep bringing it back to the child and the impact on the child".*

Another participant had this to say

> *"I say a clarity of understanding about thresholds, a focus about what is good enough, a very clear knowledge and understanding of the different categories of abuse and how they can intertwine and present as something different. Somebody with good organisation skills because if you don't get back to someone who is constantly writing to you or you don't respond to their phone calls then that becomes a reason to deflect at a meeting."*

Participants emphasised that they also needed to pay much more attention to how they presented themselves as an expert and authority figure; this included paying attention to how they dressed and spoke, as they perceived such elements form barriers to engagement with affluent families. There were two examples given of practitioners being removed from cases by their managers due to complaints by the parents that they could not understand the social workers' accents.

As one manager puts it:

> *"You need to be articulate because you have lost them if you have got an accent or English is not your first language and that's not on at all but that's how it is"*.

This raises uncomfortable questions about whether evaluative judgments are being made about the individual social worker's communication skills. Most notably, negative attitudes towards certain foreign accents are left unchallenged, so the prejudicial assumptions that these attitudes rest upon are not unpicked in order to better support minority ethnic social workers more effectively.

There was a general consensus that the stakes were higher, and in order to perform effectively and to be taken seriously, practitioners also needed to be very clear about their professional authority, and to have a very good working knowledge of the relevant legislation and statutory guidance that informs practice decisions when assessing affluent families, because these families were often very well-informed of the legal and statutory framework and were therefore much more likely to counteract their claims, than do poorer parents.

All of the participants stressed that having good supervision and a supportive manager was vitally important.

As one participant noted:

> *"You need line managers who are completely behind you all the way, and won't undermine you. You need a confident but child centred approach from line managers as well".*

The importance of good supervision, which can help to mediate the impact of parents' attempt to undermine the social workers, was emphasised. Practitioners named key elements, such as, organisational cultures of support, purposeful informal conversations about the case with colleagues, good supervision, knowledge and confidence and responsive managers, and themed learning activities, as key to their ability to work in this complex field. In some of the research sites, reflective supervision forums enabled analytical thinking that was process-orientated as an aid to understanding and analysing risk in a context where covert and nuanced class privilege operated to undermine the social workers. In one site they utilised an action-learning method to periodically focus on a particular theme or issue to do with child abuse and neglect as a way of developing practice. A consistent message from participants is that a reflective space provided a sounding board to help them to disentangle the professional practice dilemmas, and to find new approaches to solve challenges, as well as to question their values, beliefs and assumptions for dealing with what some referred to as "the affluent family effect".

In some of the local authorities, frameworks for practice, such as Signs of Safety and a problem-solving approach, were named as tools for practice that enabled practitioners to analyse all risk factors. Being solution-focused, they provided a structure for analysing complex and often highly emotional situations with affluent families. In many of the authorities, the role of the principal social workers were critical in helping to develop a culture of learning

and improvement, where practitioners were sufficiently supported to develop their practice in this complex field.

Discussion and Conclusions

The purpose of the research was to find out how social workers engaged parents from affluent backgrounds when there were safeguarding concerns of neglect. The challenges of working with affluent parents in the child protection system are multi-faceted and resource-intensive. In particular, neglect in affluent families can be difficult to recognise and address. Some of the problems concern parents' attempts to minimise the significance of emotional neglect as well as the difficulties for practitioners in assessing emotional neglect. Families may be materially advantaged, and the children's physical needs are being met, but there may be little or no emotional connection with the children, and the parents may not be psychologically available (Howarth, 2014). Other problems concern the communication between the designated safeguarding lead in private fee-paying and boarding schools and the relevant local authority children's social care department.

The research has emphasised the need for raising awareness of definitional issues of emotional neglect, in order to promote more effective responses to the needs of children and young people from affluent backgrounds who may attend schools away from their home authority. In terms of early help, the findings also suggest that younger children, and children with disabilities who are at risk of neglect, are probably more hidden from children's social care services than other children.

While working with involuntary and highly-resistant parents is a common occurrence in child protection work, there are some distinctive factors when working with resistant affluent parents. The particular challenge posed is that, while social workers were cognisant of their power as professionals, they also face hierarchical power relations between themselves and affluent parents, which meant that the parents were often very knowledgeable about the workings of the system, and socially well-placed to question decisions. As described above, the findings suggest that affluent families resented having to deal with social workers and were much more likely to oppose their decisions, thus using status and privilege to undermine and disempower practitioners. One of the most frequently discussed issues was that affluent parents' confidence and sense of entitlement meant that they felt they could diagnose their own needs, expected children's social care to accommodate them, and felt that they had a right to challenge those in authority. Practitioners reported that active engagement techniques, such as having a formal signed agreement and goal setting, often did not work with affluent parents; the parents essentially used formal complaints as a strategy to deflect attention away from doing a robust assessment, a finding also identified in other research (Laird 2013). Most participants, however, indicated that, because this group of parents are more likely to use the complaints procedures, which can deflect attention away from their parenting behaviour, it concentrated their thinking on the importance on holding the child as a central focus of the assessment, so that the parents' interests did not outweigh consideration of what was in the child's best interest. Arguably, the social workers were challenged to develop strategies to speak directly to the children whilst still

