Public Document Pack

# Safeguarding Sub (Community & Children's Services) Committee

**Date:** **THURSDAY, 17 NOVEMBER 2016**

**Time:** **11.30 am**

**Venue:** **COMMITTEE ROOM 1 - 2ND FLOOR WEST WING, GUILDHALL**

**Members:**

Gareth Moore (Chairman)
Deputy Elizabeth Rogula (Deputy Chairman)
Randall Anderson
Marianne Fredericks
Professor John Lumley
Deputy Joyce Nash
Dhruv Patel

**Enquiries:** **Julie Mayer**
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**julie.mayer@cityoflondon.gov.uk**

**Lunch will be served in Guildhall Club at 1PM**
**NB: Part of this meeting could be the subject of audio or video recording**

**John Barradell**
**Town Clerk and Chief Executive**

# AGENDA
## 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 2 June 2016 .

**For Decision**
(Pages 1 - 6)

4. **OFSTED INSPECTION REPORTS**
Reports of the Director of Community and Children's Services.

**For Information**

a) Ofsted inspection of the City of London's Services for Children in need of Help and Protection, Children Looked After and Care Leavers (Pages 7 - 16)

b) Ofsted review of the effectiveness of the City and Hackney Safeguarding Children Board (Pages 17 - 20)

c) Inspection of services for children in need of help and protection, children looked after and care leavers and review of the effectiveness of the Local Safeguarding Children Board (Pages 21 - 62)

*Please note: this document is an appendix to items 4 (a) and (b).*

5. **ANNUAL UPDATE ON CUSTODY (YOUNG PERSONS, CHILDREN AND MENTAL HEALTH) AND USE OF FORCE**
Report of the Town Clerk and Commissioner, City of London Police.

**For Information**
(Pages 63 - 88)

6. **ANNUAL QUALITY ASSURANCE REPORT 2015 TO 2016**
Report of the Director of Community and Children's Services.

**For Information**
(Pages 89 - 104)

7. **SELF NEGLECT (AND CHRONIC HOARDING) PROTOCOL**
Report of the Director of Community and Children's Services.

**For Information**
(Pages 105 - 164)

8. **SUFFICIENCY AND COMMISSIONING STRATEGY FOR CHILDREN IN CARE**
Report of the Director of Community and Children's Services.

**For Information**
(Pages 165 - 184)

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

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

11. **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**

12. **NON-PUBLIC MINUTES**
To agree the non-public minutes of the previous meeting held on 2 June 2016.

**For Decision**
(Pages 185 - 188)

13. **CHILDREN'S SAFEGUARDING REPORT FOR QUARTER 4 2015/16 AND QUARTER 1 2016/17**
Report of the Director of Community and Children's Services.

**PLEASE NOTE:** *The appendix to this document will be provided in A3 at the meeting, as the text is very small.*

**For Information**
(Pages 189 - 206)

14. **QUARTER 1 ADULT SAFEGUARDING REPORT PERFORMANCE INDICATOR OUTCOMES**
Report of the Director of Community and Children's Services.

**For Information**
(Pages 207 - 216)

15. **ANNUAL REPORT VIRTUAL SCHOOL HEADTEACHER ACADEMIC YEAR 2015/16**
Report of the Director of Community and Children's Services.

**For Information**
(Pages 217 - 226)

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

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

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# SAFEGUARDING SUB (COMMUNITY & CHILDREN'S SERVICES) COMMITTEE

## Thursday, 2 June 2016

**Minutes of the meeting of the Safeguarding Sub (Community & Children's Services) Committee held at on Thursday, 2 June 2016 at 11.30 am**

**Present**

Randall Anderson
Marianne Fredericks
Professor John Lumley
Gareth Moore
Deputy Joyce Nash (in the Chair)
Dhruv Patel
Deputy Elizabeth Rogula

**In Attendance**

**Officers:**

| | | |
|---|---|---|
| Ade Adetosoye | - | Community & Children's Services |
| Chris Pelham | - | Community and Children's Services |
| Pat Dixon | - | Community and Children's Services |
| Marion Willicome-Lang | - | Community and Children's Services |
| Paul Jackson | - | Community and Children's Services |
| Rachel Green | - | Community and Children's Services |
| Monica Patel | - | Community and Children's Services |
| Elizabeth Malton | - | Community and Children's Services |
| Kes Walker | - | Community and Children's Services |
| Julie Mayer | - | Town Clerk's |
| Sabina Johal | - | Town Clerk's |

It was proposed by Elizabeth Rogula and Seconded by Gareth Moore that Deputy Joyce Nash take the Chair.

1. **APOLOGIES**
   There were no apologies.

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

3. **TERMS OF REFERENCE**
   RESOLVED, that – the Terms of Reference be noted.

4. **TO ELECT A CHAIRMAN IN ACCORDANCE WITH STANDING ORDER 29**
   Being the only Member willing to serve, Gareth Moore was elected Chairman for the ensuing year.

5. **TO ELECT A DEPUTY CHAIRMAN IN ACCORDANCE WITH STANDING ORDER 30**

Being the only Member willing to serve, Deputy Elizabeth Rogula was elected Deputy Chairman for the ensuing year.

6. **MINUTES**

RESOLVED, that - the minutes of the meeting held on 17 December 2015 be approved.

7. **PRESENTATION: FRAMEWORK I**

The Sub Committee received a presentation and demonstration of the adult and social care recording system. During the presentation, Members noted the following features:

- Once a subject had been input, the system would provide links to various outcomes.
- Any further episodes could be recorded, along with profiles of need, next steps and referrals.
- Each stage would need to be authorised by a manager, possibly leading to a child protection 'workflow' which would include a case conference, reviews, visits etc.
- The system creates purchase orders and payments.
- The system ensures sign offs at appropriate intervals and produces statutory reports and performance data. Any missed sign-offs would trigger an alert to the caseworker.

In response to questions from Members, the following points were covered:

Framework I does not cover homelessness, which was administered by a separate system. However, it was hoped that the two systems could be consolidated in the future.

Other local authorities use the system, tailored to their specific requirements but currently the systems cannot 'talk' to each other. However, officers remain vigilant to cross border cases and keep in regular contact with colleagues in neighbouring boroughs.

The system can only be accessed by social workers, with no access outside the City of London Corporation. Adoption cases have further restrictions and the system is very robust. Amendments are restricted to the relevant case workers and are fully traceable, with audit trails.

Given the relatively small number of cases in the City of London Corporation, Case Workers have very specific knowledge of their looked after children (LACs).

Searches can include names which are spelt alike (in the case of typing errors) and post codes, addresses, NI and NHS numbers.

The details of persons reporting episodes or incidents are recorded and, should a potential client refuse help, the offer of assistance would be recorded, along with the reason for refusal. In accordance with 'making safeguarding personal' Members noted that, unless a potential client does not have mental capacity, then it is their right to refuse assistance.

8. **HOUSING SAFEGUARDING POLICY**

The Sub Committee received a report of the Director of Community and Children's Services, which detailed a specific safeguarding policy for the City of London Corporation's Housing Services, complementing the City's wider Corporate Safeguarding Policy.

*How is the attendance and impact of housing staff training monitored?*

The officer advised that a dedicated training officer monitored attendance on courses and undertook post training evaluations. Training and development were part of regular 1-1 meetings with line managers and the annual appraisal process.

*Are Housing fully engaged in the work of the Safeguarding Boards, for example, through audits?*

Members noted that all safeguarding incidents were directly supervised to ensure any gaps were identified immediately and all officer working groups had senior management representation. Local Housing Associations were expected to have similar procedures in place and effective corporate parenting required regular information sharing with host authorities.

In response to further questions, Members noted that the Guinness Trust were fully engaged in the 'Notice the Signs' campaign and City of London safeguarding officers met regularly with the Guinness Trust's Designated Officer.

Should a City of London Safeguarding Officer receive a referral from another Local Authority, it would be assessed and possibly added to Framework I. Members noted that cumulative records could help with criminal prosecution in cases of domestic violence, for example. Similarly, the City of London records all its referrals on to other boroughs and attended meetings when necessary. It was noted again that not all adults welcomed intervention and unless the person did not have mental capacity , it could not be enforced.

RESOLVED, that – the report be noted.

9. **ADULT SAFEGUARDING POLICY AND PROCEDURES UPDATE**

The Sub Committee received a report of the Director of Community and Children's Services regarding the update of the Adult Safeguarding Policy and Procedures.

*How will you ensure that practice will be compliant with these policies?*

Members noted a new approach to 'making safeguarding personal' which included individual risk assessments and co-operation with the client. The Safeguarding Team had developed a new auditing tool to use during supervisions. A new Chairman had been appointed to the Adult Safeguarding Board (Dr Adi Cooper) and the Adult Safeguarding Manager was also a Member of the Board. The Board had an action plan which included capacity and training.

In response to a question about rough sleepers, Members noted that referrals from the Square Mile would be included in these new procedures. Members noted that the safety and information of rough sleepers across London was supported by a London wide system called CHAIN.

*Will the new practice requirements place any pressure on resources/capacity to deliver?*

Demand is continuously monitored to ensure there are no capacity issues that would compromise the service ability to meet need. The service has reviewed its structural arrangements to ensure it can meet these new requirements.

RESOLVED, that – the report be noted.

10. **LOCAL AUTHORITY DESIGNATED OFFICER 2015/16 ANNUAL REPORT**

The Sub Committee received a report of the Director of Community and Children's Services regarding the activity and performance of the Local Authority Designated Role (LADO) for 2015/16.

*The good work of the LADO is noted. Is the issue regarding no referrals from the Police an issue specific to the City?*

Members noted a similar situation had arisen in Hackney and the issue had been raised at the Safeguarding Children Board, which reserved the right to scrutinise the Police's work in this area. The City of London's LADO was working with the Police to ensure they understood the role. Similarly, there had been some lack of understanding concerning the new procedures for DBS checks and the LADO had been addressing them.

Members also noted significant progress in respect of children missing from Education and an update report would be presented to the next Committee.

RESOLVED, that -

1. The report be noted

2. The Police Committee receive the regular LADO report

11. **SAFE COMMISSIONING MINIMUM STANDARDS**

The Sub Committee received a report of the Director of Community and Children's Services regarding the minimum set standards for recruitment and audit of the safeguarding mechanisms in place for commissioned services in the City and Hackney.

*What are the implications and actions taken if the provider does not comply with these minimum standards?*

The officer explained the procedures in place for holding Contractors to account and Members noted the contract was soon to be re-let and the current suppliers would be including in on-going negotiations. There could be further assurances included as part of the PQQ stage of the tender.

If necessary a poor performance notice would be issued to providers if concerns arose.

The Chairman commended the report and asked for it to be included in the welcome pack for new Members.

RESOLVED, that – the report be noted

12. **SUBMISSIONS TO THE CITY AND HACKNEY SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2015-16**

The Sub Committee received a report of the Director of Community and Children's Services regarding the City of London Corporation's submission to the City and Hackney Safeguarding Adults Board Annual Report on behalf of the services delivered by the Adult Social Care Team and City of London Corporation's partners.

*Can you explain a bit more about what Making Safeguarding personal actually means and how you will measure its effectiveness?*

Officers advised that to make safeguarding personal was a recent development in the Care Act which sought to measure outcomes and shape how people would want to continue to their lives through consultation and advocacy.

*The report is titled 'Partner Contributions' however' it seems to be mostly Adult Social Care. How effective are local partnership arrangements?*

Officers explained that, generally, the position with partnerships was good but accepted that there was always room for improved ways of working and delivering customer care. The report also included good references from partnerships and volunteering agencies.

RESOLVED, that – the report be noted.

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

There were no questions.

14. **ANY OTHER BUSINESS THE CHAIRMAN CONSIDERS URGENT**
There was no other business.

15. **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** |
|---|---|
| 16-21 | 1, 2 & 3 |

16. **NON-PUBLIC MINUTES**
**RESOLVED –** That the non-public minutes of the last meeting held on 17 December 2015 be approved.

17. **CHILDREN'S SAFEGUARDING REPORT FOR QUARTER 3 (2015/16) AND PROVISIONAL QUARTER 4 DEADLINES**
The Sub Committee received a report of the Director of Community and Children's Services regarding children's safeguarding performance information for quarter three.

18. **ADULT SAFEGUARDING - QUARTER 4 REPORT**
Members received a report of the Director of Community and Children's Services which set out the nature and level of safeguarding alerts received in the final quarter of 2015-16.

19. **CITY OF LONDON PLEDGE - UPDATE 2016**
Members received a report of the Director of Community and Children's Services which provided feedback from the City of London (Children in Care Council) and the delivery on the promises contained within the Pledge to its young people who are looked after or care leavers.

20. **NON-PUBLIC QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**
There were no questions.

21. **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 urgent business

**The meeting ended at 1.35 pm**

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Chairman

**Contact Officer: Julie Mayer/Sabina Johal**
**tel. no.: 020 7332 1410**
**julie.mayer@cityoflondon.gov.uk**

| **Committee(s)** | **Dated:** |
|---|---|
| Community and Children's Services – For Information<br><br>Audit and Risks – For Information<br><br>Safeguarding Sub-Committee – For Information<br><br>Policy and Resources – For Information | 14 October 2016<br><br>08 November 2016<br><br>17 November 2016<br><br>17 November 2016 |
| **Subject:**<br>Ofsted inspection of the City of London's services for children in need of help and protection, children looked after and care leavers | **Public** |
| **Report of:**<br>Ade Adetosoye, Director of Community and Children's Services | **For Information** |
| **Report author:**<br>Chris Pelham, Assistant Director, People's Services | |


**Summary**

This report provides Members with a summary of the outcome of the Ofsted inspection of the City of London's services for children in need of help and protection, children looked after and care leavers in July 2016, carried out under section 136 of the Education and Inspections Act 2006.

The effectiveness of children's services in the City of London was judged overall to be 'Good' with a number of 'Outstanding' features. The individual judgements were as follows:

- The experience and progress of children who need help and protection is 'Good'.
- The experience and progress of children looked after and achieving permanence is 'Good'.
- The experience and progress of care leavers is 'Good'.
- Leadership, management and governance in the City of London is 'Outstanding'.

The City of London is the sixth local authority in London to receive an overall 'Good' judgement for its children's services, out of 22 London local authorities inspected so far. The City of London is also one of six local authorities in England to receive a judgement of 'Outstanding' for its leadership, management and governance.

A separate but concurrent review of the effectiveness of the City and Hackney Local Safeguarding Children Board (LSCB) also took place in July 2016, carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

## Recommendation(s)

Members are asked to:

- Note the report.
- Note the Department of Community and Children's Services' (DCCS') plans to address the recommendations outlined in the report.

## Main Report

### Background

1. The Ofsted single inspection framework (SIF) is a statutory inspection framework, introduced in November 2013, to evaluate the experience and progress of children and young people in need of help and protection, children looked after and care leavers in all local authorities across England. A separate but concurrent review of all LSCBs in England usually takes place at the same time as the local authority inspection. All local authorities are due to be inspected under this framework by December 2017 and 110 local authority inspections have taken place so far.

2. The inspection framework tests the decision-making at all stages of a child's journey within the local authority, from accessing Early Help services through to leaving care. The inspection takes into account the full breadth of work to support children, young people and families in a local area and the difference that this makes to their lives.

3. An overall judgement of the effectiveness of children's services is given in addition to the following individual and graded judgements:

    - the experience and progress of children who need help and protection
    - the experience and progress of children looked after and achieving permanence:
        - a graded judgement in adoption performance
        - a graded judgement in the experience and progress of care leavers
    - leadership, management and governance.

4. Judgements are given on a four-point scale:

    - Outstanding
    - Good
    - Requires Improvement
    - Inadequate.

5. Of 110 inspection reports published so far, local authorities have received the following overall judgements for the effectiveness of children's services:

- 2% of local authorities have been judged to be ‘Outstanding’
- 25% of local authorities have been judged to be ‘Good’
- 49% of local authorities have been judged as ‘Requires Improvement’
- 24% of local authorities have been judged to be ‘Inadequate’.

6. The last inspection of the City of London’s safeguarding arrangements and its services for looked after children took place in March 2012, at which time the local authority was judged to be ‘Good’.

7. The DCCS senior leadership team has led an ambitious programme of child-focused service improvement to take forward the recommendations from this report and ensure improved outcomes for children and young people in the City.

8. Two independent children’s safeguarding reviews were carried out in May 2015 and May 2016 using the SIF methodology to identify the necessary single and multi-agency improvements, including those for the City LSCB and for City health and police partners, to ensure effective safeguarding services for children and young people in the City of London.

9. An independently chaired Service Improvement Board has been established to provide appropriate scrutiny of and challenge to improvement planning for children’s services. It meets on a quarterly basis and the membership includes the Director for Children’s Services and the Assistant Director for People’s Services, as well as senior managers from Early Help and Children’s Social Care, Safeguarding and Quality Assurance, Strategy and Performance, and Commissioning.

**City of London SIF inspection**

10. Ofsted completed an unannounced SIF inspection of the City of London’s services for children in need of help and protection, children looked after and care leavers from 4 to 28 July 2016.

11. The inspection team was composed of four of Her Majesty’s Inspectors (HMI) from Ofsted, led by HMI Stephanie Murray. HMI Alison Smale carried out the separate review of the effectiveness of the City and Hackney Safeguarding Children Board’s (CHSCB’s) work in the City of London. HMI Sean Tarpey provided the quality assurance function for the inspection.

12. Due to the geography and demography of the City of London, the main inspection activity for the local authority was carried out in the first three weeks of the inspection period and the LSCB review was completed in the fourth week. The main inspection evidence was collected through:

    - reading Early Help and Children’s Social Care case files
    - direct observation of practice, including home visits and children’s reviews
    - talking to children, young people, carers and families
    - observation of meetings
    - auditing, tracking and sampling cases
    - shadowing staff

- focus groups and interviews with staff, multi-agency partners, elected Members and service users
- talking with providers of commissioned services
- reviewing documentation requested over the course of the inspection, including strategic documents, minutes of meetings, improvement plans and performance reports.

13. On 20 September, Ofsted published the City of London's report, which identified children's services in the City of London to be of an overall 'Good' standard with a number of 'Outstanding' features.

14. The overall 'Good' judgement for the City of London's children's services was composed of the following individual judgements:

    - The experience and progress of children who need help and protection is 'Good'.
    - The experience and progress of children looked after and achieving permanence is 'Good'.
    - The graded judgement for the experience and progress of care leavers is 'Good'.
    - Leadership, management and governance in the City of London is 'Outstanding'.

15. Although arrangements to provide adoption services were considered, there was no graded judgement for adoption performance as, at the time of the inspection or within the timescales for judging adoption performance, the City of London had neither commenced adoption proceedings nor placed any child for adoption.

16. The City of London is the sixth local authority in London to receive an overall 'Good' judgement for the effectiveness of its children's services. The City of London is also one of six local authorities in England to receive a judgement of 'Outstanding' for its leadership, management and governance.

17. In terms of the City of London leadership, management and governance, the report noted that "Determined and inspiring leaders within the City of London take a detailed and ambitious approach to continuous improvement. For this reason, services provided for vulnerable children are consistently good and, in some instances, very good. As a result of outstanding leadership, management and governance, the trajectory is positive, with all the key components in place to enable the City to achieve exceptional outcomes for children.".

**Inspection findings**

**Children needing help and protection**

18. The inspectors found the experience and progress of children who need help and protection to be 'Good'.

19. Children in the City of London who need help are identified early. All new parents in the City receive an early help visit, which is usually a joint visit by a family

intervention worker and a health visitor. Such early identification has led to a complete take-up of two-year-old children's free childcare places. Families have access to a wide range of helpful services that make a tangible difference to their lives.

20. Early help assessments are generally of a good standard, and lead to helpful and valued support. Increasing the number of children and their families taking up early help services is a priority in the City of London. Although numbers remain low, determined work across the partnership at a strategic and operational level has led to a doubling of the number of new early help assessments completed over the last year.

21. A consultation conducted on behalf of the City indicates that parents are very positive about the help they receive. For example, parents have increased confidence, manage their children's behaviour better, strengthen their children's routines and improve their children's speech. Parents who spoke to inspectors said that staff are 'fantastic', services are provided quickly and the help that they received 'sorted things out'.

22. Inspectors found that social workers in the City of London listen to the children with whom they work and develop good relationships with them. The Children and Families team is settled and stable and all social workers have manageable caseloads. Managers at all levels provide practitioners with good formal and informal oversight and guidance.

23. When children are, or may be, at risk of significant harm, information is shared appropriately. Decisions are sound and are made promptly, and assessments are consistently good. They take into account risk, family history, children's diverse needs and relevant research. Children's views and experiences are well reflected.

24. Multi-agency work is well co-ordinated and has a positive impact on outcomes for children, including those living with parental mental ill health or learning difficulties, or domestic abuse. Child protection conferences and plans are effective in understanding, addressing and reducing risk within families.

25. Very few children are known to be at risk of sexual exploitation, go missing, live in private fostering arrangements or become homeless. Appropriate policies and procedures are in place to identify and support any children who present to social care in these circumstances. Practitioners are well trained and well informed to ensure that they can deal with new situations and presenting problems as they may arise.

**Children looked after and achieving permanence**

26. The inspectors found the experience and progress of children looked after and achieving permanence to be 'Good'.

27. All of the children looked after spoken to during the inspection were very positive about the services and help that they have received. Children are provided with highly individualised care and support, leading to them settling well and achieving

consistently good outcomes. Social workers and managers care about the children and know them very well.

28. All children are placed within 20 miles of the City in fostering placements judged to be 'Good' or better by Ofsted. Children live in families and communities that meet their diverse needs well, with interpreter services and helpful English language and educational support.

29. The Independent Reviewing Officer (IRO) provides a strong, creative and sensitive service. All reviews of children looked after are held within national timescales. The IRO visits children between reviews and closely monitors the progress of care plans. The IRO also regularly meets with the Virtual Head Teacher, health commissioners and providers to ensure that high-quality support is provided to children looked after.

30. Potential risks for children are considered well. On the rare occasion that children go missing, follow-up is swift and effective. Good information briefings are used well to raise awareness of child sexual exploitation and radicalisation, among foster carers, children looked after and care leavers.

31. Children use a number of routes to express their views. The Children in Care Council (CiCC) is well attended and has effective links to the Corporate Parenting Board.

**Adoption performance**

32. As no City of London child has had a plan for adoption since 2012, the City did not receive a graded judgement for adoption performance. However, secure and comprehensive commissioning arrangements are in place to ensure that any child or adult who requires an adoption service can access it.

**Care leavers**

33. Inspectors found the experience and progress of care leavers to be 'Good'.

34. Care leavers who spoke to inspectors were very positive about the assistance that they receive. All are allocated to a social worker who sees them, in most cases, regularly and flexibly, depending on the young person's wishes and needs. Social workers support children and young people through their time in care and throughout their transition to adulthood. This supports enduring and trusting relationships.

35. The quality of support provided to care leavers is consistently good. No young people leave care before the age of 18. Specific care leaver support starts at age 18 and continues at least until the age of 25, whether or not they are in full-time education. Those care leavers who are at university are supported beyond the age of 25. The City is in touch with all of its care leavers.

36. Accommodation for care leavers is good, and young people are supported well to remain with their carers into adulthood. High-quality independent accommodation is provided in the City or where care leavers choose to stay. The virtual school

provides valuable support to children, including to care leavers at university. Employment and training opportunities are also good.

37. Most Personal Education Plans and pathway plans are comprehensive, but a few could be improved by more focused targets and better recording of young people's views. Health support is timely and meets the needs of children. However, not all young people have received a summary of their health histories upon leaving care. Senior managers are working with health managers to progress this.

**Leadership, management and governance**

38. Inspectors found leadership, management and governance in the City of London to be 'Outstanding'.

39. All aspects of strategic, political and operational leadership are keenly focused on achieving the best outcomes, not just for children who live in the City but also for children or parents who spend time there.

40. The City of London is a caring and aspirational corporate parent. Children looked after and care leavers consistently do well, and sometimes exceptionally well. Most children looked after are unaccompanied asylum-seeking children. They are provided with good education and healthcare, many leisure opportunities, high-quality independent fostering placements and effective social work support.

41. The strong and stable senior management team has ensured a clear understanding of the quality of frontline practice. Analysis and evaluation of performance are meticulous. Quality assurance, including case auditing, is robust and leads to sustained improvements, although the voices of children and partners are not always evident. Leaders and managers are responsive to challenge and make focused improvements at a timely pace. The City Service Improvement Board has been effective in addressing areas for development.

42. The Safeguarding Sub-Committee, in its capacity as a Corporate Parenting Board, receives good-quality data and information about children's experiences, and this enables members to challenge practice effectively. The chair has a 'no nonsense' approach to getting to the heart of critical issues.

43. Leaders listen to what children think about their lives and go to great lengths to provide them with very good care.

**Recommendations for improvement**

44. The City of London received the following recommendations for improvement in the report:

- Further improve the quality and consistency of written plans for children, including early help plans, child in need plans, Personal Education Plans and pathway plans. These should be clear and simple, fully integrate the views of children and young people and clearly state what is to be achieved by when.

- When families disengage from services and the threshold is not met to escalate the case further, ensure that any ongoing work is purposeful and that case records clearly evidence managers' rationale for ceasing or continuing support.
- Ensure that permanency planning records include a record of decisions about legal permanence for children, along with the rationale for these decisions.
- Expedite the provision of health histories for all care leavers.
- Increase opportunities for direct contact between children looked after, care leavers and councillors, and between these children and the chief executive, in order to establish even more meaningful personal relationships.
- Strengthen the inclusion of the perspective of children, families and partners in case auditing, in order to improve services.

**Current Position**

45. Following the publication of the report, the City of London is required to submit a post-inspection action plan to the Secretary of State and Her Majesty's Chief Inspector under the Education and Inspections Act 2006 (Inspection of Local Authorities) Regulations 2007 by 30 December 2016. This action plan will outline how the City of London intends to address the recommendations made in the report.

46. The recommendations from the Ofsted report have already been incorporated into the Service Improvement Plan and are currently being progressed. An action planning session to consult with the cross-cutting services in the City of London that support the Early Help and Children's Social Care team will take place on 18 October. A multi-agency partnership event will also take place on 22 November to ensure that key partners receive an update on the outcomes of the inspection and can contribute to the action planning process.

47. Once the action plan is finalised, its progress will be monitored by the Children's Service Improvement Board and updates will be provided to the Safeguarding Sub-Committee to ensure timeliness in addressing the recommendations, as well as providing appropriate scrutiny and challenge.

**Corporate & Strategic Implications**

48. The City of London's commitment to provide effective Early Help and Children's Social Care services aligns with the Corporation's strategic aims of:

    - providing modern, efficient and high-quality local services, including policing, within the City for workers, residents and visitors
    - providing valued services, such as education, employment, culture and leisure, to London and the nation.

49. The ongoing improvement work for the City of London's children's services underpins the first priority of the DCCS business plan: 'Priority one – Safeguarding and early help: Ensuring effective arrangements are in place for

responding to safeguarding risks, promoting early identification and support to prevent escalation of issues and keeping children and vulnerable adults safe.'

50. Safeguarding and early help are also key priorities in the Children and Young People's Plan and the City of London Corporation Safeguarding Policy.

## Conclusion

51. The DCCS senior leadership team is committed to taking forward the recommendations outlined in the Ofsted report to ensure that we have the key components in place to consistently achieve exceptional outcomes for children. This work will be done in conjunction with our multi-agency partners and the CHSCB to ensure effective services for children across the City of London.

## Appendices

- Ofsted single inspection framework report of the City of London's services for children in need of help and protection, children looked after and care leavers (pp 1-32 – item 4c)

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| Committee(s) | Dated: |
|---|---|
| Community and Children's Services – For Information<br><br>Audit and Risks – For Information<br><br>Safeguarding Sub-Committee – For Information<br><br>Policy and Resources – For Information | 14/10/2016<br><br>08/11/2016<br><br>17/11/2016<br><br>17/11/2016 |
| **Subject:**<br>Ofsted review of the effectiveness of the City and Hackney Safeguarding Children Board | **Public** |
| **Report of:**<br>Director of Community and Children's Services | **For Information** |
| **Report author:**<br>Chris Pelham, Assistant Director, People's Services | |


**Summary**

This report provides Members with a summary of the outcome of the recent Ofsted review of the effectiveness of the City and Hackney Safeguarding Children Board (CHSCB), carried out under the Local Safeguarding Children Boards (Review) Regulations 2013. The CHSCB review was separate but concurrent to the Ofsted inspection of the effectiveness of the City of London's services for children in need of help and protection, children looked after and care leavers.

The CHSCB is a dual-borough Board, covering both the City of London and Hackney due to the range of organisations covering both areas. The CHSCB received two separate judgements of 'Outstanding' for the effectiveness of its work in the City of London and in Hackney respectively. The CHSCB is the first Local Safeguarding Children Board (LSCB) in England to have received an 'Outstanding' judgement out of 110 LSCB reviews completed so far.

This report summarises the key findings of the review, as well as the recommendations for the CHSCB to take forward following the review.


**Recommendation(s)**

Members are asked to:

- Note the report.

**Main Report**

**Background**

Under the requirements of the Children Act 2004, a Local Safeguarding Children Board (LSCB) must be established for every local authority area.

The LSCB is the key statutory mechanism for agreeing how statutory partners co-operate to safeguard and promote the welfare of children in their local area.

The City of London Corporation and Hackney Council agreed to the operation of a dual-borough Board given the range of organisations covering both areas.

**Current Position**

1. The City and Hackney Safeguarding Children Board (CHSCB) was reviewed separately but concurrent to the Ofsted inspection of the City of London's services for children in need of help and protection, children looked after and care leavers from 4–28 July 2016.This review was carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

2. The CHSCB received two separate judgements of 'Outstanding' for the effectiveness of its work in the City of London and in Hackney respectively. It is the first LSCB in England to have received an 'Outstanding' judgement.

3. Ofsted combined the reports for the City of London and the review of the CHSCB in accordance with s.152 of the Education and Inspections Act 2006.

**Inspection findings for the CHSCB's work in the City of London**

4. The CHSCB is a highly accomplished safeguarding Board, supported by solid governance arrangements. The separate City and Hackney Executive Boards ensure that rigorous oversight of safeguarding practice in each local authority area is achieved, while also benefiting from economies of scale created through their shared sub-groups.

5. The Independent Chair provides strong, credible and influential leadership, facilitating a culture of openness and challenge that has positively influenced wider partnership working. Safeguarding is a firm priority for all Board members, demonstrated by consistently good levels of attendance, effective engagement in sub-groups, and a strong culture of constructive challenge and debate.

6. The Board's relationship with City of London leaders is highly effective. Governance arrangements are robust, with clear lines of communication between the Independent Chair of the LSCB, the Director for Children's Services, the Lead Member for Children's Services and the Town Clerk.

7. The productive Safeguarding Inter-Board Chairmen's Meeting links the chairs of the LSCB, the Health and Wellbeing Board, the Adult Safeguarding Board and the Safer City Partnership. It shares annual reports and business plans, which feed into strategic documents. As a result, the Board effectively influences partner agencies and provides persistent challenge, to ensure that safeguarding is a golden thread running through all strategic documents.

8. The CHSCB has influenced and supported the City to maintain a strong focus on the safety and wellbeing of children. The Board and City leaders have

worked together to engage more closely with private schools, in order to ensure that safeguarding is their first priority. The addition of lay people to the Board has strengthened links to schools and other settings.

9. The Board has made substantial progress in raising awareness of female genital mutilation, forced marriage and child abuse through faith, belief or culture. The Board has worked closely with public health services to influence and monitor the multi-agency response to female genital mutilation.

10. The Board closely monitors the City's 'Prevent' duty and holds agencies to account for driving their response, including awareness-raising and recognition. The City 'Prevent' co-ordinator post is well established. Designated 'Prevent' leads are in place in each Corporation department. Awareness-raising sessions have been held across agencies, foster carers and community groups, and the co-ordinator links with other boroughs to share information and good practice. Risk assessments include awareness of risks within affluent communities.

11. The LSCB supported the City in its highly effective and innovative 'notice the signs' campaign, utilising a range of communication media to raise staff understanding of the signs of child and adult abuse, including child sexual exploitation. This included blogs, a website and a film. Senior leaders, including the Town Clerk, distributed leaflets. This stimulated many conversations with members of the residential and business communities, schools and other agencies involved with children who live or spend time in the City.

12. Early help remains a firm priority for the Board, with the effectiveness of early help services evaluated through the learning and improvement framework and City sub-group. The City early help sub-group has led to improvements in practice and services. Forty partners attended a multi-agency partnership event in February 2016, which included a presentation covering the strategic objectives and operational priorities for early help.

13. The Board maintains a very strong focus on hearing the views of children and using their experiences to influence developments to improve local safeguarding arrangements. In partnership with the City, consultations with children led to the commissioning of a new children's rights service and training sessions for independent reviewing officers on immigration rights.

14. The Board has created and fostered an effective learning culture that extends to frontline practitioners and embraces the community. Professional relationships across the City are based on a team approach, ensuring excellent communication and an atmosphere of continuous improvement.

## Recommendations

15. Ofsted identified one recommendation for improvement:

- Take steps to engage with children and families in all diverse communities within the City, for example through the role of lay members.

16. This recommendation will be taken forward through the workplan of the City Executive and reviewed by the work of the City of London's Service Improvement Board.

## Corporate & Strategic Implications

17. The outcome of the CHSCB review supports the Corporation's strategic aims:

- Provide modern, efficient and high-quality local services, including policing, within the Square Mile for workers, residents and visitors.
- Provide valued services, such as education, employment, culture and leisure to London and the nation.

18. It also supports the first priority of the Department of Community and Children's Services (DCCS) Business Plan:

- Priority one – Safeguarding and early help: Ensuring effective arrangements are in place for responding to safeguarding risks, promoting early identification and support to prevent escalation of issues and keeping children and vulnerable adults safe.

## Conclusion

19. The DCCS senior leadership team welcomes the recognition of the outstanding work of the CHSCB in the City of London. We are committed to working with the CHSCB to take forward this recommendation and working towards consistently exceptional outcomes for children and young people across the City of London.

## Appendices

- Ofsted review of the effectiveness of the City and Hackney Safeguarding Children Board (pp. 33–42 – item 4 c).

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# City of London

## Inspection of services for children in need of help and protection, children looked after and care leavers

and

## Review of the effectiveness of the Local Safeguarding Children Board[1]

Inspection date: 28 July 2016

Report published: 20 September 2016

| **Children's services in the City of London are good** | | |
|---|---|---|
| **1. Children who need help and protection** | | Good |
| **2. Children looked after and achieving permanence** | | Good |
| | 2.1 Adoption performance | Not judged |
| | 2.2 Experiences and progress of care leavers | Good |
| **3. Leadership, management and governance** | | Outstanding |

[1] Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspections Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

## Executive summary

Determined and inspiring leaders within the City of London take a detailed and ambitious approach to continuous improvement. For this reason, services provided for vulnerable children are consistently good and, in some instances, very good. As a result of outstanding leadership, management and governance, the trajectory is positive, with all the key components in place to enable the City to achieve exceptional outcomes for children.

The senior leadership team is stable and entirely child focused. Governance arrangements facilitate a culture of firm challenge and generous support, which extends beyond the City limits. Partners agree on their priorities and work together with real energy to achieve them. Leaders and partners have ensured that they know their community extremely well. This has resulted in a highly individualised approach, which takes full account of the unique, diverse and sometimes challenging City context. Services, including those that are commissioned, consistently meet the needs of local families. They are also well targeted to safeguard children who do not live in the City yet are supported by its services, or whose parents work there.

Early help services are effective, and some are particularly strong. A comprehensive early help strategy underpins the partnership approach to providing support to families before their problems worsen. Parents told inspectors that they are very happy with the help that they receive. Although positive impact can be evidenced for individual children, the City is yet to introduce a multi-agency evaluation tool to help them to judge how effective their early help services are, overall.