respecting and acknowledging the status of the parents. Where the practitioners were able to engage directly with the children and were not intimidated by the parents, they were much more likely to achieve better outcomes for the children involved. In such situations, what made a difference was that the social workers had the self-confidence, practice wisdom, professional curiosity and most importantly, the support of their managers, which enabled a focus to be kept on the child without letting the complaints from the parents cloud the risk assessment. The participants' narratives offer key insights into the ways in which the threats of complaints instil fear and operate to deescalate concerns in some cases. It would suggest that one factor concerns how supported some social workers felt by their managers. Whilst there has to be a degree of confidence to not be deterred by the threats of complaints, notwithstanding, practitioners also need to have supportive managers behind them. This is an important consideration, given that a key role that managers have in supervision is to help social workers process the complex emotional demands of the work, and since the view of managers significantly influenced the direction that the investigation would take in some cases.

Participants in the research consistently stated that engaging affluent parents to address specific parenting behaviour to make robust risk assessments of children's needs was often time-consuming and resource-heavy, as well as frustrating and stressful. Arguably, given the considerable number of children's social care personnel that tend to be involved in a single case (including social workers, team managers, and service managers to respond to the demands of parents), it is important to consider whether the

practitioners offered a different level of service to affluent families because they expected to be questioned more. The research also challenged participants to reflect on whether in some cases professional judgements were particularly susceptible to unconscious bias as a result of the families' socio-economic status. This particular issue has been highlighted in a number of serious case reviews (Brabbs 2011; Carmi and Walker-Hall 2015).

In terms of knowledge and skills, all participants in the study frequently emphasised the importance of having a good understanding of the threshold for neglect in order to take authoritative action. Also critical were practice wisdom and confidence, coupled with child-focused communication skills, an ability to manage conflict and challenges, as well as good problem-solving and procedural skills (Keys 2009); these tools were essential for frontline social workers to effectively assert their professional authority with affluent parents when there were concerns about abuse and neglect. With regards to interventions that are effective for families that are highly resistant to social work intervention, some practitioners found that risk assessment tools such as the neglect toolkit were useful in helping them to stay focused on the child to assess levels of risk and in evidencing assessments in order to escalate concerns when there was a need to do so. However, it is important to recognise that whilst standardised assessment tools such as the neglect toolkit is a necessity for assessing risk, social workers also need to be confident and assertive in their professional judgements to identify and name deficits and neglectful caregiving in affluent families. Thus, if practitioners are to engage with the complexity of safeguarding children in affluent families, they also need to be able to acknowledge and discuss the power of social

class and how it impacts the child protection processes. As a number of serious case reviews point out, class does get in the way of child protection work (Brabbs 2011; Nicolas 2014).

The study has implications for how social workers understand and work with affluent families when there are safeguarding concerns. Though class pervades much of social work with families, the stratification of class is not explicitly named or explored in training events in working with resistant families, for instance. A striking example from this study is that even in those local authorities where a good proportion of their interventions involved affluent families, training events on working with difficult or resistant parents only used case scenarios depicting poor and working class families, thus reinforcing the idea of neglect as a social and economic disadvantage phenomenon. In effect, social class as it frames the lens through which neglect is analysed needs to be a central issue in practitioners' discussions and reflections on child neglect. Essentially, the nuances of class division as it impacts interpretation of and responses to neglect in affluent families need to be unpacked. The findings from this study thus highlight the need to have more critical dialogue about social class and privilege as it frames understanding of risk factors for children in affluent families.

Limitations

It is worth noting some of the limitations of this study. The small-scale, exploratory nature of this study, means that it was not trying to elicit statistical or generalisable data. Caution is needed before generalising to all affluent parents.

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Appendix 1.

Types of Neglect

Neglect type	Features associated with type of neglect
Educational neglect	Where a parent/carer fails to provide a stimulating environment or show an interest in the child's education at school. They may fail to respond to any special needs and fail to comply with state requirements about school attendance.
Emotional neglect	Where a parent/carer is unresponsive to a child's basic emotional needs. They may fail to interact or provide affection, undermining a child's self-esteem and sense of identity. (Most experts distinguish between emotional neglect and emotional abuse by intention; emotional abuse is intentionally *inflicted*, emotional neglect is an *omission* of care.)
Medical neglect	Where a parent/carer minimises or denies a child's illness or health needs and/or fails to seek appropriate medical attention or administer medication and treatment.
Nutritional neglect	Where a child does not receive adequate calories or nutritional intake for normal growth (also sometimes called 'failure to thrive'). At its most extreme, nutritional neglect can take the form of malnutrition.
Physical neglect	Where a parent/carer does not provide appropriate clothing, food, cleanliness and/or living conditions.
Supervisory neglect	Where a parent/carer fails to provide an adequate level of supervision and guidance to ensure a child's safety and protection from harm. For example, a child may be left alone or with inappropriate carers, or appropriate boundaries about behaviours (for example, under-age sex or alcohol use) may not be applied.

(Flood & Holmes 2016)

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Committees	**Dated:**
Children's Executive Board Safeguarding Sub Committee	16/01/2018 06/02/2018
Subject: Special Educational Needs and Disability (SEND) Update Report	**Public**
Report of: Andrew Carter, Director of Community and Children's Services	**For Information**
Report author: Theresa Shortland, Head of Service – Education and Early Years	

Summary

Members of the Community and Children's Services Grand Committee were previously updated in 2017 about the work with children and young people with special educational needs and disability (SEND) in the City of London. That report set out what the vision and strategy was for SEND. It was agreed that Members would subsequently be regularly updated via reports to the Safeguarding Sub Committee, on the progress in respect of this work. This report provides a further update on this work.

Recommendation

Members are asked to:

- Note the report.

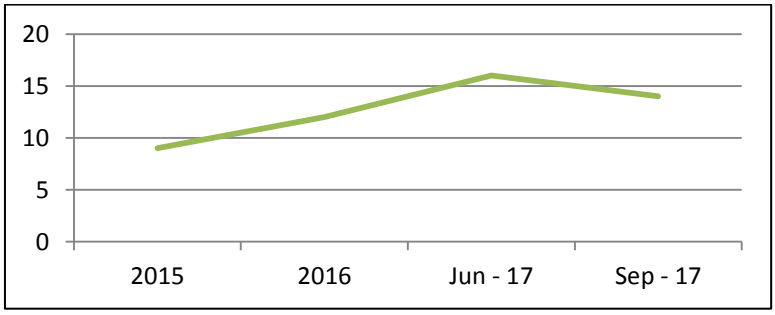
Main Report

Background

1. The duties on local areas regarding provision for children and young people with SEND are contained in the Children and Families Act 2014. The Ofsted/Care Quality Commission (CQC) Inspection Framework sets out the legal basis and the principles of inspection. The Minister of State for Children and Families has tasked Ofsted and the CQC with inspecting local areas on their effectiveness in fulfilling these duties.

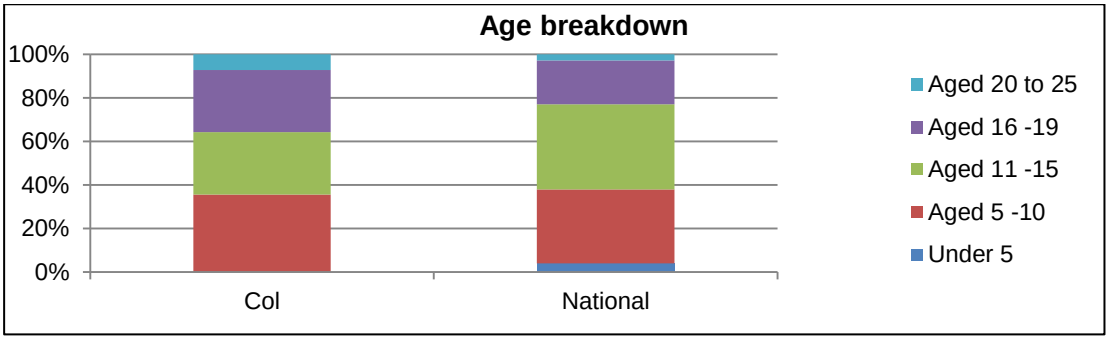
Current Position

2. Since 2014, when the reforms contained in the Children and Families Act 2014 were introduced, the City has seen the number of children with an Education, Health, Care (EHC) plan or Statement of Educational Need increase from eight in September 2014 to fourteen by September 2017. This number has doubled and the highest number of children and young people with statutory plans at any one time has been 19. The main reason for the increase in the number is new arrivals to the City.



Graph 1: Total number on EHC plans/ Statements of Educational Need

3. In the City, the majority of children with EHC plans are boys (92%). This is higher than the national average (73%). Five out of 14 (36%) children with EHC plans are of White ethnicity. Nearly all of the children with EHC plans are of school age, with nearly 30% aged between 11 and 15, which is below the national average of 39%. The City does not have any children under statutory school age with EHC plans (see graph 2 for breakdown). All City of London children with an EHC plan attend schools that are judged “Good” or “Outstanding” by Ofsted. Three children with EHC plans attend Sir John Cass’s Foundation Primary School, the only local authority maintained school in the City.



Graph 2: % of Children with EHC plans/Statements of Educational Need by age

Health

4. Children and young people on SEND support or with EHC plans may also access provision provided by the Clinical Commissioning Group (CCG) for the City and Hackney. The City of London also receives notifications of children who may have SEND as referrals from health services. Since April 2017, there have been two referrals.

5. Data from NHS City and Hackney Community Health Services shows 22 children registered and receiving a service in November 2016. This figure includes children with EHC plans or SEND support. Out of the 22 open cases, five are receiving more than one service. See Table 1 for a breakdown of services City children are accessing.