Partners have a clear understanding of local thresholds of need and support, and children consistently receive help at the right level for them. Targeted work with partners has led to an increase in referrals and early help assessments, which is a positive development. The social work response to risk and need within families is swift and reliably good, with analytical assessments leading to helpful support that demonstrably improves children's lives and makes them safer. Although working plans are effective, written plans are not always clear enough to make sense to all families. In a small number of cases, the work with parents who disengage from support lacks purpose and clarity. It is positive that the City has commissioned innovative research into neglect within affluent families.

The City of London is a caring and aspirational corporate parent. Most children looked after are unaccompanied asylum-seeking children. They are provided with good education and healthcare, many leisure opportunities, high-quality independent fostering placements and very effective social work support. This enables them to do well in their lives. Social workers and children enjoy enduring relationships beyond childhood, built on meaningful time spent together. All children looked after experience good outcomes, and some are doing exceptionally well in the context of their life experiences. Senior and commissioning managers have taken steps to further improve placement choice in order to enable social workers to consistently achieve the ideal match for children.

The City is very committed to its care leavers and continues support until, and sometimes beyond, the age of 25, whether or not they are in full-time education. All care leavers live in safe and suitable accommodation, guided by their own choices and needs. Social workers consistently stay in touch with young people and work closely with other services to ensure that the young people reach their full potential. Healthcare for care leavers is very good, but not all care leavers have been provided with information about their health histories. Planning for these young people is effective, and their diverse needs are particularly well addressed. Written plans should include more focused personal targets and better attention to young people's views.

Children looked after and care leavers are actively encouraged to share their views. Direct contact with senior managers, the highly effective independent reviewing officer service, independent advocates and visitors, and an annual consultation event ensure that their voices are heard. The Children in Care Council (CiCC) enables young people to use their direct link to leaders to effect positive change. Children looked after and care leavers meet with the corporate parenting board. However, council members and the town clerk (chief executive) could further strengthen these relationships by spending more informal time hearing about young people's lives.

No children have had a plan for adoption for some time, but commissioned and shared services are in place to provide a full range of adoption and post-adoption services. Social workers and managers ensure that children experience a strong sense of belonging to their carers. Care plans address children's need for permanence well and in good time.

The City of London's approach to increasing the skills and abilities of childcare professionals to provide outstanding services is exemplary. The knowledge transfer programme, an innovative partnership with a local university, provides practitioners with valuable opportunities to improve their practice. Training, supervision and support of social workers are comprehensive and contribute to good and improving outcomes for children. The workforce is stable, and this is linked to the vibrant learning environment. Caseloads are manageable and allow social workers to spend the time that they need with children and their families.

Supported by thorough quality assurance processes and excellent performance information, leaders and managers routinely identify where services for children need to be improved in order to be consistently good or better than good. This is reflected in strategic service plans and translated into specific actions that are assertively progressed. Case auditing is well established and ensures that leaders and managers are confident that they know what is happening on the ground. However, audits do not routinely include the perspectives of children, families and partners.

At the time of the last inspection in 2012, services for children were judged to be good. A number of areas for development were identified, including improving and integrating performance and quality assurance systems. Supported by the children's improvement board, all these areas have been rigorously addressed.

# Contents

# The local authority

## Information about this local authority area[2]

### Previous Ofsted inspections

- The local authority operates no children's homes.
- The last inspection of the local authority's safeguarding arrangements was in March 2012. The local authority was judged to be good.
- The last inspection of the local authority's services for children looked after was in March 2012. The local authority was judged to be good.

### Local leadership

- The director of children's services (DCS) has been in post since April 2013.
- The DCS is also responsible for adult services and housing services.
- The chair of the Local Safeguarding Children Board (LSCB) has been in post since April 2013.
- The LSCB is shared with the London Borough of Hackney.
- The local authority has commissioned out the following services:
  - information, advice and guidance for children looked after and care leavers (Prospects)
  - advocacy services (Action for Children)
  - adoption services (Coram)
  - youth offending services (London Borough of Tower Hamlets)
  - emergency duty team (Hackney).

### Children living in this area

- Approximately 1090 children and young people under the age of 18 years live in the City of London. This is 12.4% of the total population in the area.
- Approximately 14.3% of the local authority's children are living in poverty.
- The proportion of children entitled to free school meals:
  - in primary schools is 20.8% (the national average is 15.6%)
  - there are no state secondary schools in the City of London.

[2] The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data, where this was available.

- Children and young people from minority ethnic groups account for 42.6% of all children living in the area, compared with 21.5% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Asian, Asian British and Mixed.
- The proportion of children and young people with English as an additional language:
  - in primary schools is 64.6% (the national average is 19.4%)
  - secondary schools data is supressed (the national average is 15%).
- The City of London is just over one square mile in size. It contains 15,105 enterprises and is a key transport hub within London. The residential population is approximately 8,000. Only 10% of households have children, compared with 30% in Greater London and nationally. The City's daytime population is over 50 times greater than the resident population.

**Child protection in this area**

- At 1 July 2016, 37 children had been identified in need of a specialist children's service, including child and family assessment. This is an increase of one from 36 at 31 March 2015.
- At 1 July 2016, two children and young people were the subject of a child protection plan. Data at 31 March 2015 was suppressed.
- At 1 July 2016, no children were living in a privately arranged fostering placement. This was also the case at 31 March 2015.
- Since the last inspection, no serious incident notifications have been submitted to Ofsted and no serious case review (SCR)s had been completed or were ongoing at the time of the inspection.

**Children looked after in this area**

- At 1 July 2016, 10 children were being looked after by the local authority (a rate of 91.7 per 10,000 children). The number was in line with that at 31 March 2015, although the rate had increased (84.0 per 10,000 children at 31 March 2015). Of this number:
  - 10 (all) children live outside the local authority area
  - no children live in residential children's homes
  - no children live in residential special schools
  - 10 children live with foster families, all of whom live out of the authority area
  - nine children are unaccompanied asylum-seeking children.
- In the last 12 months:
  - there have been no adoptions

- two children became the subject of special guardianship orders
- six children ceased to be looked after, none of whom subsequently returned to be looked after
- three children and young people ceased to be looked after and moved on to independent living
- no children and young people ceased to be looked after and are now living in houses in multiple occupation.

## Recommendations

1. Further improve the quality and consistency of written plans for children, including early help plans, child in need plans, personal education plan (PEP)s and pathway plans. These should be clear and simple, fully integrate the views of children and young people and clearly state what is to be achieved by when.

2. When families disengage from services and the threshold is not met to escalate the case further, ensure that any ongoing work is purposeful and that case records clearly evidence managers' rationale for ceasing or continuing support.

3. Ensure that permanency planning records include a record of decisions about legal permanence for children, along with the rationale for these decisions.

4. Expedite the provision of health histories for all care leavers.

5. Increase opportunities for direct contact between children looked after, care leavers and councillors, and between these children and the chief executive, in order to establish even more meaningful personal relationships.

6. Strengthen the inclusion of the perspective of children, families and partners in case auditing, in order to improve services.

## Summary for children and young people

- The City of London is a small area where many more people come to work than to live. Just over 1,000 children live within the City of London, and many older children travel outside of the City to go to school.
- Services for children in the City of London are good. Some children have difficulties within their families. When this happens, a social worker steps in early, to see whether they would like some support. This help is very good and families are very happy with it. It improves children's lives and, for most families, it stops their worries increasing.
- Social workers spend a lot of time with children and families who have bigger problems, making sure that they understand what has gone wrong. This means that the help that they offer is what families need. When there is a risk that children may be unsafe, social workers talk to other adults like the police and teachers. Together, they make good decisions about what to do next to keep children safe.
- Some parents do not want a social worker to help them, even though they have problems that are making their children unhappy. Social workers need to be clearer about why they are involved with these families and what they are doing to help them.
- When children need to be looked after, they are found caring foster homes. Almost all children who are looked after have moved here from another country, often because they were scared or unhappy where they were living before. They are given good help to speak English, to talk about their experiences, and to settle into their new homes and schools. As a result, they make friends and quickly become more confident. They are helped to be healthy and to do many enjoyable things like playing sports and going to the theatre.
- Social workers and managers are proud of the children whom they look after and they care about them, as a loving parent would. They make sure that children go to good schools and that they get a lot of help so they achieve well. Social workers encourage young people to stay living with their foster carers for as long as possible, and this means that they only leave home when they are ready.
- When children leave care, they receive good help and support. They live in safe homes that they are proud of, and most find a job or carry on with their education. Senior managers and local politicians are very interested in the children whom they look after and those who have left care. They listen carefully to the CiCC and have meetings to find out what young people think. Relationships between young people and local politicians would be even better if they spent more informal time together.

| The experiences and progress of children who need help and protection | Good |
|---|---|

**Summary**

Social workers in the City of London listen to the children whom they work with and develop good relationships with them. The children and families team is settled and stable, and all social workers have manageable caseloads, allowing social workers to spend the time that they need with families. This supports good direct work with children. Managers at all levels provide practitioners with good formal and informal oversight and guidance.

Children in the City of London who need help are identified early. They are supported by a range of services that make a tangible difference to their lives. Increasing the number of children who benefit from early help has been a priority for the City and partners. This has successfully led to a doubling in the number of children being helped in the last year.

In a few cases, families do not believe that they need help and disengage from services. As a result, support plans are difficult to achieve. Plans are regularly reviewed, and efforts to re-engage with families are tenacious, but the rationale to continue or cease involvement is not always recorded well.

When children are, or may be, at risk of significant harm, information is shared appropriately. Decisions are sound and are made promptly, and assessments are consistently good. They take into account risk, family history, children's diverse needs and relevant research. Children's views and experiences are well reflected. Children's case files are generally clear and up to date, although a very small number of children in need cases do not include an up-to-date chronology.

Multi-agency work is well coordinated and has a positive impact on outcomes for children, including those living with parental mental ill health or learning difficulties, or domestic abuse. Child protection conferences and plans are very effective in understanding, addressing and reducing risk within families.

Very few children are known to be at risk of sexual exploitation, go missing, live in private fostering arrangements or become homeless. Appropriate policies and procedures are in place to identify and support any children who present to social care in these circumstances. Practitioners are well trained and well informed to ensure that they can deal with new situations and presenting problems as they may arise.

## Inspection findings

7. Strong arrangements are in place to identify children in need of early help. All new parents receive an early help visit. This is often a joint visit by a family intervention worker and a health visitor. Such early identification has led to a complete take-up of two-year-old children's free childcare places. Families have access to a wide range of helpful services. The 'friendly dentist' scheme provides dental checks for all under-fives and parenting support is available from a child psychologist through a commissioned service, while weekly speech and language sessions, 'stay and play' and other activities are available through the City's children's centre. Parents are well supported with benefits advice and debt counselling by a commissioned service. The 'nanny network', launched in 2015 to establish links between the City's early help services and this large group of private childcare providers, runs weekly 'stay and play' sessions for approximately 10 nannies and the children for whom they care.

8. Increasing the number of children and their families taking up early help services is a priority in the City of London. Although numbers remain low, determined work across the partnership at a strategic and operational level has led to a doubling of the number of new early help assessments completed over the last year.

9. Early help assessments are generally of a good standard, and lead to helpful and valued support. Team around the child meetings are held when they are needed, and there is good engagement in these by a range of professionals. Although there are individual agency tools to measure progress, there is not yet a single agreed system to measure family improvements so that they can be aggregated and reported on. Work with partners to agree a suitable tool is already underway.

10. A consultation conducted on behalf of the City indicates that parents are very positive about the help that they receive. For example, parents increase in confidence, manage their children's behaviour better, strengthen children's routines and improve their children's speech. Parents spoken to by inspectors said that staff are 'fantastic', services are provided quickly and the help that they received 'sorted things out'.

11. The children and families team includes social workers and early help practitioners, and is fully staffed and stable. An experienced manager has been in post for over a year, and oversees both the practice of social workers and early help staff. Practitioners who spoke to inspectors during the inspection were positive about working in the City of London. Senior managers are described as visible, approachable and knowledgeable about children's circumstances. Staff feel well supported and have access to a wide range of training and development opportunities. They were able to describe how they apply learning from training to their work with individual children.

12. Secure arrangements are in place in relation to contacts and referrals that are made to children and family services. All calls are taken by a qualified social worker, and recommendations made by them are signed off by a manager. Appropriate and detailed instructions about next steps are included in the management decision record. Decisions are made promptly, and all records seen during the inspection were signed off within 24 hours.

13. The thresholds of need document is clear and up to date. When making decisions about how to respond to referrals, social workers consistently apply the guidance appropriately. Consent is sought explicitly, with careful consideration to overriding it given when it is necessary. Partners report a clear understanding of thresholds, and this is supported by close partnership working. Police forward all notifications to the children and families team when there are potential child welfare concerns. These often relate to children who have been stopped in the key transport hubs of the City. Many of these children do not live in the City, and some are flagged for child sexual exploitation concerns. When this is the case, the duty social worker proactively ensures that the referral is made to, and received by, their home local authority area.

14. When children are identified as being at risk of significant harm, prompt action is taken to understand their circumstances and to protect them. Strategy discussions include relevant professionals, and appropriate decisions are made. In one case, details of significant relevant information were not shared by the police. This was appropriately escalated and resolved by senior managers.

15. Children are seen, and seen alone, as part of their assessment. When case auditing, senior managers specifically look for evidence of regular and meaningful visits to children. Inspectors saw case examples, where senior managers had appropriately raised questions about visits to children, leading to actions to strengthen practice further. Social workers know the children whom they work with well. They use a range of tools to work with them to ensure that their views are understood and reflected in assessments and plans. Some very good examples of bespoke direct work were seen by inspectors. Social workers include detailed observations of the demeanour and developmental progress of younger children in case records and assessments.

16. Assessments are comprehensive. They consider family history and reference the appropriate research. Strong examples were seen of social workers identifying presenting and emerging risks, including those arising from domestic abuse, sexual exploitation, honour-based violence and parental mental ill health. In almost all cases, children's diverse needs resulting from disability, ethnicity and religion were well considered. Good use is made of advocacy services when parents with learning difficulties need support to engage with and understand the assessment and planning process.

17. Assessments lead to appropriate plans that make a difference to children. A parent of a disabled child described the support that his child receives from the City of London as 'amazing'. Child protection conferences are well attended, and enable professionals and families to reach a clear understanding of risk and need. Children make use of advocacy services to share their views, and professionals take careful account of these views when agreeing the plan. Subsequent work is consistently effective, and risks for children reduce as a result of good multi-agency intervention. Inspectors saw cases where children were being supported to develop an understanding of the risk of child sexual exploitation, with effective strategies leading to a marked reduction of risk.

18. Although the support provided to children and families is effective, not all written plans are in simple language that clearly describes the desired outcomes. Some actions do not specifically include the date by which they should be completed. (Recommendation)

19. Practitioners demonstrate tenacity in working with the small number of children whose parents do not wish to accept support, yet the threshold is not met, in order to escalate to child protection procedures. However, in a few cases, child in need plans remain in place but are not purposeful, due to the disengagement of the family. Managers need to ensure that their rationale for continuing involvement or ceasing support is clearly recorded. A research project considering neglect within affluent families is nearly complete. It has been commissioned with a view to assisting practitioners in working successfully with such families. (Recommendation)

20. Multi-agency working to meet children's needs and keep them safe is effective. Early help, child in need and child protection plans are regularly reviewed. Inspectors saw examples of effective joint work with an independent school, a homelessness officer, a housing support worker and a debt advice service, as well as a specialist parenting support agency and adult services. Bringing together agencies and working in a coordinated manner consistently leads to improved outcomes for children and their families, such as moving to suitable housing, managing debt, improving school attendance and the provision of intensive support for a mother to continue to care for her child.

21. Case records seen were generally up to date and comprehensive, and showed evidence of clear and regular management oversight and direction. Although family history is considered well in assessments, in a very small number of children in need cases chronologies are not kept up to date on children's files. This is a lost opportunity to maintain a clear record of significant incidents, themes and patterns in children's lives.

22. No child has been reported missing from home in the City of London in the last 12 months, and very few children have been identified as at risk of sexual exploitation. Clear and well-publicised processes are in place to monitor and coordinate services, through the multi-agency sexual exploitation group, for those children who may be at risk. This group has an intentionally low threshold, to identify children who may be at risk at the earliest opportunity. Awareness raising about child sexual exploitation across the City is comprehensive and is targeted at residents, businesses and those who work in the City. Positive links have been made with the two independent secondary schools in the City to raise awareness of a range of safeguarding issues, including sexual exploitation. A drama production with a sexual exploitation theme was commissioned for the girls' school during this school year, and will be delivered at the boys' school in the new school year.

23. Although no children were known to be living in private fostering arrangements at the time of the inspection, a small number of arrangements have been identified in the past year. Thorough assessments, in line with requirements, are completed with appropriate and timely ongoing support.

24. Effective work has been completed in relation to raising agencies' awareness of their responsibilities in relation to allegations against adults who work with children. This has led to an increase in the number of referrals received. Processes to manage allegations, once they are made, are comprehensive. In one case, the City took responsibility for coordinating the multi-agency response to concerns in order to avoid further delay, even though the professional no longer worked in the City and the child lived in another area. This demonstrates a commitment to good practice.

25. Multi-agency risk assessment arrangements to support vulnerable victims and children affected by domestic abuse are effective. Meetings are convened when required, are well attended and lead to appropriate support plans. Support to victims of domestic abuse is available from the advocate for vulnerable victims. Specialist programmes and services for individuals, including perpetrators, are provided on a case-by-case basis when needed.

26. At the time of this inspection, no children were missing from education. Managers frequently and assiduously monitor children's school attendance both within and outside the City. Very good processes are in place through productive partnerships with schools, to respond when safeguarding concerns are identified. An effective risk RAG-rating (red, amber, green) system and procedure is in place for those children at risk of missing education.

27. Very few children are electively home educated in the City of London. For those children who are, good arrangements are in place to monitor their progress, in cooperation with their parents.

28. Out-of-hours services are commissioned from a neighbouring authority. The commissioning arrangement is sufficient to meet current need and any unexpected peaks in activity outside of office hours. Inspectors saw an example of effective joint working between the out-of-hours team, City police and children's social care when there was concern about possible child trafficking.

29. No 16- to 17-year-old young person has presented as homeless in the last 12 months. Close working relationships are in place between the housing department and the children and families team. These support clear arrangements that would be put in place if a young person presented to either department. This includes an assessment and consideration of whether the young person should be looked after by the City of London.

| The experiences and progress of children looked after and achieving permanence | Good |
|---|---|

**Summary**

All of the children looked after and care leavers spoken to during the inspection were very positive about the services and help that they have received. Inspectors found that the support provided is reliably good. Many children looked after are unaccompanied asylum seekers with no previous links to the City. Children are provided with highly individualised care and support, leading to them settling well and achieving consistently good outcomes.

By design, there are no care placements in the City of London. All children are placed within 20 miles of the City in fostering placements judged to be good or better by Ofsted. Children live in families and communities that meet their diverse needs well, with interpreter services and helpful English and educational support. Social workers and managers care about children and know them very well. The small number of placement breakdowns are due, in the main, to a lack of in-depth knowledge of children who have recently arrived in the United Kingdom (UK). The range of placements is being improved. A permanence panel monitors children's care plans well, although some decisions could be recorded more clearly.
No City of London child has had a plan for adoption since 2012. However, a secure and comprehensive commissioning arrangement is in place to ensure that any child or adult who requires an adoption service can access this.

The independent reviewing officer has established strong relationships with children. Children looked after reviews are purposeful, and plans are rigorously progressed. Potential risks for children are considered well. On the rare occasion that children go missing, follow-up is swift and effective. Good information briefings are used well to raise awareness, of child sexual exploitation and radicalisation, among foster carers, children looked after and care leavers.

Accommodation for care leavers is good, and young people are supported well to remain with their carers into adulthood. High-quality independent accommodation is provided in the City or where care leavers choose to stay. The virtual school provides valuable support to children, including to care leavers at university. Employment and training opportunities are also good. Most PEPs and pathway plans are comprehensive, but a few could be improved by more focused targets and better recording of young people's views. Health support is timely and meets the needs of children. Mental health assessments are particularly good. Not all care leavers have been provided with information about their health histories.
Children use a number of routes to express their views. The CiCC is well attended and has effective links to the corporate parenting board. The group makes good use of its direct link to senior and political leaders.

## Inspection findings

30. Services for children looked after in the City of London are somewhat unique. Although the proportion of children who are looked after is similar to that in other local authorities, the number is small in comparison. All children looked after are between the ages of 14 and 17, and only one was resident in the City prior to being received into care. The other children are unaccompanied asylum seekers who are the responsibility of the City through a London-wide dispersal scheme for sharing refugees across the capital. Most of these young people have arrived in the country and become looked after in the past year. Inspectors looked at the support provided to all of these children and found social work to be, in the main, of a high standard and, in some cases, of an exceedingly high standard. Many children looked after achieve very good outcomes. However, support is not yet consistently demonstrating an exceptional and sustained difference to all children's lives.

31. All children receive at least a good service. They are supported and helped by social workers and managers who have found creative ways to ensure that they know them well. Visits are regular. Children are seen alone. The children spoken to by inspectors were very positive about the support that they have received. Their views are considered very well in visits, meetings and plans, and are recorded, in the vast majority of cases, to a high standard.

32. There is a strong focus, led by the DCS, on building high-quality relationships between social workers and children. Social workers and children spend time together doing fun activities on both a one-to-one basis and as a group, and this strengthens their relationships. An annual holiday for social workers, children looked after and care leavers is valued by children and social workers as an opportunity to get to know each other much better. This complements the time spent during other visits. All children's cases are known, in depth, by the DCS and the assistant director, who, commendably, visits all children looked after on a bi-annual basis.

33. Due to the unique nature of the City, and in order to maintain sufficient matching choice, the City of London has chosen not to provide any in-house foster placements for its children looked after. No children are placed within the City, and all children are placed in foster placements within 20 miles. The quality assurance of these placements is rigorous. The City has decided that children will only be placed in placements that Ofsted has judged to be good or better. The City complements the training offered by foster carers' own agencies with additional targeted learning, for example through the provision of workshops on countering radicalisation and child sexual exploitation. Overall placement stability is good. There have been a small number of placement breakdowns, due in part to the lack of knowledge about children who have recently arrived in the country. Work is ongoing to improve further the choice of carers available. Related children are placed together, when

appropriate. Effective support is provided to children to have continued contact with their families, including for unaccompanied asylum seekers.

34. All children looked after attend school regularly. During 2014–15, the attendance rate was 96%. No children have been excluded from school permanently in the past three years, and only two have been excluded for a day or so, and the isolated incidents were resolved. No children looked after are in alternative provision. Children participate and make the expected progress in their learning. Staff at the virtual school, in good partnership with teachers, work relentlessly to make sure that children with vastly different starting points, most with skills levels below level 1 in key stage 3, receive bespoke individual support. This ensures that they develop the skills that they need for life in the UK.

35. All but one child looked after came into care as an unaccompanied asylum seeker at secondary school age. Just over half of these have achieved entry-level qualifications in English and have progressed to the next level. Some children looked after have made particularly good progress, and others have made sufficient progress in their studies towards achieving GCSE qualifications. Good advice and guidance from experienced advisers ensures that all children looked after are prepared well to make the next steps in their education or training. For instance, a wide range of progression opportunities is provided to learners who are about to progress to key stage 5.

36. Most PEPs are purposeful, and staff are particularly effective in monitoring each child's progress. Targets for children looked after to improve their academic skills and knowledge, particularly English and mathematics, are clear. A few identified gaps in personal skills, which are recorded well in the plans, do not translate sufficiently well to targets. (Recommendation)

37. The City virtual school team implements effective measures to make sure that children looked after get the support that they need through, for example, pupil premium funding. This includes funding for targeted support to help those who are falling behind with their GCSE studies or to improve the English skills of unaccompanied asylum seekers who have recently come into care. The City ensures that foster carers are well equipped to care for children for whom English is not the main language. For example, a toolbox including a whiteboard, word box, world map and role-play pictures is provided to foster carers, along with helpful guidance. This enables them to help children to improve their English at a faster pace than through formal education alone.

38. Good enrichment opportunities have had a visibly positive impact on the confidence and attitude to learning of children looked after. Children looked after participate in a good range of activities, including sailing, football, cricket and art classes. They enjoy trips that staff facilitate. One such trip to a local maritime museum, where there is a large map of the world, provided a safe

catalyst for a group of unaccompanied asylum seekers to show each other where they had come from and to get to know each other better.

39. Health outcomes are improving. Most children looked after have needs arising from poorer health provision, or from the ways in which they were treated in their home countries or on their journeys to the UK. Most initial health assessments are done promptly and all are undertaken by a paediatrician. Children also receive timely dental support, immunisations and further health support, when needed. All children receive a baseline extended mental health assessment by City of London child and adolescent mental health services (CAMHS), wherever they are placed. This has been specifically negotiated by senior managers with the local CAMHS. Children are referred promptly and receive ongoing support when further emotional or mental health needs are identified. No children are known to be misusing substances.

40. A small number of children looked after have gone missing over the past year. This has mainly been for a matter of hours. The response by children's services and police has been swift and robust. All of these children were offered a timely return home interview, and strategy discussions were initiated to consider any wider safeguarding issues. One child was subject to a more in-depth assessment, which was of a high quality, to look at risks of child sexual exploitation. Careful consideration is given to potential ongoing risks to those children who had been trafficked by organised criminal networks into the UK. No children looked after have been involved in offending during the time covered by this inspection.

41. All children looked after reviews are held within national timescales. Reviews seen and attended by inspectors were of a high standard, with children fully engaged. The independent reviewing officer provides a strong, creative and sensitive service. She visits children between reviews and closely monitors the progress of care plans. Her interaction with children was observed by inspectors to be warm and engaging. She also regularly meets with the head of the virtual school, health commissioners and providers to ensure that high-quality support is provided to children looked after. Plans are well focused and child centred, and actions decided at reviews are, in the main, actioned promptly.

42. All children looked after have clear and appropriate plans for permanency before or by the time of their second looked after review. The permanence panel ensures good oversight of all children in care, and includes the assistant director, legal services and the independent reviewing officer. Consideration is given to whether care proceedings should be initiated to provide security for children, although decisions with accompanying rationale are not always explicitly recorded in permanency panel minutes. In addition to ensuring that social workers and managers have access to these decisions in the future, better recording would ensure that, in later life, children can fully understand why these judgements were made. (Recommendation)

43. There are no current or recent care proceedings, although the City of London maintains good relationships with the family courts and the Family Court Advisory and Support Service. No children have had a plan for adoption in the past three years. Secure and appropriate commissioning arrangements are in place to ensure that the full range of adoption and post-adoption services is available for adults and children, if these are required. A small number of children looked after have recently left care and are subject to special guardianship orders. The full range of permanence options was considered for these children, and the resulting care arrangements meet children's needs well. Court work in relation to these children was of good quality, and the ongoing support provided is appropriate.

44. Direct work is a strong feature of social work with children looked after in the City. Some of this is of an exceptional standard. For the unaccompanied asylum seekers, there is sensitive and sustained support to help them with their claims for refugee status. Local children are also well supported through family- and community-focused activities. Careful and sensitive life-story work is provided for all children looked after, to help them to gain a better understanding of their backgrounds and of what has happened to them. Work is underway to extend the skills of staff in culturally specific life-story work, in particular for children who have experienced disrupted childhoods before arriving in the UK. Support to children and children from different ethnicities, faiths and beliefs is very good.

45. Independent visitors are provided to over half of children looked after, and they are matched well to children's interests and hobbies. Some of these relationships have been sustained over many years through shared interests, such as going to the theatre and sports. Two further children were being matched at the time of the inspection.

46. Formal advocacy support is available and well publicised, but it is not taken up by many children, who rely more on their social workers, their independent visitors, the support of the independent reviewing officer and visits from the assistant director. When children raise concerns, they are responded to swiftly and appropriately, including when it is felt that a change of social worker would genuinely make a difference to them. In one instance, a young person asked the independent person who visited him after he had gone missing from his placement to sort out a worry about his placement. This was quickly resolved, leading to the 'missing' episodes ceasing. There have been no formal complaints from children and young people in the past year, although concerns or worries expressed by children, for instance through the independent reviewing officer, have been responded to promptly and to the satisfaction of the children.

47. Thresholds for whether children and young people should become looked after are clear. Agencies understand these well, and social work support to

children and families at home is good. A small number of cases have met the threshold to be dealt with through the Public Law Outline. In these cases, high-quality social work resulted in there being no need for legal proceedings to protect children further. Managers appropriately involved the commissioned adoption service at an early stage, ensuring that all permanence options were considered to avoid potential delay for children. Care proceedings involving the High Court were also initiated last year, as the case involved the citizens of another European Union country. This was resolved promptly with the family returning home, supported by their local social services department.

48. The CiCC is well attended and meets quarterly. Members receive child-friendly versions of key policies and strategies. There have been a number of improvements facilitated by this group, including improvement of the pledge for children looked after and care leavers. This, along with a welcome pack, is provided to all children looked after, in both English and the child's first language. CiCC members have been involved in interviewing new staff and producing reports for the safeguarding sub-committee on the services available for care leavers. It is good that members of the CiCC have also been involved in mentoring children who have become looked after more recently.

**The graded judgement for adoption performance**

At the time of the inspection, and within the timescales for judging adoption performance, the City of London has neither commenced adoption proceedings nor placed any child for adoption. Therefore, arrangements to provide adoption services were considered, but adoption performance was not judged.

**The graded judgement about the experience and progress of care leavers is that it is good**

49. Care leavers who spoke to inspectors were very positive about the assistance that they receive. All are allocated to a social worker who sees them, in most cases, regularly and flexibly, depending on the young person's wishes and needs. Social workers support children and young people through their time in care and throughout their transition to adulthood. This supports enduring and trusting relationships.

50. The quality of support provided to care leavers is consistently good. No young people leave care before the age of 18. Specific care-leaver support starts at age 18 years and continues at least until the age of 25, whether or not they are in full-time education. The care leavers who are at university are being supported beyond the age of 25. The City is in touch with all of its care leavers.

51. All but one care leaver is an unaccompanied asylum seeker. All care leavers live in suitable accommodation. This is either in 'staying put' arrangements, whereby they remain with their former foster carers, or in independent accommodation provided in the City of London or an area where the young person wishes to live. Social workers undertake checks to ensure that proposed independent accommodation is not in an area known by police to cause concern, due to anti-social behaviour, gangs or drugs-related activity. There has been a good range of awareness-raising courses for care leavers, for instance on the dangers of child sexual exploitation and radicalisation. No care leavers are known to be involved in criminal activity.

52. The large majority of planning for care leavers is effective. Education and employment outcomes for most of those leaving care are good. Of the current care leavers, 80% are following courses in further or higher education, are in training or are in employment (EET). A few care leavers achieved particularly good results, following completion of their degree courses at university. For those care leavers who are currently not in employment or training, there have been concerted efforts by the virtual school to enable them to participate in a range of work experience opportunities. The City commissions a targeted service to help young people to access and sustain EET opportunities. The support includes attending college open days, accompanying young people to maths and English tests, completing enrolment forms and helping with bursary paperwork. Advisors are steadfast in the help that they provide and, in most cases, this increases young people's ability to succeed with their choices.

53. The City provides care leavers with work experience opportunities within its own services. At times, this is used as a creative way to encourage young people to re-engage with a meaningful daily activity or for staff to re-establish

contact with older young people who are resisting support. Senior leaders such as the DCS and the chief executive promote and support these opportunities.

54. The advice and guidance for young people leaving care are supportive and skilled. Good links to the City of London adult learning service mean that care leavers have the option to start apprenticeships and higher apprenticeships in subjects such as butchery and accountancy. Two care leavers will soon be commencing a traineeship programme to help them to progress onto an apprenticeship. Support to prepare young people for independence is good. Examples were seen by inspectors of focused programmes that had assisted children looked after in developing their practical skills in preparation for future career opportunities.

55. The large majority of needs assessments and pathway plans are good. The diverse needs of young people are particularly well considered in these records, with sensitive consideration of young people's asylum-seeker status and preparation for the possibility that they will not be allowed to remain in the UK. Access to good legal advice is prioritised for young people who are making asylum-related claims. The best pathway plans have clear, aspirational targets and desired outcomes. A few pathway plans have actions that do not move the young people forward quickly enough. In a small number of cases, pathway plans had not been shared with care leavers, and the voice of the young people was not consistently recorded. (Recommendation)

56. The availability of health support is good. The provision of care leavers' support to one young person was extended beyond his 25th birthday to allow time for the social worker to ensure that his emotional well-being was stable. However, not all young people have received a summary of their health histories upon leaving care. Senior managers are working with health managers to progress this. As most of the care leavers are unaccompanied asylum seekers, these health records would assist in proving an overview of their emotional, mental and physical health needs, wherever they choose to live in the UK. This is currently being taken forward by the CiCC. (Recommendation)

57. The CiCC includes care leavers. It has developed the Pledge, which also incorporates the City's promises to its care leavers. It is provided to all young people in their first language. This ensures that care leavers have a good understanding of their entitlements. Activity-based schemes are run, through the CiCC, to provide learning experiences and to maintain contact with care leavers. For instance, a popular annual activity holiday strengthens social work relationships with care leavers and facilitates mentoring relationships between young people.

58. Over the past year, the corporate parenting board has met with the CiCC for lunch and young people attended a board meeting. The board has considered

messages from the annual consultation with young people. However, regular informal contact is not yet a strong enough feature. Members have a good awareness of their responsibilities, but have underestimated how powerful regular, direct contact with children looked after, in particular care leavers, is likely to be. (Recommendation)

| Leadership, management and governance | Outstanding |
|---|---|

**Summary**

Leadership, management and governance in the City of London are outstanding. All aspects of strategic, political and operational leadership are keenly focused on achieving the best outcomes, not just for children who live in the City but for children or parents who spend time there. Senior and political leaders know their local community very well indeed. Scrutiny arrangements are challenging and support improvement. Leaders and managers work proactively with key partners and forums to ensure that services meet the needs of the diverse and unique population. The response to the potential risks of female genital mutilation and radicalisation is robust. Commissioning arrangements, including those to meet the needs of any child or adult who may require adoption services, are evidence based and sensible, and demonstrate the City's exacting standards for its children.

Leaders are attentive and proud corporate parents. Children looked after and care leavers do consistently well and, sometimes, exceptionally well. Leaders listen to what children think about their lives and go to great lengths to provide them with very good care. However, council members have not used all available opportunities to further strengthen their informal relationships with children looked after and care leavers.

The strong and stable senior management team has ensured a very clear understanding of the quality of frontline practice. Analysis and evaluation of performance are meticulous. Quality assurance, including case auditing, is robust and leads to sustained improvements, although the voices of children and partners are not always evident. Leaders and managers are responsive to challenge and make focused improvements at a timely pace. The City improvement board has been very effective in addressing areas for development.

Leaders and managers have created a safe and vibrant environment in which social workers and their practice can continually improve. Learning opportunities are rich and wide ranging. They include the knowledge transfer programme, through which a local university and the City work together to strengthen practice through research. Caseloads are manageable, supporting social workers to establish meaningful relationships with children. Social work practice is consistently strong, and consideration of children's diverse needs at all levels is extensive. The children's workforce is stable. Good management oversight of practice is evident, and social workers appreciate opportunities for reflection, although records do not always evidence this well. Leaders commit their time to supporting local authorities that are not performing well. This illustrates the City's approach to improvement, and has not detracted from the quality or effectiveness of leadership in the City.

## Inspection findings

59. The DCS has been in post since April 2013 and the chief executive since September 2012. The DCS is responsible for community and children's services, which include education, community housing, and adults' and children's services. Together with the assistant director for children's services, they provide strong and inspiring leadership, with a steady determination to use all the skills and resources available to them to benefit children in the City and in Greater London. The DCS's capacity to undertake his roles and responsibilities has been thoroughly explored by a test of assurance undertaken by an independent person. He states that he is 'a social worker first and a senior leader second', demonstrating this through a highly detailed and enthusiastic approach to all areas of social work practice and a keen interest in individual children. Senior leaders have an outward-looking and philanthropic approach to improvement, for example in their willingness to invest their time in mentoring and supporting senior leaders from other London boroughs.