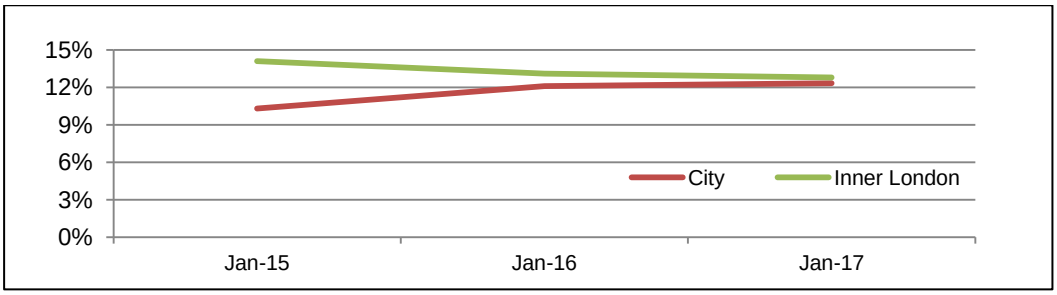
Cases open to City and Hackney CCG		**Number of cases***
Child and Adolescent Mental Health Services (CAMHS)	Specialist CAMHS First Steps Early Intervention Community Psychology Service	3 3
Speech and language therapy		3
Child development paediatricians		9
Occupational therapy		3
Physio		3
Vision clinic		0
Other		0
Total		**22**

Table 1: Cases open to City and Hackney CCG November 2016

* Note: Some children are accessing more than one service

SEND Support

6. The number of children receiving SEND support has gone up in the last three years from 9.2% in 2014 to 12.3% in 2017. This is slightly lower than the Inner London average (12.8%) but is higher than the national average of 11.6%.



Graph 3: Percentage of children with SEND support

Self-evaluation

7. We have established a clear strategic direction in the SEND Strategy 2017–20 with a strategic plan and action plans to drive forward the priorities within the six work streams. There is clear governance in place to ensure that we are developing our local area vision for children and young people with SEND in the City of London.

8. There is a good understanding of what we do well, and plans are underway to develop service impact and reach further. The Self-evaluation Summary (see Appendix 1) sets out our progress towards meeting the priorities for 2017/18.

Areas of progress

9. The areas where we are making good progress are:

- raising the profile of the SEND Reforms agenda with key internal and external target audiences (including City of London Corporation staff and elected members) and highlighting what we are doing to support this
- increasing the participation of children, young people and families in co-production at a strategic level so that their voices are integral and have an impact on the specification, quality and delivery of services
- improving communication between health professionals and the local authority as soon as emerging needs are identified, including improved sharing of information from early health screening programmes
- developing closer relationships, including data-sharing protocols, with the early years settings, schools and colleges outside the borough and in the independent sector where children and young people with SEND who are resident in the City are educated so that we can evaluate outcomes for these pupils and more closely match services to their needs and aspirations
- increasing the participation of children and young people with EHC plans in strategic planning and service development
- ensuring that the integrated commissioning arrangements reflect and meet the needs of City of London children and young people with SEND and, in particular, strengthening the relationship with Tower Hamlets CCG to ensure clear pathways for City of London children and young people with SEND who are registered with Tower Hamlets GPs
- developing increased social care and Early Help joint working through the multi-agency referral process in order to create more effective pathways for children and young people with SEND
- promoting the redesigned Local Offer to key target audiences through a range of communication channels
- developing a systematic, comprehensive Children's Centre offer that is based on, and targets, need.

Areas for further development are to:

- broaden the parents' forum to include parent carers of children on SEND support in City of London schools
- develop effective systems to improve the engagement and participation of young people with SEND

- provide performance analysis and reporting and a quality assurance framework that better enables our strategic planning, oversight and scrutiny
- put broad scope plans into place for post-16 and post-19 progressions and exit pathways so that, when children and young people are transitioning into adulthood, their access to training and employment is facilitated
- develop links with available resources for employment and training support
- ensure action pathways are in place to work towards increased employability and raised employment levels.

The local offer

11. The local offer was launched in October 2017 after a period of working with local parents to design a user-friendly website. The touch and feel of the new local offer is much improved and has been well used in the initial few months. The local offer aims to increase access to services for parents and carers of children with SEND. In one location it sets out information about available services and provision for children and young people with SEND in their area.

12. Officers have continued to meet with the parents' forum. The City of London parents' forum has invited the National Network of Parent Carer Forums (NNPCF) to work with them to further establish the group.

13. In December 2017 the parents' forum organised an event at Artizan Library and Community Centre on Sunday 17 December 2017. This event gave children and parents an opportunity to take part in a project with an art student who is working with the Museum of the Order of St John in Farringdon to produce an exciting new art project with the SEND community. The families that attended will continue to work on the project.

Multi-agency partnership working

14. The City has excellent relationships and partnerships with City and Hackney CCG to underpin joint working and commissioning. A core specification has been developed, ensuring that all services commissioned/recommissioned are able to demonstrate inclusive practice. There are well-developed plans for achieving integrated commissioning and aligned budgets.

15. Joint working takes place when children and young people with SEND are also known to Social Care teams. If anyone with an Education, Health and Care plan accesses short break services, this is linked to the appropriate outcome in the plan. The short breaks offer is not yet fully embedded in the City local area, the views of children, young people and parents will influence future provision so that more activities are made available locally.

Conclusion

16. There has been good progress in the development and quality of work with children and young people with SEND in the City of London. Plans are in place to continue to focus on improvement and preparation for the Area Inspection.

Appendices

- Appendix 1 – Self-evaluation Summary

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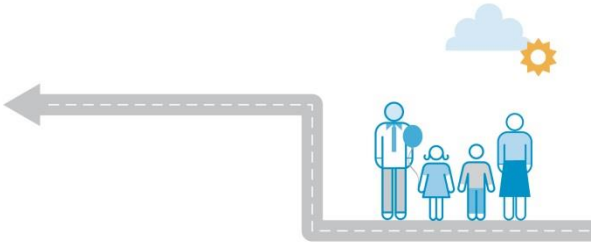
APPENDIX



The City of London Local Area SEF Summary: The SEND Reform in the City of London

Our Journey 2014 – 2017

Our Local Area vision for children and young people with special educational needs and disability (SEND) is that the City of London is a place where children and young people with special educational needs (SEN), disabilities, mental health conditions, or other long-term medical conditions, can thrive and experience a smooth progression into adulthood. We want our children and young people to be confident that they are highly valued, equal to all of their peers, and have high expectations for their futures.

Our SEND strategy includes six priorities that represent a cycle of support. These priorities are:

1. identifying needs early
2. effectively assessing and meeting needs
3. protecting children from harm and supporting independence
4. removing barriers to participation
5. creating smooth transitions between stages and services
6. improving long-term outcomes and creating area-wide impact.

These priorities are covered in our SEND Strategic Action Plan (StrAP) and SEND Service Action Plan (SAP).

Areas where we are making the most progress

We have a clear strategic direction that is well understood There are clear policies in place and leaders are ambitious for City children and young people. There is good understanding of strengths and plans are underway to develop service impact and reach. Key managers in education and social care co-produce strategies and work in partnership on strategic decision-making groups. The City is a small authority with relatively few children and young people; however, we have commissioned a wide range of services so that pathways and support systems are in place for most eventualities. The role and purpose of key

strategic groups has been reviewed and a more streamlined and focused system is now in place.

A priority is to raise the profile of the SEND Reforms agenda with key internal and external target audiences (including City of London Corporation staff and elected members) and highlight what we are doing to support this. (StrAP 3.2)

Sound governance structures have been developed and successfully implemented
The overall governance is clear with the Grand Committee, chaired by a Lead Member, having the overarching strategic overview. The accountability structure under the Grand Committee ensures senior leadership oversight via the Children's Executive Board which has achievement, Early Help and SEND as standing agenda items. Members will also be kept up to date regularly through the Safeguarding Sub Committee and annually via the Health and Social Care Scrutiny Committee. Governance has been strengthened further with the creation of a SEND Programme Board, chaired by the assistant director with responsibility for children and adult services, co-chaired by a representative from the Clinical Commissioning Group (CCG), and with a parent carer as vice-chair. This structure means that there is a high level of accountability throughout the borough, and outcomes for children and young people with SEND are a priority.

A priority is to increase the participation of children, young people and families in co-production at a strategic level so that their voices are integral and impact on the specification, quality and delivery of services. (StrAP 1.3)

Identification and assessment for children and young people is good because of effective multi-agency working.
The City of London proactively collects information from early years providers and Sir John Cass's Foundation Primary School on the number of children who receive SEN support. Information on pupils with SEND is also sought from independent schools and colleges in other boroughs where City-resident children and young people are educated. City of London Early Help services regularly bring together professionals from all agencies to develop effective strategies to support families, children and young people (SEND Strategy Priority 1, p11).

A priority is to improve communication between health professionals and the local authority as soon as emerging needs are identified, including improved sharing of information from early health screening programmes. (StrAP 2)

Progress and attainment for children and young people with SEND in the City is better than national average
All but one of the City of London's schools is in the independent sector and there are no special schools in the City. Educational test results for children with SEND in the City – that is, those attending Sir John Cass's Foundation Primary School and those with Education, Health and Care (EHC) plans, are better than national and gaps between those with SEND and those without are narrow. Results for 2017 show that, in Key Stage 2, achievement at the expected standard in all subjects is 27% above the national average. At Key Stage 1 the results are above national average.
Those children and young people who are in public care are well understood and the Virtual School Headteacher is able to access support

services (such as educational psychology) as soon as necessary. The difference between SEND and English as an additional language/English as a second language (EAL/ESL) is well understood and 'under attainment' triggers additional tuition support.

A priority is to develop closer relationships, including data-sharing protocols, with the early years settings, schools and colleges outside the borough and in the independent sector where children and young people with SEND who are resident in the City are educated so that we can evaluate outcomes for these pupils and more closely match services to their needs and aspirations. (StrAP 1.2 and SAP 1.6)

Statutory timescales are met and all statements have been transferred to EHC plans

Timescales are being met in regard to transfer of statements to EHC plans and in the production of new EHC plans. All transfers are complete. Due to the small numbers involved, children and families receive a highly personalised approach and senior officers know the children and young people well. Care is taken to ensure that appropriate regard is paid to the wishes and aspirations of children, young people and their parent carers. There has been strong engagement with parent carers to transfer statements to EHC plans and to develop each plan. This personalised approach extends into transition arrangements and young people eligible for adult social care are well known and well planned for.

A priority is to increase the participation of children and young people with EHC plans in strategic planning and service development. (StrAP 1.3)

Joint commissioning arrangements have set firm foundations for achieving good outcomes.