60. Governance arrangements are highly effective in prioritising and improving the well-being, safety and outcomes of children who live or spend time in the City. Safeguarding is a clear theme through all City strategic documents. The DCS, chief executive and the lead member for the City are active and committed partners of the City LSCB. The priorities within the children and young people's plan are clearly linked to measurable objectives, with a strong emphasis on early help, and on preventing domestic abuse, radicalisation, neglect and child sexual exploitation. They are congruent with the priorities and plans of the LSCB, the children's services improvement plan, the health and well-being strategy and the City's education strategy.

61. The City executive links proactively with a range of partnerships, including Transport for London's safeguarding board and the Safer City Partnership, through formal membership, informal meetings and an inter-board chairs' meeting. Importantly, all strategies, priorities and plans relating to City children are rooted in a highly detailed understanding of the local community. The joint strategic needs assessment has been supplemented by the resident insight database, the 'troubled families' analysis and a detailed review of a particular neighbourhood in the City to enable partners to gain a clearer understanding of the local resident and non-resident population. Assertive steps have been taken to understand this diverse City, for example through the public health analysis of more than 300 local private health providers. This has been scrutinised by the City executive and is being taken forward in partnership to ensure that these providers fully understand their safeguarding duties towards children.

62. Partners share a firm commitment to innovate and to tailor safeguarding activity to the unique way in which children live in and connect with the City. For example, strong performance management information and tracking systems identify, monitor and respond to children who live locally yet may go

missing from education outside of the City, and children at risk who pass through the area or use its public transport.

63. Children's casework at all levels of need, including for those children who are in need of protection, is overseen by experienced managers who have a sound understanding of the legal and statutory framework in which they work. In almost all cases, decision-making at key points in children's lives is considered and unambiguous, leading to plans that meet children's needs and reduce risk. Managers demonstrate a clear understanding of the importance of establishing permanent care arrangements for children. Case supervision is regular, and social workers have many opportunities to discuss children with managers at all levels. Social workers are clear about plans for children and can articulate these well. However, not all staff supervision records are up to date and, in a few instances, they do not reflect the key discussions about professional challenges and dilemmas that social workers describe.

64. Leaders and managers are nurturing, determined and aspiring corporate parents. Care and ambition are backed up by personal and financial investment. The assistant director visits all children looked after, personally addressing the issues that they raise with him. The City supports care leavers to the age of 25 years and sometimes beyond, whether or not they are in full-time education. Senior leaders, in partnership with the head of the virtual school, make effective use of their chain of academies to ensure that children are matched with good schools that meet their needs. They welcome care leavers into the City for work experience and apprenticeships, as they would a family member. Senior and political leaders use these arrangements creatively to establish and maintain helpful contact with young people.

65. All care leavers are in suitable accommodation and almost all are in employment, education and training. The City sets very high standards for the provision of support to its children looked after and they are adhered to. For example, through a commissioning arrangement, CAMHS assessment and, if needed, ongoing therapeutic support are provided to all children looked after, wherever they are placed. Bed and breakfast accommodation is never used.

66. The corporate parenting board receives good-quality data and information about children's experiences, and this enables members to challenge practice effectively. Questions asked by members demonstrate genuine scrutiny and insight. The scrutiny function of the safeguarding sub-committee is effective. The provision of good-quality performance information and reports enables the committee to decide what it wishes to analyse. The chair has a 'no nonsense' approach to getting to the heart of critical issues. The dual adults' and children's focus of this sub-committee enables helpful crossover and resolution of shared issues, such as young people's transition to adult services.

67. The views of children and young people are sought and acted upon. Annual consultation, undertaken by the commissioned children's rights service, results

in an action plan that is closely monitored by the improvement board and safeguarding sub-committee. Senior managers are held firmly to account for their actions, in response to the issues raised by children. For example, they have raised the profile of the virtual school and have taken appropriate steps to increase the knowledge of practitioners about immigration issues. With a direct link to senior managers, the independent reviewing officer acts as a strong and influential voice for children subject to child protection plans, children looked after and care leavers. Children are confident to raise their concerns or worries, and these are swiftly addressed. Formal complaints are rare, but when they are received they are dealt with quickly and fairly. Members of the corporate parenting board have met with children looked after and care leavers through joint meetings and a lunchtime event. Council members and the chief executive could establish even more meaningful personal relationships with children and young people by seeking out informal opportunities to get to know them well. (Recommendation)

68. Senior leaders ensure that they have an exceptionally clear line of sight on frontline practice. They have achieved this through the combination of a comprehensive quality assurance framework, a very detailed and analytical approach to performance information, and a personal interest in children's experiences. The quality assurance framework provides a clear structure, which ensures that practice is thoroughly explored and analysed through the routine oversight of case work, a robust cycle of independent and in-house case auditing, learning from complaints and consultation, and detailed scrutiny by the independent reviewing officer. Learning is translated into whole-service change through the service improvement plan. For example, quality assurance activity highlighted some areas for improvement in the independent reviewing officer service, leading to the service being brought back in house. This is now a highly effective and child-centred service.

69. The lead member for children's services takes a direct interest in practice. Over the past year, he has attended a step-down meeting, a child protection conference and a multi-agency sexual exploitation (MASE) meeting. He assertively exerts his influence on behalf of individual children. The DCS regularly reviews and audits cases, inviting social workers to reflect with him on his findings. The audits carried out by managers for this inspection were reflective, clearly focused on children's experiences and, on the whole, accurate in their appraisal of the quality of practice. Early help audits consistently include the views of families and partners, but other audits do not do this routinely. (Recommendation)

70. The quality assurance of independent fostering arrangements is detailed and effective. The voice of children is a key part of twice-yearly monitoring reviews. This leads to improvements in the quality of placements. For instance, as a result of a quality assurance visit, additional training was provided for an independent foster carer, to enable her to respond more effectively to a young person's alcohol use.

71. Live and retrospective performance information is very comprehensive and is shared with the right people and forums. Performance reports are detailed, and commentary is particularly helpful where numbers are low, enabling managers at all levels to maintain a sharp oversight of services and to identify patterns and trends to scrutinise further. Low numbers do not lead to data being dismissed as insignificant. For each area of data, analysts, leaders and managers ask, 'Does this mean anything?' and, 'If so, what?' As a result, no assumptions are made about how relevant or otherwise the data is. Where numbers are low, additional child-level detail is provided. Rigorous analysis of performance information has led to targeted work and practice improvements, such as raising overall referral rates to children's services and increasing referrals to the designated officer about adults who work with children. Proactive steps are taken to improve the use of performance information continually, for example through collaboration with another London borough to improve the City's child sexual exploitation dataset.

72. Senior managers recognise that local professionals who work with children will not necessarily have the same breadth of opportunity to develop their practice skills as those who work in other areas. This potentially reduces their ability to make an exceptional difference consistently to children's lives. There are relatively low numbers of staff in the City and, as a result, they are required to deal with a wide range of tasks that would be undertaken by more specialist teams in most other areas. In response to this, and to ensure that services for children are as good as they can be, leaders have taken determined steps to provide many innovative and creative learning opportunities for staff.

73. The knowledge transfer programme, a three-year partnership between the City of London and Goldsmith's University of London, was established in 2014, to increase the ability of staff to provide outstanding services through ready access to high-quality research and knowledge. A launch event and four seminars have been attended by over 90 professionals, combining policy, practice and research, to explore subjects such as mental health and risk, and domestic abuse. The programme has completed research projects on the longitudinal impact of early help and the impact of social isolation on City families. Structured reflective practice sessions help staff to think more creatively about their work with local families. The learning in relation to domestic abuse has led directly to the development of a revised City domestic abuse policy and to the creation of a new coordinator post to counter domestic abuse.

74. In response to the recognition that abuse and neglect within affluent families can be harder to recognise and address, the DCS, the chair of the LSCB and the chief executive have worked together to commission a research project in partnership with Goldsmith's University of London. The findings of this project are due to be shared with stakeholders in autumn 2016. The City will draw on the findings to promote a greater understanding of the issues, with a view to enabling practitioners to respond better to the needs of children who may experience harm within affluent families.

75. Social workers and practitioners are very positive about the environment in which they work. It affords them the right learning opportunities to strengthen their practice and to prepare them to respond effectively to a wide range of complex case situations. For example, social workers attend the adoption and fostering boards in Hackney, and any referrals and assessments relating to the children of staff who are employed by a neighbouring borough are dealt with by the City to enhance the range of work in which social workers are involved. Moreover, staff are supported to attend higher-level courses in order to benefit individuals and all staff. In one instance, a manager undertaking a Master's level degree in strategic management was able to use her learning to strengthen further the impact of case audits on staff and on practice.

76. The children's services training programme is closely linked to City priorities and complements the LSCB training provision very well. All of the 15 training priorities for 2015–16 were achieved, including the legal context for unaccompanied asylum-seeking children, the use of research in assessments and life-story work. During the inspection, the positive impact of this training was seen by inspectors in casework, such as the helpful use of research to inform assessments and plans for children, and the quality of life-story work.

77. The City's approach to staff retention is well considered and effective. It is realised on a number of levels, including providing social workers with the right technology to do their jobs, good-quality supervision and support, the care and interest of senior managers, appropriate financial reward, generous investment in training and a firm commitment to using research to improve practice. Social workers are afforded rich opportunities to develop meaningful relationships with children, through low caseloads, direct work and activity breaks. Staff reported to inspectors that the approach to improvement and the City's outward-facing culture attracted them and retains them. The children's workforce is stable at all levels and turnover is very low indeed.

78. The strong commitment to promoting learning and development extends to the independent foster carers who care for City children. Free training has been provided to carers to counter radicalisation, child sexual exploitation and children going missing. The City provides all foster carers with an innovative toolbox to enable them to help children to improve their English at a faster pace.

79. The City works resolutely with the LSCB to reach out to professionals who work in the City of London, in order to ensure that they take their safeguarding responsibilities seriously. There is a particular focus on those who might not usually engage closely with children's services, such as private healthcare professionals and public schools. The 'nanny network' identifies and reaches out to carers, many of whom look after children who do not live within the City, and provides them with safeguarding advice alongside 'stay and play' sessions. The network is also used as an opportunity to raise their awareness of private fostering.

80. Commissioning arrangements are based on a clear understanding of the local population and the needs of children. Where services have not been deemed to be consistently good enough, senior and commissioning managers have rigorously reviewed arrangements. This has resulted in the decommissioning and recommissioning of services, such as the independent reviewing officer and children's rights services, leading to better quality provision and improved outcomes for children. Arrangements to meet the needs of any child who may have a plan for adoption in the future are robust. A comprehensive commissioning partnership, established in June 2015, is in place. This includes the provision of a good range of services, including post-adoption support and services for individuals who wish to seek information or help in later life. When specific commissioning needs are identified, new arrangements are made, for example through the provision of a targeted service to support young people who need intensive help to engage with work or learning. This is particularly helpful to young people whose first language is not English.

81. City leaders and partners have worked together in a focused and determined way to develop clear and practical procedures and guidance for agencies to identify and tackle child sexual exploitation. The City has its own well-structured operating protocol to counter child sexual exploitation. Wide-ranging education and awareness raising have been undertaken in the City in partnership with the LSCB. Senior leaders, including the chief executive, were closely involved in the highly successful 'notice the signs' campaign. Multi-agency training is comprehensive and targeted awareness raising includes local hoteliers. Although numbers of children at risk of child sexual exploitation in the City are low, MASE meetings ensure that children, adults and places of concern are identified and that targeted support is provided. The City has established helpful intelligence-sharing links with neighbouring authorities. All child sexual exploitation concerns are referred to and followed up by the child and family team, whether or not the children are resident in the City.

82. Partners are highly proactive in their approach to issues such as female genital mutilation and radicalisation, which have not, to date, been a problem in the City. Few cases of concern have been raised in relation to radicalisation. However, the response by partners to potential risks is very robust, demonstrating a sound knowledge of the community, effective partnerships, the interconnectedness of strategic priorities and a determined approach to identifying the individuals of concern.

83. Leaders have ensured that they are fully engaged with the 'Prevent' duty, with regular updates to the City executive and the identification of 'Prevent' leads in all 19 of the City's departments. They have worked with police to provide free 'Prevent' workshops to all foster carers caring for City children, all children looked after and care leavers, police cadets, young apprentices and those undertaking adult skills courses. The City supported the police to run a 'fun day' to engage with the local Bangladeshi community. Partners are aware of the possible links between radicalisation and child sexual exploitation, prompting 'Prevent' leads to deliver a presentation to the City MASE group.

Police and City leaders have forged links with neighbouring boroughs to share intelligence and good practice.

# The Local Safeguarding Children Board (LSCB)

## The Local Safeguarding Children Board is outstanding

## Executive summary

This is an outstanding Local Safeguarding Children Board (LSCB). It is a dual board, covering both the City of London and Hackney. The board demonstrates an unwavering determination to safeguard children who live in or visit the City, or whose parents work there, with a firm commitment to sustaining and improving partnerships. The board has an ambitious resolve to be the best that it can be, to contribute the best possible outcomes for children, and to learn from itself, external sources and, most importantly, from children and their communities. Strong governance arrangements are evident across partnerships, developed to ensure that the City of London is not overshadowed by its dual partner authority on the board. As a result, it is making a real difference to children's lives. An example is the chair's persistent escalation of a recommendation from a SCR to the Home Office, Department of Education and the national police chief's council.

The board has inspirational leadership, which is open and reflective, with a relentless focus on quality and a passion for improvement. Outstanding partnership working has enabled the board to respond to emerging safeguarding issues through highly effective strategic approaches that positively influence children's lives. The board robustly reviews progress and takes decisive and prompt action when necessary in order to meet its objectives. The board's business plan is pivotal in improving safeguarding practice.

The board is unrelenting in its challenge to partners to improve services to safeguard children. It scrutinises agencies' compliance with safeguarding policies and procedures through effective bi-annual section 11 audits and evaluation. The board is forward thinking, demonstrates an impressive ability to reflect on a range of critical issues and robustly considers creative solutions to address individual and collective partnership concerns. Learning from SCRs, as well as from other LSCBs and relevant research, is well embedded across the partnership. The LSCB annual report provides a rigorous assessment and overview of key strengths and weaknesses across safeguarding services in the City of London and Hackney.

Learning and practice improvement is systematically cascaded to frontline staff through a wide range of creative and highly effective opportunities. The board's analysis and evaluation of performance are effective, and help partners to understand the impact of services and the quality of practice, and to identify areas for improvement. However, it would benefit from stronger links to the diverse communities within the City.

## Recommendations

84. Take steps to engage with children and families in all diverse communities within the City, for example through the role of lay members.

## Inspection findings – the Local Safeguarding Children Board

### Inspection findings

85. The LSCB is a highly accomplished safeguarding board, supported by solid governance arrangements. It demonstrates exemplary effectiveness in holding partners to account to ensure that they safeguard children. The separate City and Hackney executive boards ensure that rigorous oversight of safeguarding practice in each local authority area is achieved, while also benefiting from economies of scale created through their shared sub-groups. The board's relationship with City of London leaders is highly effective.

86. The independent chair provides strong, credible and influential leadership. He has successfully facilitated a culture of openness and challenge that has positively influenced wider partnership working. LSCB members express a high level of confidence in the chair, who is extremely knowledgeable across all areas of the board's business. As a result, board members are motivated and engage fully with the work of the board. Safeguarding is a firm priority for all board members, demonstrated by consistently good levels of attendance, effective engagement in sub-groups, and a strong culture of constructive challenge and debate.

87. Governance arrangements are robust, with clear lines of communication between the chair, DCS, lead member and chief executive. A productive inter-board chairs' meeting, alongside clear protocols, links the chairs of the LSCB, the Health and Wellbeing Board, the Adult Safeguarding Board and the Safer City Partnership. It shares annual reports and business plans, which feed into strategic documents. As a result, the board effectively influences partner agencies and provides persistent challenge, to ensure that safeguarding is a golden thread running through all strategic documents.

88. The senior professional advisor, board manager and community partnership advisor provide highly effective support to the board. The senior professional advisor has been pivotal in strengthening the board's scrutiny function, as well as providing a valued resource to partners.

89. The board is forward thinking, demonstrating an impressive ability to reflect on a range of critical issues. It robustly considers creative solutions to safeguarding or partnership challenges. For example, female genital mutilation is now flagged on the City's electronic recording systems, and a private fostering mobile phone application (app) is disseminated by the board and the City to provide information for residents, practitioners, children and parents. It

is of note that the City has recently received two private fostering notifications.

90. Board members describe the chair as seeking opportunities through 'horizon scanning', to ensure that the board is proactive in anticipating new issues. This enables the board systematically to investigate emerging evidence, which might pose new and future safeguarding threats to children. For example, in response to challenges identified by City of London leaders, the board has worked with the City to commission independent research on effective intervention with affluent families in need. The board has also introduced a comprehensive and up-to-date strategy to tackle online safeguarding challenges. This sets out guiding principles for professionals about how to keep children safe in the context of social media and technology.

91. Serious incident notifications are thoroughly scrutinised by board partners through the joint SCR sub-group. This leads to appropriate and timely recommendations that are reviewed and endorsed by the chair. The national panel of independent experts has validated these decisions, commending the clear and analytical correspondence and the inclusion of children's voices in the process. Opportunities for learning from national SCRs and multi-agency case reviews are comprehensive. Lessons concerning neglect, sexual abuse and domestic abuse are widely disseminated in the City through well-attended learning events, lunchtime seminars and 'things you should know' (TUSK) briefings. Discernible differences have been made, including the implementation of an escalation policy for practitioners and managers. The majority of practitioners spoken to by inspectors had attended briefings, and almost all articulated the lessons learned.

92. The board demonstrates respectful, rigorous and tenacious challenge of partners and agencies. One member who sits on other boards said that this board is 'the most challenging, rigorous and child focused' of those he attends. It has an impressive and up-to-date log that identifies challenges, alongside persistent tracking of recommendations until sustained evidence of improved practice occurs. For example, the LSCB continues to challenge the Home Office with regard to its position on a recommendation arising from an SCR. The board is requesting a review of Home Office guidance for police on how to disclose 'soft intelligence'. This is not yet fully resolved, but the determination of the board in pursuing the issue is testament to the culture of resolute challenge.

93. The City of London has a small residential population characterised by extremes of wealth and poverty and a broad range of ethnic groups. The board has a clear commitment to safeguard and promote the welfare of children and to build partnerships based on mutual respect and trust. An example of this is the work of the board's community partnership advisor, who provides extensive support to community and voluntary organisations on a range of issues, such as economic and cultural diversity, female genital

mutilation, forced marriage, radicalisation, child trafficking and honour-based violence.

94. There are numerous examples of where the board has influenced and supported the City to maintain a strong focus on the safety and well-being of children. The board and City leaders have worked together to engage more closely with private schools, in order to ensure that safeguarding is their first priority. The addition of lay people to the board has strengthened links to schools and other settings.

95. The board maintains a very strong focus on hearing the views of children and using their experiences to influence developments to improve local safeguarding arrangements. Board members make extensive efforts to engage with children who have experienced services and, from a wider group, to use their feedback to inform practice developments. In partnership with the City, consultations with children led to the commissioning of a new children's rights service and training sessions for independent reviewing officers on immigration rights. The 'say something if you see something' campaign was launched at Hackney's youth conference, following consultation with children who challenged professionals about the original ideas for communication. The focus of the campaign changed from one of raising awareness in the local community, in order to spot signs of child sexual exploitation, to encouraging children to identify friends who may be at risk of, or experiencing, exploitation. The introduction of lay people who engage directly with children in settings such as schools and other services for children is already having an impact, but it requires further development to ensure that the authentic voices of harder-to-reach children and communities are heard. (Recommendation)

96. The board's business plan is comprehensive. It has three key strategic priorities that are underpinned by strategies to tackle safeguarding, relating to neglect, domestic violence and child sexual exploitation and preventing radicalisation and female genital mutilation. Sub-group work plans provide a robust framework detailing how the board works to safeguard children. These plans are well coordinated, effectively monitored, challenged and used to drive priorities for children robustly. Specific City sub-groups have been established to ensure that the needs of local children are prioritised.

97. The board has made substantial progress in raising awareness of female genital mutilation, forced marriage and child abuse through faith, belief or culture. The board has worked closely with public health services to influence and monitor the multi-agency response to female genital mutilation. The chair has hosted meetings with the voluntary sector and survivors of these abusive practices, enabling the board to take account of these voices in the development of the strategy to counter female genital mutilation.

98. The board closely monitors the City's 'Prevent' duty and holds agencies to account for driving their response, including awareness raising and recognition. The City 'Prevent' coordinator post is well established. The post

holder is also the community safety manager. Designated 'Prevent' leads are in place in each corporation department. Awareness-raising sessions have been held across agencies, foster carers and community groups, and the coordinator links with other boroughs to share information and good practice. Risk assessments include awareness of risks within affluent communities.

99. The 'Prevent' lead is approved to deliver workshops to raise awareness of the 'Prevent' duty. The widely disseminated Safer City 'Prevent' roadmap is informative, comprehensive and well presented. A designated email address is available for people to seek advice, alongside clear referral processes. Innovation is evident, with discussions and challenge regarding the links between radicalisation and mental health, and the connection between radicalisation and child sexual exploitation. Extensive awareness raising, using a variety of media, has been effective. For example, a foster carer reported a concern about radicalisation. Work is underway to develop the use of social media to increase the community's understanding of risks further.

100. The board continues to drive the strategy and action plan to counter child sexual exploitation effectively and coordinates the partnership response through a highly effective child sexual exploitation and 'missing' working group. The board's data analyst has ensured that comprehensive information about children informs the local child sexual exploitation profile. The City's operating protocol sets out comprehensive, well-structured and practical guidance. Extensive work has been undertaken through a City-specific children sexual exploitation working group. The group coordinated a targeted City campaign with hoteliers, alongside multi-agency training and support for children, together with research and intelligence. The police refer all children at risk of sexual exploitation to City child and family services, regardless of where children reside. Effective intelligence-sharing links with neighbouring authorities are in place.

101. In May 2016, the LSCB supported the City in its highly effective and innovative 'notice the signs' campaign, utilising a range of communication media to raise staff understanding of the signs of child and adult abuse, including child sexual exploitation. This included blogs, a website and a film. Senior leaders, including the chief executive, distributed leaflets. This stimulated many conversations with members of the residential and business communities, schools and other agencies involved with children who live or spend time in the City.

102. The LSCB led the 'say something if you see something' campaign to raise public awareness of child sexual exploitation. This included a film made by young people for young people, leaflets on countering sexual exploitation for parents and young people, and free sessions of the 'Chelsea's choice' play, attended by more than 1,300 students across the City of London and Hackney. During 2015–16, the LSCB delivered seven separate training sessions on child sexual exploitation to 113 staff from the City and Hackney. A further 199 staff from the two local authorities attended the board's

conference on the theme of child sexual exploitation. 'Operation Makesafe' continues to raise awareness in the business community, including hotels, taxi companies and licensed premises.

103. The board utilises a comprehensive range of multi-agency performance information, which includes children with disabilities, unregistered schools and, more recently, attendance and reports received by agencies at child protection conferences. The dataset is clear. It represents all agencies' contributions to safeguarding and fully supports an understanding of effective practice across the whole partnership. Data and commentary are thoroughly scrutinised by the quality assurance sub-group, executive group and the main board, with appropriate focus on the board's priorities. The board receives regular reports regarding the few children who go missing in the City and the actions taken when they return, including return home interviews. However, the board has not sufficiently scrutinised the timeliness of these interviews.

104. The board comprehensively monitors multi-agency frontline practice. An extensive programme of themed audit activity is determined by the board's priorities, and local and national concerns. These include early help and intervention, child sexual exploitation, children who go missing, the journey of the child and the experiences of children with disabilities. The board considers findings from its own audits, alongside those from City single-agency audits and from staff surveys. Learning is carefully fed back to staff and findings inform training.

105. The board has ensured that safeguarding is a priority for all partner agencies through rigorous scrutiny of agencies' compliance with safeguarding policies and procedures. A comprehensive section 11 audit process engages all partners. Returns are rigorously analysed by the quality assurance sub-group. Bespoke training to support agency participation and peer reviews provides the board with assurance that agencies are meeting their safeguarding responsibilities. Training extends to diverse sections of the community. Audits have led to changes, which have improved the safety of children in the City, for example joint actions with British Transport Police regarding children using public transport. Low referral rates led to the scrutiny of two hospitals outside the City, where City children are born, to assure the board that safeguarding practice was robust. Further work is progressing to map the private health providers in the City, in order to engage them in the safeguarding agenda.

106. Early help remains a firm priority for the board, with the effectiveness of early help services evaluated through the learning and improvement framework and City sub-group. The board rigorously monitors the numbers of children who receive early help assessments, through its multi-agency dataset. The annual report provides a comprehensive overview of early help services. A multi-agency audit of the effectiveness of early help identified strengths and learning, which are widely disseminated through TUSK briefings. The City early help sub-group has led to improvements in practice and services. For example, good performance data increased the focus on concerns about

adults who work with children, and this led to an increase in referrals. Awareness raising and protocols to counter child sexual exploitation led to the identification of a small number of children with vulnerabilities. 40 partners attended a multi-agency partnership event in February 2016, which included a presentation covering the strategic objectives and operational priorities for early help.

107. The board has adopted pan-London LSCB policies and procedures, which are adapted to the City and reviewed regularly. The City has refreshed and relaunched a revised threshold document, which is comprehensive and practical. Descriptors provide clear examples for each level of need, including child sexual exploitation, radicalisation and disability, as well as a link to the joint City and Hackney escalation policy, which staff reported as extremely useful in achieving resolution when agencies disagree. Thresholds are now understood well and used by staff across the City.

108. Arrangements for the review of child deaths are highly effective. The child death overview panel (CDOP) is well attended by the right professionals and has clear terms of reference. The CDOP annual report provides a comprehensive analysis of local issues and appropriately sites this in a national and regional context. It identifies issues of concern and themes, for example the risks associated with baby slings and co-sleeping with infants. Both have resulted in well-targeted public awareness raising across the City. The panel identified the need to discuss a range of issues with the senior coroner. As a result, all coroner reports concerning the prevention of future deaths are now sent to the panel to ensure that learning is widely circulated.

109. The board has created and fostered an effective learning culture that extends to frontline practitioners and embraces the community. Professional relationships across the City are based on a team approach, ensuring excellent communication and an atmosphere of continuous improvement. The board delivers a comprehensive range of training for managers and practitioners relating directly to multi-agency improvement priorities. Technology is used creatively and well, for example the online booking system and the provision of a range of online training modules through its website. The training and development sub-group ensures highly effective planning, monitoring and oversight of all training activity. Regular reflection by the board on the learning arising from SCRs, reviews and case audits further enhances the training programme, with relevant themes shared effectively with trainers. Contemporary messages to improve safeguarding of children are comprehensively included in the rolling programme of training. The board regularly monitors the effectiveness of its training courses. This includes observation of trainers, post-course evaluation, staff surveys and random telephone calls to participants and their managers, to assess how learning has influenced practice. Following safeguarding awareness training, a City apartment receptionist raised concerns about a child to the police.

110. The annual report for 2014–15 is well written, comprehensive and evaluative, providing rigorous and detailed overview of the board's work. The report clearly identifies learning and provides documented examples of effective and constructive challenge to partner agencies and other boards. The board's website is accessible, mobile telephone friendly, easy to navigate and well used. It includes a comprehensive and up-to-date set of procedures with links to research information, legislation and practice guidance. The latest news from the board is highlighted on the home page and is disseminated through monthly TUSK briefings. There are regular tweets from the Twitter account to update staff.

## Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference that adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition, the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people whom it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

Ofsted produces this report of the inspection of local authority functions and the review of the Local Safeguarding Children Board under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006.

The inspection team consisted of four of Her Majesty's Inspectors (HMI) from Ofsted.

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| Committee(s): | Date: |
|---|---|
| Police Committee- For information<br><br>Safeguarding Sub Committee | 22nd September 2016<br><br>17th November 2016 |
| **Subject:**<br><br>Annual update on Custody (Young Persons, Children and Mental Health) And Use of Force | **Public** |
| **Report of:**<br>Town Clerk and Commissioner of Police | **For Information** |
| **Report authors:**<br>Craig Spencer, Town Clerk's Department<br>Supt Helen Isaac, Uniformed Policing Directorate | |


**Summary**

This report provides an overview and update on three key areas of policing; young persons and children in custody, mental health crisis in custody and use of force. The City of London Police (CoLP) collects and analyses information across these areas, in response to national recommendations from Her Majesty's Inspectorate of Constabulary (HMIC) amongst others and in recognition of the importance of understanding and responding to any potential issues or trends.

The force will provide an annual update on these areas to continue its commitment to accountability and transparency, informing on developments in best practise, any improvements which may be required and issues of note, in addition to data reported against that for 2015/16 within this report.

Young persons and children who are held in custody may be vulnerable for a number of reasons and the CoLP and City of London Corporation (CoL) have established processes in place for when this occurs; this report presents annual statistics for those brought into CoLP custody between April 2015 and March 2016.

The report presents the national developments taking place to safeguard those suffering a mental health crisis and explains the procedure for when a crisis develops once someone is within the custody suite against when police are called to assist someone on the street. Data is presented from between April 2015 and March 2016 for those experiencing mental health issues under 136 Mental Health Act 1983 where police assistance was required.

Confidence and trust in the police service is essential, but a recent study by the Independent Police Complaints Commission (IPCC) into police use of force showed that there is some work to do to increase confidence in this area. This section of the report highlights the work taking place to address recommendations arising from the IPCC study and presents the good practise already taking place around training and scrutiny. Use of force data from August 2015 to August 2016 is provided for consideration.

## Recommendations

Members are asked to:

- Note the report.
- Endorse report format and data for future annual update and comparison against baseline statistics for 2015/16

## Main Report

### Young Persons and Children in Custody

### Background

1. England, Wales, Northern Ireland and Scotland each have their own guidance for organisations to keep children safe. They all agree that a child is anyone who is under the age of 18. The Police and Criminal Evidence Act 1984 (PACE) define a young person or child to be between the ages of criminal responsibility 10yrs and have not reached the age of 18. We use the term 'child' to refer to younger children who do not have the maturity and understanding to make important decisions. We use the term 'young person' to refer to older or more experienced children.

2. Custody officers are required to make a decision about whether they should treat the individual as a juvenile or as an adult. *PACE Code C paragraph 1.5 - states that where someone appears to be under 17, or to have reached the age of 17 but be under 18, officers and staff are to treat them as a child/young person.*

3. The law already recognises that police cells are not a suitable place for young persons and children. The Police and Criminal Evidence Act 1984 requires the transfer of children who have been charged and denied bail to be moved to more appropriate local authority accommodation.

4. The related duty to local authorities set out by the Children Act 1989 is to accept these requested transfers. The detention of a child in the custody of a police cell is only allowed where exceptional circumstances prevent movement or where such children are at risk to the public and themselves, or no local authority accommodation is available.

5. Young persons and children in custody legally require an appropriate adult (AA) to be appointed as soon as possible and to be present during specific stages whilst in custody. These include the booking in procedure, interview, charge and other custody processes such as custody staff taking DNA, photographs and fingerprints to the provisions of the Police and Criminal Evidence Act 1984.

6. The release of the 'Concordat on Children in Custody' by the Home Office in March 2016 aims to set out the role of each organisation in the process of detaining a child into custody and where responsibility lies. This clarifies the legal requirements and offers guidance on how these are put into place; particularly around the transfer of children from custody to local authority accommodation.

7. The Concordat is there for the Police and Local Authorities in aiding compliance with their statutory responsibilities and to bring about a decrease in the number of children held overnight in police custody. The concordat sets out seven principles to achieve these aims:

   - Whenever possible, charged children will be released on bail.
   - Children denied bail will be transferred whenever practical.
   - Secure accommodation will be requested only when necessary.
   - Local authorities will always accept request for non-secure accommodation.
   - The power to detain will be transferred to the local authority.
   - Where a local authority fails to provide accommodation it will reimburse the police.
   - Police forces will collect data on transfers.

8. On behalf of the City of London Police the Commissioner has signed the Concordat. The Corporation of London is yet to sign the Concordat and is discussing the guidelines with the Home Office.

9. The HMIC published a report ***'In Harm's Way'*** in July 2015 which outlined the role of the police in keeping children safe. As a result of the recommendations within the report, the Custody Manager developed a process of capturing information on juveniles who have been in CoLP police custody, which is circulated to senior managers on a monthly basis and has informed the data within this report.

## Current Position

### Process in custody

10. The first point of contact for young persons and children when they enter custody is an assessment interview with a liaison and diversion nurse to ensure CoLP are not missing any incidents of Child Sexual Exploitation or criminal factors of adult cohesion. The liaison and diversion staff is currently available for assessments in custody during 8am-9pm Monday to Friday, which has been extended from previous arrangements. Specially trained police officers will undertake the assessment interview at all other times

11. The CoLP has two custody suites based at Snow Hill and Bishopsgate. The principle custody suite is Bishopsgate which has a secure Perspex room, commonly known as 'the bubble' within the reception area of custody. It is designed for use by children and vulnerable persons who have been detained for a criminal matter. This is believed a more suitable place than a cell, as

both police and the detained person continue to be visible to each other and there is less chance of the detainee being further alienated or stressed by their predicament. A custody cell is used only as a last resort, dependant on the circumstances at the time and this would be with other control measures in place to reduce stress and risk as much as possible.

12. Meetings have taken place to confirm arrangements for young people and children between the CoL, CoLP and Committee Members. This has resulted in the creation of a *'Children and Young People Held in Police Stations Protocol'* for the City of London Corporation and the City of London Police. This is attached in *Appendix 1* and will instruct future actions by staff from both organisations.

13. The City of London Police has a clearly articulated police process for children in custody which is in the form of a flowchart responding to a young person being charged with an offence. The Corporation have also produced a similar flowchart to reflect process from a local authority and this is attached as *Appendix 2*.

14. The Appropriate Adult service is currently commissioned by the Community and Children's Services Department (CCS) but is managed by CoLP. The service meets with CCS quarterly and statistics are provided on how often the service is used.

15. When a person under the age of 18 years enters custody, every effort is made by the Custody Sergeant and Designated Detention Officer to keep the young person from being placed within a custody cell. The booking in procedure is initiated on arrival to establish many important facts, such as name, age, address, mental wellbeing and health. During the interaction with the detained young person/child, concerted attempts are made to establish the parents or family member details to act as an Appropriate Adult (AA). In some cases there is no alternative but to use the Appropriate Adult service.

16. Once the AA has attended the police station, the Custody Sergeant will explain the full circumstances why the young person is detained, what the AA role is and custody procedure. The initial booking in process is repeated, this time with the AA present. The Police National Computer is searched on details the young person has given which will establish if they are known to police for previous offences or wanted for outstanding matters. Police officers will submit an intelligence document, a form 377, which is comprehensive information to assist the Public Protection Unit (PPU) and social services and allow appropriate follow up processes to be initiated.

**Local Authority Transfer Arrangements**

17. The CCS department within the City are called initially. If out of hours this is then referred to the relevant authority (this can depend on where the child lives). There is a separate out of hour's service which is referred to Hackney, who request accommodation from Tower Hamlets. Historically this has been rarely available. The requirement for children to be transferred to overnight

accommodation is only for those who have been charged and remanded, where bail has not been granted. Where the pre-charge investigation is on-going, the child remains in the custody suite, although every effort is made to reduce the length of time they are there, with bail used where appropriate to allow the investigation to proceed without their continued presence.

18. All Custody Sergeants are fully aware of the current process both inside and outside of working hours and this has been shared with Corporation staff to ensure wider knowledge of the process. Police are mindful that juveniles should not be detained for longer than needed in accordance with paragraph 1.1 of Code C of PACE and should avoid holding young persons and children overnight in police custody cells unless absolutely necessary.