The Commissioning Team is embedded in the work of Children's Services with a high focus on outcomes for children and young people with SEND. Pathways and access to services are well understood so that children and young people do not have to wait long for support to be put in place. The City has excellent relationships and partnerships with City and Hackney CCG to underpin joint working and commissioning. A core specification has been developed, ensuring that all services commissioned/recommissioned are able to demonstrate inclusive practice. There are well-developed plans for achieving integrated commissioning and aligned budgets.

A priority is to ensure that the integrated commissioning arrangements reflect and meet the needs of City of London children and young people with SEND and, in particular, to strengthen the relationship with Tower Hamlets CCG to ensure clear pathways for City of London children and young people with SEND who are registered with Tower Hamlets GPs. (StrAP 2)

Social care provides high-quality support and encourages families to be self-sustaining and access resources within the community.

Teams across education and social care know their children and young people and their families well. Joint working takes place when children and young people with SEND are also known to social care teams. If anyone with an EHC plan has a short break, this is linked to the

appropriate outcome in the plan. An Early Help Toolkit has been developed that includes a 'distance travelled' tool to capture the impact of interventions.

A priority is to increase social care and Early Help joint working through the multi-agency referral process in order to create more effective pathways for children and young people with SEND. (SAP 1.8 and 1.9)

The City of London SEND Local Offer is becoming established as the one place for up-to-date information about provision and how to access it.

The SEND Local Offer is a key tool for supporting and communicating information so that parents can find the information they need to access services and understand processes. The consulting agency, Communitas, was commissioned to engage parents to develop the Local Offer further. Based on this consultation, a more accessible and user-friendly Local Offer was launched at the end of October 2017.

A priority is to promote the redesigned Local Offer to key target audiences through a range of communication channels. (StrAP 3.1)

The Local Area system for Early Years and childcare is working effectively for families.

The local authority Education and Early Years team has built strong relationships with early years settings and provides effective support and challenge to improve provision and outcomes for children with SEND. Practitioners and settings are clear about the identification process and the graduated approach of 'assess, plan, do and review'. Public health services are performing well – for example, for vulnerable families, health visitors make two visits in addition to the mandatory five and 100% of mothers are still breastfeeding at six weeks because of this good support. The Family and Young People's Information (FYI) Service and Local Offer set out clearly what support is available for families from different targeted and specialist services for early years and how support can be accessed. Advice, guidance and training for early years providers is established, ensuring that children with SEND are supported by inclusive practice in early years and childcare settings. Children's centre activity is delivered across a number of sites but is not yet effectively coordinated so as to meet strategic priorities and will be subject to a full review in 2018.

A priority is to develop a systematic, comprehensive Children's Centre offer.

Areas where we are making less progress

The engagement of parents and carers of children on SEN Support and the engagement and participation of young people.
Feedback from parents and carers of children and young people with EHC plans shows a high level of satisfaction and engagement. Engagement with parents and carers has recently been strengthened with a more formalised mechanism of parental representation on the SEND Programme Board. Work is underway to also establish a parent forum at Sir John Cass's Foundation Primary School that will better represent the views of parents and carers and the range of children and young people with SEND, especially those receiving SEN Support. The engagement and participation of young people is at an early stage of development but is seen as a vital and urgent initiative if strategic and service developments are to be effective.

A priority is to broaden the parents' forum to include parents and carers of children on SEN Support in City of London schools and to develop effective systems to improve engagement and participation of young people with SEND. (SAP 1.3)

The consistent use of data to evaluate and drive outcomes.
A SEND dataset has been developed and is regularly updated, however, some of the health data is collected across a number of boroughs and City data is difficult to disaggregate. As a result, outcomes are not routinely measured within the wider system, making effectiveness and value for money difficult to determine. Consideration has been given to developing a cross-agency tool to evaluate the impact on progress towards outcomes of all interventions. Data is being used to enable strategic oversight and teams are far more aware of the need to evaluate their interventions.

A priority is to provide performance analysis and reporting and a quality assurance framework that better enables our strategic planning, oversight and scrutiny. (StrAP 1.2)

Preparing children and young people for adulthood.
Planning pathways and opportunities to prepare children and young people for adulthood have yet to be fully embedded. Young people's views are sought on their experiences and their involvement in identifying needs, but these are not currently collated and analysed. We are considering how to help young people with complex needs to access social activities in their community with growing independence. This will include support during holiday periods for children and young people to practice independence skills in the community to support long-term inclusion and embed the skills being taught in schools and colleges. The short breaks offer is not yet fully embedded in the City area. The views of children, young people and parents will influence future provision so that more local activities are available.

A priority is to put broad scope plans into place for post-16 and post-19 progressions and exit pathways so that, when children and young people are transitioning into adulthood, their access to training and employment is facilitated. (SAP 5.6)

Pathways to employment for adults with learning difficulties.
Work is underway to facilitate smooth transitions to adulthood, with cases being discussed at the transition forum. There is also effective planning for post-16 and post-19 progression for individual children and young people through the EHC plan process. However, few adults with learning difficulties resident in the City of London are currently in employment and we are liaising with local businesses to identify possible routes to employment, including supported internships. To date, outcomes-focused assessments and the use of desired outcomes has not been part of planning or service development. Therefore, low aspirations may be limiting the degree of independence and employment opportunities for young people coming through the system. The Local Offer is being developed to include more information about preparing for adulthood and employment and to signpost pathways to employment and independence.

A priority is to develop links with available resources for employment and training support and to ensure that action pathways are in place to work towards increased employability and raised employment levels. (SAP 6.1)

Committee	Dated:
Safeguarding Sub Committee	06/02/2018
Subject: Financial Abuse Update	**Public**
Report of: Director of Community and Children's Services	**For Information**
Report author: Adam Johnstone, Strategy Officer – Housing and Adult Social Care	

Summary

This report presents an update on the work undertaken by the Financial Abuse Task and Finish Group. The group was established to provide a co-ordinated approach to reducing financial abuse – the second most prevalent cause of safeguarding alerts in the City of London.

Recent work has included combining a variety of datasets to produce an overview of financial abuse across the City, a public campaign to coincide with Scams Awareness Month, and a partnership event to raise awareness of the issue among practitioners.

Recommendation

Members are asked to:

- Note the report.

Main Report

Background

1. The City and Hackney Safeguarding Adults Board City Sub Group has identified tackling financial abuse as a priority for the City. Financial abuse is the second most prevalent cause of safeguarding alerts in the City, making up 28% of the safeguarding caseload.

2. The Financial Abuse Task and Finish Group was therefore established to bring together officers from Community and Children's Services, Trading Standards, the City of London Police and Toynbee Hall to develop and implement a joint plan to tackle the issue.

3. The group's early work included producing a leaflet which is available in public buildings across the City. The leaflet was circulated with residents' annual

Council Tax bills and is given to anyone registering a death at St Bartholomew's Hospital. More recent work has included:

- combining a variety of datasets to produce an overview of financial abuse in the City
- a public campaign to coincide with Scams Awareness Month, and
- a partnership event to raise awareness of the issues among practitioners.

Overview of Financial Abuse in the City

4. A scoping report found limited data available on financial abuse in the City. The Financial Abuse Task and Finish Group collected data from Adult Social Care, City Police/Action Fraud and City Advice to provide a better overview of financial abuse across the City.

5. It is difficult to determine any clear patterns or trends from the data. In just under half of cases reported to Adult Social Care, the source of risk was known to the individual. Cases reported to Action Fraud tend to involve younger victims and fraud that occurs online.

6. The dataset will be regularly refreshed to track financial abuse across the City, regardless of which agency it is reported to. This will provide a way to measure the effectiveness of the group's work, with reports of financial abuse expected to increase as public awareness grows.

Public Campaign

7. During the latter half of Scams Awareness Month 2017 (17–28 July), a range of activities were held to raise the awareness of members of the public and City Corporation staff on how to spot the signs of scams and financial abuse and let people know what they can do if they are concerned about someone.

8. Outreach activities at supermarkets, at Guildhall and at residents' meetings were successful in giving out a large volume of printed material. A social media campaign received significant exposure with 3,914 page views.

9. Letters have been sent to all Adult Social Care service users, offering a personal visit from a Trading Standards officer to provide advice and practical support. One resident responded by requesting a visit and this was arranged at the end of December 2017.

Partner and Practitioner Event

10. A Partnership Event was held on Monday 4 December at Guildhall. This was aimed at practitioners, partner agencies and community leaders. It was intended to be a practical event, where attendees could learn how to protect themselves and others from financial abuse, gain confidence sharing this information with others in their networks, and learn where to direct people for further help.

11. The event consisted of interactive workshops, pop-up exhibition stalls and plenary sessions, with Professor Keith Brown, Director of the National Centre for Post Qualifying Social Work at Bournemouth University, delivering the keynote speech. Other sessions included ‘Take a stand against scams’ training, ‘Financial abuse, scams and fraud in later life’, ‘Peer-to-peer information sharing with older people’ and ‘The impact of loan shark debt on individuals and communities’.

12. A total of 63 delegates attended the event from a range of partner organisations, including Age UK, the City & Hackney Older People's Reference Group, Healthwatch, the East London NHS Foundation Trust, The Diocese of London and Toynbee Hall.

13. Of the 21 delegates who completed an evaluation form, all said they felt more confident sharing prevention messages with those who might be at risk of financial abuse and all said they felt more confident signposting people to appropriate sources of help. One delegate commented:

> “[This is] very relevant in my work as a Mental Health Nurse. We have many patients who are, or have been, victims of scamming and loan sharks.”

Conclusion

14. This report presents an update on the City of London’s financial abuse work. A further report detailing the impact of the work of the Financial Abuse Task and Finish Group will be presented to the Sub Committee at a future date.

Appendices

- Appendix 1 – Financial Abuse Work Plan

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Financial Abuse Task and Finish Group

March 2017 – September 2017

Introduction

The task and finish group has been established to:

Ensure the delivery of the financial abuse recommendations in the City of London. This will include producing a partner-wide communications and engagement plan and tracking of a number of key areas of work via this combined action plan.

Facilitating the co-ordination of existing work streams across the partnership and tracking work via this shared action plan.