19. If there are no available spaces within the social services' remit 'to house the young person or child at an appropriate site' then current arrangements to provide a cell in extremis could potentially lead to extended periods of time for children in custody. The minimum stay for a detainee for the period recorded as shown in Appendix 3, figure 2 was around 14.2 hours, with the maximum being towards 19 hours in total which included two separate periods of detention, with the young person returning to police custody on bail.

**Detention data for 2015/16**

20. For this first report it has been agreed to use data which has been collated from custody records over the period of April 2015 to March 2016 of Young Persons and Children being detained in custody. The ages are shown at Appendix 3 in figure 6 with ethnicity in figure 7. This report will provide a baseline and enable a comparison to be made over future years. All figures referred to in this section are at Appendix 3.

21. The data provided within figure 1, 'Number of children and young people including 18 year olds in custody 2015/16' shows 77 ( Including 18 year olds, 121) young persons and children entered City of London Police custody that year; this equates to an average of just over 6 a month (including 18 year olds, 10 a month). January saw the highest number with 9 (Including 18 year olds, 14) whilst October had the lowest number of 1 (Including two 18 year olds).

22. The length of time young persons and children were detained following arrest/caution is shown at figures 2 and 3, clearly displaying maximum and minimum times with the average times shown.

23. Documentation shows, of the 77 young persons and children detained in custody, 63 were male and 14 female. The youngest person detained in police custody was recorded as a 13 year old white British male for an offence of 'theft – pedal cycle' in April 2015. He had been detained at 17:55hrs and the procedure of booking in and obtaining the required appropriate adult took 2.5 hours; the child was interviewed with a solicitor within 3.5 hours and left custody with no further action within 5 hours.

24. The length of time a young person or child was detained following arrest/caution awaiting an appropriate adult is shown in figure 4 and figure 5 displaying the average time waiting for an appropriate adult.

25. A breakdown of offences for which young persons and children were brought into custody during 2015/16 is at figure 8. There were 19 different offences documented, along with one classed as 'other.' The most common offence is theft – shoplifting with 16 offences with five others having just one instance. During the recorded period from April 2015 to March 2016 the City of London Police did not require accommodation for any young person or child. None were refused bail.

26. Statistics show that a use of force or restraint was used for those under 18 in 38 out of the total 121 occasions. Handcuffs were used in 35 instances, 1 person was restrained for the purpose of a search and 2 were restrained upon arrest.

27. The annual figures show that of the 121 young persons and children brought into custody for the first time, of those under 18, all but 6 had been detained previously in custody.

28. Referrals and pathways to external agencies are currently not implemented but Community Policing and PPU are considering better pathways with Social Services. The documentation of the 377 form for young person and children and vulnerable persons is passed to the Social Services of the area in which the person resides. To date there is no administration for Social Services to keep the arresting force up to date with any of its findings or progress.

## Mental Health Crisis in Custody

### Background

29. The issue of mental health is now a prominent factor within today's community and policing across the capital and country. The police service acknowledges that police custody is not the most appropriate environment for treating and housing those suffering mental health issues. Guidelines implemented will ensure vulnerable people, including those with a mental health issue, should not use a police station as a place of safety but instead use the more suitable facility of a hospital or other agreed organisation or approved venue.

30. Whilst the use of Section 136 Mental Health Act 1983 and Section 5-6 mental Capacity Act 2005 has decreased within police stations, mental health has remained a crucial issue within custody. 8 of the 17 people who died in police custody nationally in 2014/15 had mental health concerns. A higher proportion (24%) of detained people with mental health concerns experienced force in the custody environment than (13%) detained people with no mental illness identified.

31. The policy covering guidance within custody on mental health is the Police and Criminal Evidence Act 1984 (PACE) which states below:

    *'It is imperative that a mentally disordered or otherwise mentally vulnerable person, detained under the Mental Health Act 1983, section 136, be assessed as soon as possible. A police station should only be used as a place of safety as a last resort but if that assessment is to take place at the police station, an approved mental health professional and a registered medical practitioner shall be called to the station as soon as possible to carry it out.'*

32. New legislation intended under the Policing and Crime Bill will greatly restrict the circumstances when a custody cell can be used in this situation. Previously, a 2014 review found people were being detained in police cells because of the lack of available NHS Trust health-based places of care and safety due to capacity, staffing or opening hours.

33. In May 2015, the Government announced up to £15m of funding to provide health-based alternatives to police cells, with 15 NHS Trusts and partnership organisations covering 11 police force areas receiving a total of £6.1m. This amount will however only deal with the tip of an ever increasing populace. The funding is part of the mental health crisis care agreement to support people in a mental health crisis.

34. Whilst the use of police cells as a place of safety has declined by almost a third in England and Wales between 2013/14 and 2014/15, both the Home Secretary and Secretary of State for Health have said they want to see an end to people with mental health issues being locked up in police cells because appropriate health services are not available.

35. The Department of Health is now inviting bids from Crisis Care Concordat groups in 10 police force areas for funding to provide alternative places of safety, to allow people experiencing mental health issues to receive compassionate care and support in the right setting.

36. Police cells can be a daunting environment for anyone who may be experiencing a mental health crisis, as they can make one feel criminalised and inevitably exacerbate the levels of distress the person may be already suffering. This is especially true for those under 18 years of age. Although the picture is improving (see table 1.1[1] below), the government are keen for this engagement and trend to continue.

| Section 136 Detentions to a Place of Safety | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|
| Police Custody | 8,667 | 7,881 | 6,028 |
| Hospital | 14,902 | 14,053 | 17,008 |
| Total | 23,569 | 21,934 | 23,036 |

Table 1.1 England and Wales figures

37. Therefore, the government intends to make the following changes to the Mental Health Act under the upcoming Policing and Crime Bill:

- Police cells will no longer be considered a place of safety for under-18s and will only be used in very limited situations for adults.
- The maximum duration of detention will decrease from 72 hours to 24 hours for the purposes of an assessment.
- The extension of police powers to act quickly to detain and remove people experiencing a mental health crisis.
- The requirement for police officers to consult health professionals prior to detaining someone under the Act's provisions.

38. Recently, there has also been the introduction of the Mental Health Crisis Care Concordat which aims to set out an agreement between health, criminal justice and social care agencies for expected responses to people in need of emergency mental health care. The Concordat reiterates government policy and sets out how to achieve a crisis service where 'no-one in crisis will be turned away', which is 'available 24 hours a day, 7 days a week' and is 'community-based, closest to home and is the least restrictive option available.

39. Nine police force areas have been piloting the system of 'street triage'. This is where a police officer and mental health worker act in partnership to assess people on the street and where necessary, take them directly to a health care facility.

40. Within these schemes, mental health professionals provide on the spot advice to police officers who are dealing with people with possible mental health issues. This advice can include an opinion on a person's condition, or appropriate information sharing about a person's health history. The aim is, where possible, to help police officers make prompt and appropriate decisions, based on a clear understanding of the background to these situations.

41. The announcement last December from the Home Office over the NHS commissioning of custody healthcare means a decision on the national way forward has been delayed until December 2017. The City of London Police is

about to go out for tender for a new healthcare contract after this was agreed at Police Committee in February 2016.

**Current Position**

**Mental Health Process**

42. The City of London Police has two standard operating procedures (SOP's) that relate to mental health, these being: Dealing with Mental Health Incidents and Medical and Mental Health Issues in Custody.

43. These policies provide a framework for dealing with aspects of managing and dealing with persons in police detention to the required standard, as set out in Code C of the Police and Criminal Evidence Act 1984, the Code of Ethics and the College of Policing Authorised Professional Practice (APP) for detention and custody.

44. Both of these procedures are regularly reviewed and updated and are readily accessible for members of staff on the Force's intranet.

45. When a person has been arrested and it becomes apparent whilst the person is in custody they are suffering from a mental health issue, the custody officer must implement the procedure for a mental health assessment. The custody officer will request the Health Care Practitioner (HCP) for an initial assessment of the detained person and if found the detained person is displaying symptoms of a mental health crisis the HCP will initiate a full assessment. The detained person will be assessed in one sitting within custody as soon as practicable by doctors and social services. On their decision only and not the police, it will result in the detained person being transferred to a designated Mental Health Trust Hospital for further evaluation or to remain in custody for continuation of the criminal process.

46. However, if mental health illness has been exhibited and diagnosed whilst in a public place, then the City of London Police will not use custody or the police station as a place of safety. Community Engagement has employed every effort to establish a better working environment between the London Ambulance Service (LAS) and the Mental Health Trust at the Homerton Hospital. All parties have agreed to a working guide 1) LAS will attend S.136 MHA 1983 calls within half an hour. If LAS are unable to provide a priority ambulance and if there are exceptional circumstances, CoLP will convey a person to Homerton Hospital. 2) Homerton will accept the S.136 within one hour of police attendance.

47. The Force has taken the initiative by using a specific point of contact within the community and partnerships team to take the lead in S.136 MHA 1983 issues, developing a liaison with the London Mental Health Trust, recording encounters, increasing links with external organisations and continuing communications with our nominated place of safety, the Homerton Hospital.

48. In the rare circumstances when the Homerton Hospital is unavailable officers are aware through policy and procedure to use the command and control structure to establish an alternative space at another authorised mental health hospital near to the City, such as St Thomas', The Royal London or UCH.

**Mental Health Data**

49. Throughout the period of April 2015 and March 2016 there have been an ever increasing number of reported incidents involving mental health. Police are often first to attend a report to provide reassurance, ensure public in the vicinity are safe and to provide an initial response to any person requiring assistance.

50. Incidents are recorded on a Force form, documenting whether action was taken under section 136 Mental Health Act 1983 or Section S.5- S.6 Mental Capacity Act 2005, providing a detailed account of police action and hospital interaction.

51. During the period of April 2015 - March 2016, 129 people were sectioned under S.136 MHA 1983, 2 of these were under the age of 18 and 1 was recorded as not known. Of the 129 people, 89 were male and 40 female. All were conveyed to a place of safety, 75 by Ambulance, 52 by a police vehicle, and 2 not known.

52. The places of safety are documented as Hospital 121, and the front reception area of a police station 2 and a private home care 2, not known as 1 and other 1. The two under 18 years of age, both attended hospital. These figures are highlighted within Appendix 4 within figures 9, 10 and 11.

**Use of Force**

**Background**

53. Police use of force follows the College of Policing Authorised Professional Practise (APP) which states that any officer considering the use of force must consider three core questions:

- Would the use of force have a lawful objective (for example, the prevention of injury to others or damage to property, or the effecting of a lawful arrest) and, if so, how immediate and grave is the threat posed?
- Are there any means, short of the use of force, capable of attaining the lawful objective identified?
- Having regard to the nature and gravity of the threat, and the potential for adverse consequences to arise from the use of force (including the risk of escalation and the exposure of others to harm) what is the minimum level of force required to attain the objective identified, and would the use of that level of force be proportionate or excessive?

54. The National Decision Making model (NDM) is central to each decision an officer makes, with decisions on use of force being made in fast moving, high risk and stressful situations, often in a split second.

55. The Criminal Law Act 1967, the Police and Criminal Evidence Act 1984, Common Law and the rights and freedoms contained within the European Court of Human Rights (ECHR) govern the police use of force. The requirement that domestic law and ECHR impose is that, if possible, non-violent means should be used to resolve an incident before force is used.

56. The Criminal Law Act 1967, the Police and Criminal Evidence Act 1984 and common law apply to all uses of force by the police and require that any use of force should be 'reasonable' in the circumstances. Reasonable in these circumstances means:

- Absolutely necessary for a purpose permitted by law
- The amount of force used must also be reasonable and proportionate (i.e., the degree of force used must be the minimum required in the circumstances to achieve the lawful objective) otherwise, it is likely that the use of force will be excessive and unlawful.

57. Earlier this year, the Independent Police Crime Commission (IPCC) published their report 'Police use of force; evidence from complaints, investigations and public perception,' as a result of a comprehensive study of many aspects of this subject. This report made a number of recommendations, most for police forces, but some also for the National Police Chiefs Council (NPCC), College of Policing, Her Majesty's Inspectorate of Constabulary (HMIC) and Police and Crime Commissioners (PCCs).

58. It was recommended that where forces record data about the use of force, PCCs should ensure data is collected and analysed and that action is taken to follow up on trends or issues of concern. It was also recommended that PCCs ensure that forces develop an action plan to take forward the recommendations from the study.

59. A recommendation for the NPCC is to develop national recording standards and provide guidance on the use of the data collected, recognising that forces currently record force differently, some comprehensively and some not at all.

**Current Position**

60. In addition to the Use of Force APP, the Force also has a standard operating procedure covering local practises. This states that a record is to be created when one of the following techniques or tactics is used:

- Handcuffing (compliant and non-compliant)
- Unarmed skills (including pressure points, strikes, restraints and take downs)
- Use of dogs
- Drawing or use of baton
- Drawing or use of irritant spray

- Limb / Body restraints
- Spit guard
- Shield
- Conductive Energy Device (C.E.D. currently TASER) (in any of the 7 categories of use)
- Attenuating Energy Projectile (AEP): drawn or discharged
- Firearms: drawn or discharged
- Other / improvised

61. At present the Force uses the Human Resources system for capturing use of force information from officers and although this system has fulfilled the purpose for a number of years, it has been challenging to extract and scrutinise data and it does not capture all of the elements required by the forthcoming new standard.

62. Following on from their recommendation to develop a national recording standard, this was circulated to forces by the relevant NPCC lead in July, with an expectation that forces will have the new standard in place for recording from the 1st October 2016. In line with the new standard, the Force's SOP will be reviewed and updated to reflect the changes.

63. Options have been explored and the Force plans to progress with an app developed and trialled by West Yorkshire Police, who use the 'Pronto' mobile working solution, which has also been adopted by CoLP this year. The app is fully compliant with the required standard, provides a number of business benefits and will allow us to monitor and extract data with ease, whilst allowing officers to access and record a use of force report easily on their mobile device.

64. The Force has set up a new working group earlier this year, the Stop and Search and Use of Force working group, recognising the additional work that was required in both of these areas for progression of action plans and to increase scrutiny of and transparency of data. An action plan has been developed to progress the recommendations made by the IPCC and progress is monitored and updated monthly by the working group.

65. The Force has also set up a new Community Scrutiny Group, focused on not just stop and search as was previously the case, but also use of force and deployment of Taser. This group has community membership including Nick Bensted-Smith, a Member of Police Committee and a member of the Independent Advisory Group and new members are actively being sought.

**Professional Standard Department monitoring of use of force**

66. The Professional Standard Department (PSD) who govern the discipline, complaints and conduct matters are categorised in accordance with Home Office categories. Use of Force is not one of those categories. There are, however categories which fall into the overarching theme 'Use of Force';

- Serious non-sexual assault (A)

- Sexual assault (B)
- Other assault (C)
- Oppressive conduct or harassment (D)
- Unlawful/unnecessary arrest or detention (E)
- Other (W)

67. All complaints and conduct matters are reported to the Professional Standards and Integrity Sub-Committee quarterly. This Sub Committee reports to the Police Committee, which acts on behalf of the Court of Common Council as our 'police authority'. The quarterly report is an analytical document which, amongst other things reports on any identified themes. Summaries of all concluded PSD investigations are presented to the Members.
    Internally there are a number of other ways in which emerging trends are identified and dealt with;

- Tactical Coordination and Tasking – this is held fortnightly and any identified emerging trends can be brought to the attention of our Senior Management Team (SMT) for action plans to be developed where appropriate.
- Subject Intervention Matrix – (SIM). The conduct records of Officers and Police Staff who have been subject of complaint and/or conduct allegations are examined using a matrix system. The outcome of this process ('score') determines whether or not any proactive intervention is required to reduce the risk of further allegations or loss of public confidence.
- PSD Working Group – This meeting is held quarterly and chaired by the Director of PSD. Each of the Force Directorates is represented. Trends or other areas of risk are identified to the Directorate representatives for them to address with their respective SMT's.
- Organisational Learning Forum – Held quarterly and chaired by the Assistant Commissioner. PSD matters are discussed at this forum so that the organisation is able to benefit from learning resulting from both local and national investigations and themes.

**Training in use of force**

68. COLP ensures its officers undertake the mandatory Personal Safety Training (PST). Human Resources and the Duty Planning departments keep an auditable process to record and monitor police officers, Police Community Support Officers (PCSO) and Dedicated Detention Officers (DDO) training status. A record is made of the content of training sessions, details of the staff trained, details of the assessment process, level of staff competence following assessment, occurrences, injuries sustained and near misses.

69. Within every six monthly period the Officer will undergo a single day training session of physical techniques which incorporate the guidance in Home Office approved techniques and demonstration of use of the National Decision Model (NDM) in scenarios allowing Officers to quickly make applied decisions of spontaneous incidents or planned operation.

70. The Personal Safety Training contains five separate modules

- Module 1 – Managing Conflict
- Module 2 – Personal Safety
- Module 3 – Equipment and Restraints – Baton Incapacity/Irritant Spray, Handcuffs
- Module 4 – Role Specific Skills
- Module 5 – Refresher/Development

71. Staff must demonstrate both initial and ongoing competence for each of the techniques taught and be assessed as competent against the requirements of the National Occupation Standard. COLP ensures that personal safety training is delivered with such frequency as to maintain competence and development of skills and knowledge.

72. Officers are trained and fully aware they should use force only when other methods have proved ineffective, or when it is honestly and reasonably judged that there is no realistic prospect of achieving the lawful objective identified without force. The National Decision Model puts the Code of Ethics at the heart of all police decision making.

**Use of force data for 2015/16**[2]**

73. CoLP has collated data of its Use of Force statistics for 12th August 2015 and 12th August 2016 (See footnote 2). This shows during this period officers have documented 737 incidents where Use of Force has been used. It displays that 155 women, 564 men and 18 not classified came into contact by way of Use of Force with CoLP police officers.

74. The figures express that 236 incidents were to affect an arrest with 1 being recorded as accidental.

75. Officers attend many differing incidents during their working duty and some are inevitably violent which is reflected by figures showing protecting oneself or other officers at 355 and concealment of items on person at 11.

76. More so than ever, police are called to members of the community who suffer mental health crisis as already highlighted within the report. Officers had to use force on 70 people to prevent self harm to the subject and 59 reports to protect secure property and evidence. The use to remove handcuffs is 3 and other not defined is 2

77. These figures clearly interpret how officers engaged with its community when called upon to initiate positive action and use of force.