Key leads and those responsible for completing actions:

Name	Title
Chris Pelham (Chair)	Assistant Director, People
Anna Grainger	Interim Service Manager, Community & Children's Services
Rachel Morrison	Strategic Communications and Engagement Manager, Community & Children's Services
Adam Johnstone	Strategy Officer - Housing and Adults, Community & Children's Services
Valeria Cadena-Wrigley	Community Safety Officer, Safer City Partnership
Steve Playle	Trading Standards Manager, Markets & Consumer Protection
Helen Evans	Toynbee Hall
John Ellul	Communications, City of London Police
Bayo Igoh	Head of Estates – Housing & Neighbourhoods

Dave Manley	City of London Police

1. Communications: Partner-wide awareness and prevention work					
Aim: to increase resident awareness of the range of risks/methods associated with this form of abuse and how they can protect themselves. This will involve co-ordinating communications across the Partnership, running joint campaigns where appropriate					
	Actions	**End date**	**Lead Officer**	**RAG**	**Comments**
1.1	Awareness leaflet to be launched in resident's council tax bills in March.	On-going	RM	Complete	Leaflet mailed with resident's council tax bills w/c 13th March. Leaflet also to be circulated via Carer's Network, CoL libraries and at St Barts for those registering a death.
1.2	Plan an awareness/training workshop in Autumn 2017	Dec-17	RM/AG/CoLP	Complete	The event took place on 4 Dec. There were 70 attendees and the event received positive feedback.
1.3	Operation Signature	On-going	DM	Complete	The work of the Task and Finish Group has been funded as part of Operation Signature.
2. Research: Increase the City of London's understanding of Financial Abuse:					
Aim: further work with stakeholders, residents and victims to give a greater understanding of the nature of the problem, how it is changing and evolving in the City.					
	Actions	**End date**	**Lead Officer**	**RAG**	**Comments**
2.1	Possible research to run a long side the campaigns	Dec-18	N/A	N/A	To be removed. It is not clear how a research project would help achieve the Task and Finish Group's objectives at present.
3. Performance and Information Sharing					
Aim: Further work with stakeholders to measure and share data on financial abuse					
	Actions	**End date**	**Lead Officer**	**RAG**	**Comments**
3.1	Establish direct contact with Top 100 vulnerable people in CoL at risk of Financial Abuse- this piece follows up on Info Sharing Agreement	Nov-17	Steve Playle / Dave Manley / Anna Grainger	Complete	A letter has been agreed and mailed to all Adult Social Care Service Users. One resident took up the offer of an advice visit from Trading Standards.
3.2	Monitor outcomes of complex cases via MSP		Ian Tweedie / Sukhi Gill	Amber	IT to prepare a report on MSP, financial abuse and outcomes to go to CHSAB.
3.3	Review application of MSP principles to investigating cases of Financial Abuse		Ian Tweedie / Sukhi Gill	Amber	IT to prepare a report on MSP, financial abuse and outcomes to go to CHSAB.

3.4	Brief AAG on work of Task and Finish Group	Jun-17	Gemma De La Rue / Chris Pelham	Complete	A briefing on work so far has taken place and this will be continued.
3.5	Update Police led vulnerability steering group on progress		Maria Woodall / Chris Pelham	Complete	A briefing on work so far has taken place and this will be continued.
3.6	Consider multi agency dataset to measure volume of cases of CoL residents reporting Financial Abuse		Sukhi Gill	Complete	A performance framework to provide a profile of financial abuse across the City. This combines data from Adult Social Care, City Police / Action Fraud and City Advice.
3.7	Invite Bournemouth University to review our approach	Nov-17	Steve Playle	N/A	To be removed. It is not clear how a research project would help achieve the Task and Finish Group's objectives at present.
3.8	Report on activity , outputs and outcomes to the CHSAB	Jun-17	Gemma De La Rue / Chris Pelham	Complete	A report has been drafted for Safeguarding Sub-Committee (7 June) and Safeguarding Adults Board (13 June).

Objectives

The group will focus on:

1. Ensuring the delivery of the financial abuse recommendations in the City of London. This will include producing a partner-wide communications and engagement plan, commissioning a research piece and tracking of a number of key areas of work via a combined action plan.
2. Facilitating the co-ordination of existing work streams across the partnership and tracking work via a shared action plan.

Membership

The group will consist of key strategic partners across the City of London. The meetings will be chaired by Chris Pelham, Assistant Director, People.

Suggested membership:

Name	Title
Chris Pelham (Chair)	Assistant Director, People
Marion Willicome Lang	Service Manager, Community & Children's Services
Rachel Morrison	Strategic Communications and Engagement Manager, Community & Children's Services
Gemma De La Rue	Executive Support Officer, Community & Children's Services
Adam Johnstone	Strategy Officer - Housing and Adults, Community & Children's Services

Gary Griffin	Project Manager - Safer Communities Project, Town Clerks
Valeria Cadena-Wrigley	Community Safety Officer, Safer City Partnership
Steve Playle	Trading Standards Manager, Markets & Consumer Protection
Helen Evans	Toynbee Hall
Maria Woodhall	City of London Police
John Ellul	Communications, City of London Police

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