[2] Please note, this data set runs from 12th August 2015 to 12th August 2016- this is because the data was collated locally rather than from the Duty Management System which was undergoing an upgrade. Future reports to your Committee will give the financial year data.

## Conclusion

78. This report presents information to Members and the Force's current position on three key areas. This is the first report in this format, initially prompted by a number of HMIC and IPCC recommendations, but also recognising that these are important areas on which Members would wish to be informed. The data presented in this report will provide a baseline against which future annual reports can be considered, allowing a comparison to be made and potential issues or trends highlighted.

79. The City of London Police and City Corporation have processes in place to consider the welfare of children entering the custody environment and the force has further demonstrated its commitment by signing up to the 'Welfare of Children in Custody' Concordat. Data shows that on average around 10 children or young people enter City of London Police custody each month and over the period considered, none of these were charged and remanded overnight in police cells, with no requests made for overnight local authority secure accommodation. Data is captured by the Custody Manager on all children and young people entering police custody and shared with senior management, allowing on-going scrutiny and the identification of any potential issues.

80. The Force has standard operating procedures in place to manage mental health crises both in custody and outside on the street. CoLP does not use police cells as a place of safety for those identified as needing assistance on the street, with tried and tested processes in place under the agreement with the Homerton Hospital. Sadly, 129 people required assistance under section S.136 of the Mental Health Act in 2015/16, only 2 of these were under 18 and both were transported from the street direct to hospital. If someone is detained and a mental health issue is identified once in custody, a mental health assessment procedure is instigated. With the expected changes to the Mental Health Act under the upcoming Policing and Crime Bill, the Force is well placed to deal with these and will continue to monitor the situation to ensure our processes are updated in accordance.

81. There has been increased focus on police use of force as a result of the IPCC's comprehensive report considering all aspects of this area. A number of recommendations have come out of their study and the force has put together an action plan to assess compliance and monitor improvements in a number of areas. CoLP has recognised the importance of increased scrutiny in this area, setting up the Stop and Search and Use of Force working group to progress action plans and improve the recording, monitoring and transparency of data. A revised Community Scrutiny Group, considering use of force amongst other key areas, provides external scrutiny and will consider data quarterly, with this also being available on the force's website.

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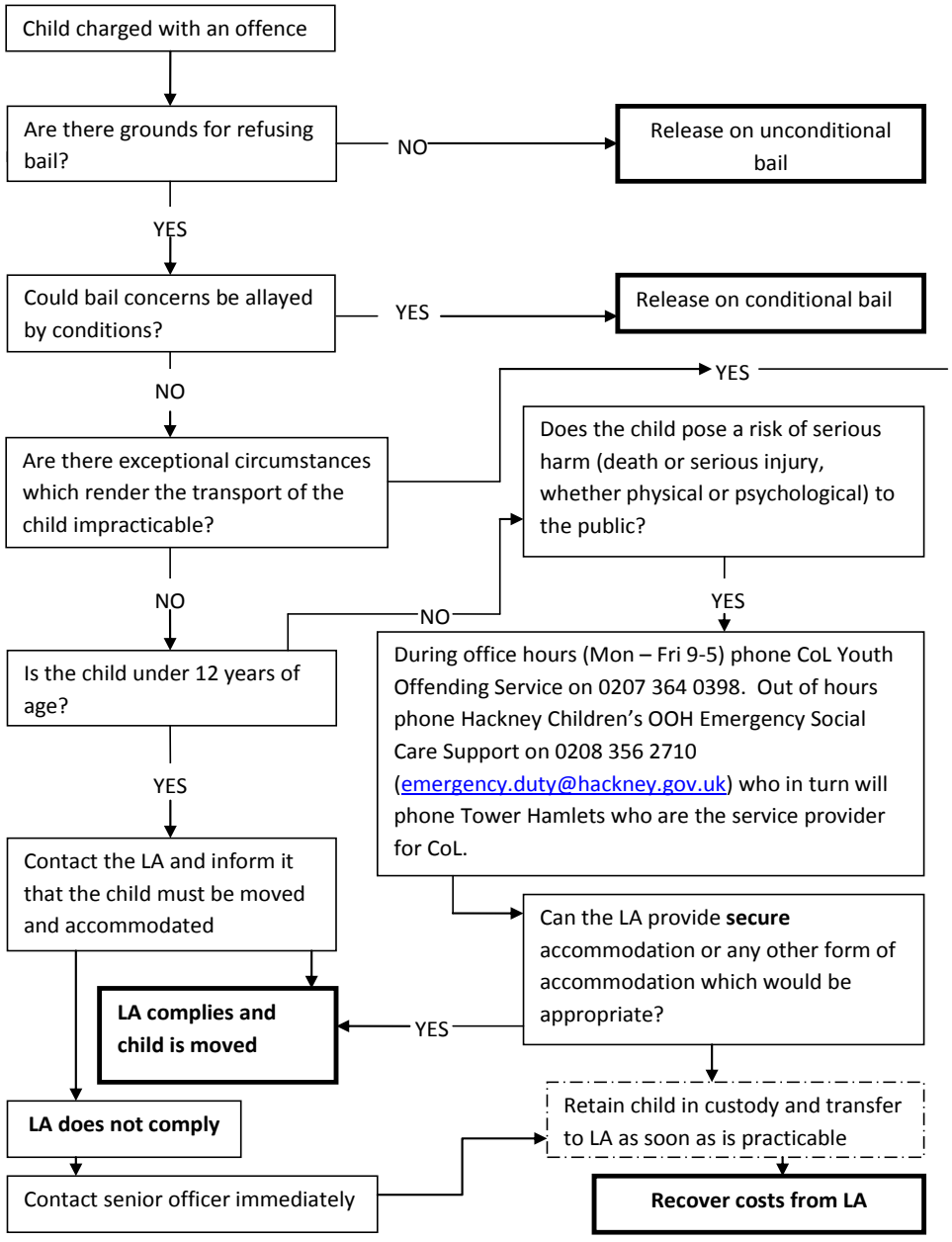
**Appendix 1 – flow chart of custody procedure for detained Young Person and Children**

CITY OF LONDON POLICE

**Police process for children in custody** PACE s.38(6)



## Appendix 2 – City of London process for finding accommodation for children

### 1. Purpose and scope of protocol

Children and young people can find being held in police custody distressing for a variety of reasons, and are recognised as being particularly vulnerable. Deprivation of liberty is to be likely the most invasive of state intervention in a child's life. The overriding principle of this protocol is that children should be bailed rather than remaining in police custody.
The purpose of this protocol is to reduce the time that children spend in police custody, by making pathways clear to suitable alternative accommodation where needed.
The protocol applies to children and young people who are aged between 10-16 years.
Reducing the time that children are in police custody requires clear communication and referral pathways. The City of London Corporation, due to unique composition, commissions its Youth Offending Service (YOS) from the London Borough of Tower Hamlets, and commissions its Emergency Duty Team (EDT) from the London Borough of Hackney. The City Corporation has its own police force. Therefore City of London children and young people may come to the attention of either the City of London Police or other police forces, most likely the Metropolitan Police.

This protocol aims to ensure that the City of London Police, Tower Hamlets and City of London YOS, Hackney EDT and City of London Children's Social Care Service work together to safeguard the welfare of young people held in police custody. The protocol covers:

- Interagency communication
- Alternatives to custody
- Welfare checks when children remain in custody
- Record keeping
- Monitoring the implementation of the protocol

The scope of the protocol covers those children who are denied police bail; it does not cover those children who are released on police bail who may need support and protection. In this case a referral to Children's Social Care would be required.

This protocol applies to young people who are subject to a PACE transfer (Police and Criminal Evidence Act 1984). The protocol does not cover those who are arrested for breach of bail or those held under warrant. These young people will be held in a police cell prior to their court appearance.

This protocol does not apply to secure accommodation being sought by the Local Authority on welfare grounds under s25 Children Act 1989.

## 2. Legal Framework

Section 38(6) of the Police and Criminal Evidence Act 1984 (PACE) requires that a young person who is denied bail and detained overnight be transferred to local authority accommodation unless the custody officer decides it is impracticable to do so (s38(6)(a)), impracticable meaning that no secure accommodation is available and alternative local authority accommodation would not be adequate to protect the public from serious harm (s38(6)(b).

Section 21(2)(b) Children Act 1989 says that every local authority shall receive and provide accommodation for children whom they are requested to receive under the above section of PACE .

## 3. Communication between the City of London police and City of London Children's Social Care

The City of London Police will alert Children's Social Care of all children or young people coming to the attention of the police, including those denied bail and detained in custody. The alert will be via a 377 report (known as Merlin Reports outside of the City of London), and the alert will be raised regardless of where the child ordinarily resides.

To note: outside a situation needing an immediate response, with lower risk of harm, the City of London Children's Social Care will review the alert and respond to the situation and to the police within 24 hours.

## 4. Procedures for seeking local authority accommodation

The underlying principle of this protocol is that wherever possible and safe, children should be bailed rather than remaining for long periods or overnight in a police cell.

Children under 12 years of age, and children between 10-16 with additional needs are likely to be particularly vulnerable in detention, and should not remain in custody overnight. Alternative accommodation should be arranged. In the rare incidence where bail cannot be given and alternative accommodation is not suitable, a decision to hold in the cell overnight should be made jointly by the Senior Inspector on Duty in conjunction with the Emergency Duty Team worker. Any such detention must be reported to the Assistant Director of the People Department the next working day.
High threshold for detention in police custody
In making any decision to deny bail, and consider local authority accommodation, the custody officer and EDT/YOS worker must show evidence of one the following:

- Failure to appear in court likely
- Further offences likely
- The child would suffer harm and needs incarceration for short term protection
- Others need protecting
- To protect police investigation
- Doubt as to identity/name/address
- The custody officer believes it is in the child's best interests

The social worker should advocate for the child to be bailed. The final decision rests with the custody officer. If bail is declined, then local authority accommodation should be considered. The social worker should seek suitable available accommodation and provide detail to the custody officer for consideration as to whether this would be an alternative to police detention or custody. Factors that might render local authority accommodation unsuitable would be risk to staff or other residents, including on transfer to, from and at placement. A child centred position will need to be taken on timing and placement.

All children in custody will have a telephone welfare check via EDT or YOS, dependant on the time of day.

Who to speak outside of ordinary working hours – 5pm to 9am, weekends and bank holidays
Whenever a child or young person is detained overnight in police custody in the City of London, the custody officer's first point of contact will be the Emergency Duty Team provided via Hackney Children's Services. This is regardless of where the child is ordinarily resident.

If the child or young person detained is ordinarily resident in the City of London, then the Emergency Duty Team worker will discuss alternative accommodation and suitability.

If the child or young person is resident outside of the City of London, then the custody sergeant needs to also call the Emergency Duty Team in the local authority in which they reside, to discuss alternative accommodation.

No child should be moved to a local authority placement after midnight, when a court appearance would be due in the morning, on account of the level of disruption resulting from the time taken to reach the placement, settling in to placement, and the need to allow for a period of sleep and then travel to court.

Who to speak to in the daytime – 9am to 5pm
If a resident child or young person is detained during the daytime in the City of London, then the custody officer's first point of contact is the duty worker at Tower Hamlets and City of London Youth Offending Service (YOS) (See communications manual).

If the child or young person detained is not ordinarily resident in the City of London, then the custody officer will call the Youth Offending Service responsible for that area.

## 5. Recording and monitoring

CoL Children's Social Care uses Frameworki (FWi), The London Borough of Hackney records on Frameworki for all our EDT work, and the Tower Hamlets and City of London YOS uses YOIS. A protocol between City of London Children's Social Care and the Emergency Duty Team at the London Borough of Hackney agrees that EDT workers use Frameworki to record all work for the City of London. Email and telephone provide back up as needed.

Each child in custody must have a police record, and a social care record (at least a contact note). All contacts and conversations will be recorded in writing, YOS on YOIS, EDT and Children's Social Care on Frameworki, and the police on their system. This will include decision and rationale to deny bail, and decision and rationale to agree local authority accommodation.

The City of London commissions an Appropriate Adult service, and the City of London police will contact this service for all children in custody (see communication manual).

City and Tower Hamlets YOS, and City and Hackney EDT will provide quarterly reports on the young people detained in custody as part of their quarterly monitoring returns. This will be collated for the City of London Children's Social care, by the commissioning service.

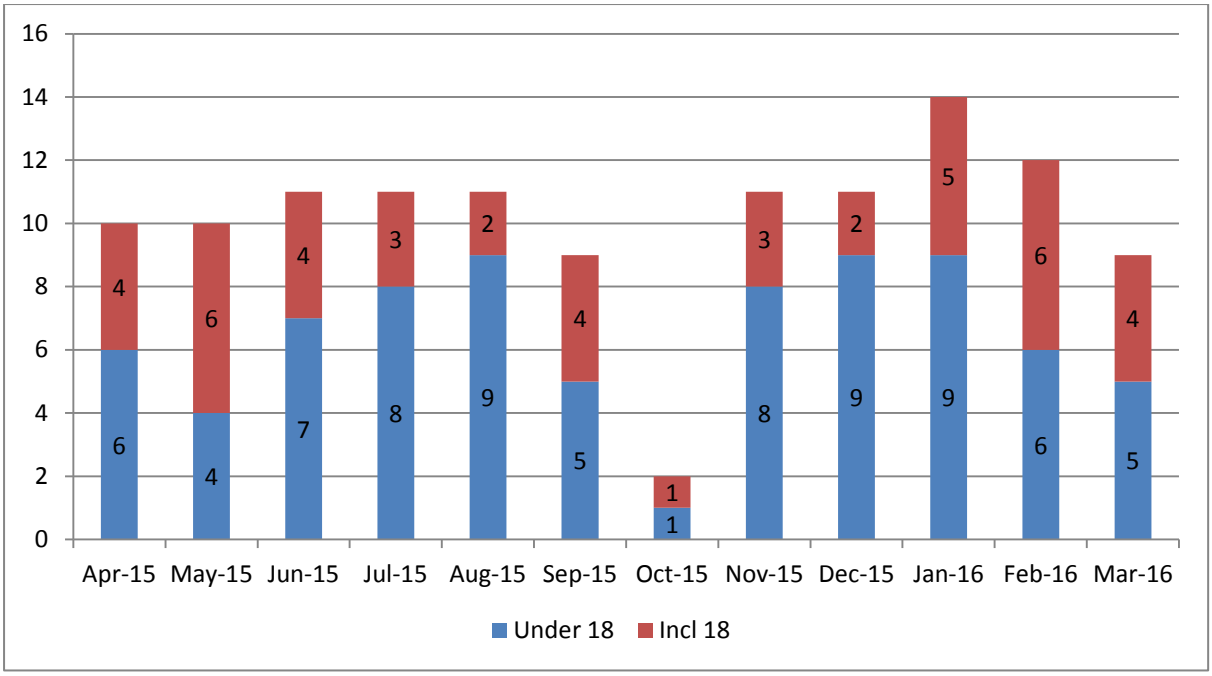
## 6. Summary

a. As per current agreement, City of London Children's Social Care will be informed of all children coming to notice of City of London police via 377 (Merlin) notification.
b. The custody officer must always inform the home Local Authority of any young person denied bail, and who they intend to keep in custody.
c. If the home authority is the City of London Corporation, between 9am-5pm, the custody officer will inform City and Tower Hamlet's YOS. Out of hours, the custody officer will call City and Hackney's Emergency Duty Team.
d. The custody officer can contact City of London Children's Social Care between 9am-5pm for advice and guidance as needed.
e. The presumption will be that bail will be given.
f. Where bail is not allowed, the custody officer will call EDT/YOS and discuss local authority accommodation. The young person should then be transferred to this accommodation.
g. Where such accommodation is unsuitable, decisions must be made jointly by the custody officer and the local authority officer and recorded.

h. The Assistant Director of the People Department will be informed of any child with additional needs who is detained in police custody on the next working day.

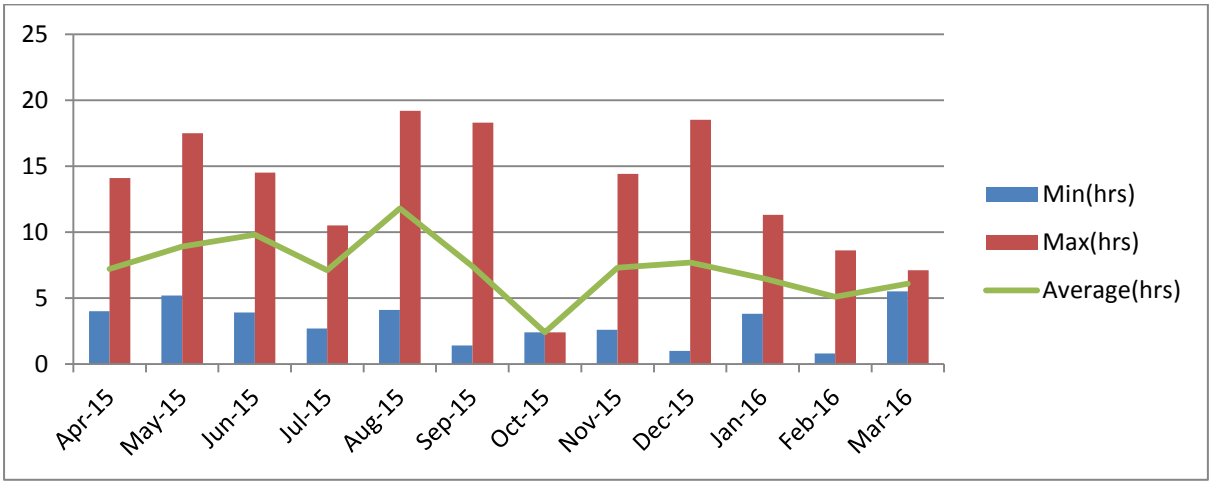
# Appendix 3 – Custody Data: Children and Young Persons

**Figure 1: Number of children and young people including 18 year olds in custody 2015/16**




**Source: NSPIS Custody System**

**Figure 2: Length of time detained [under 18]**



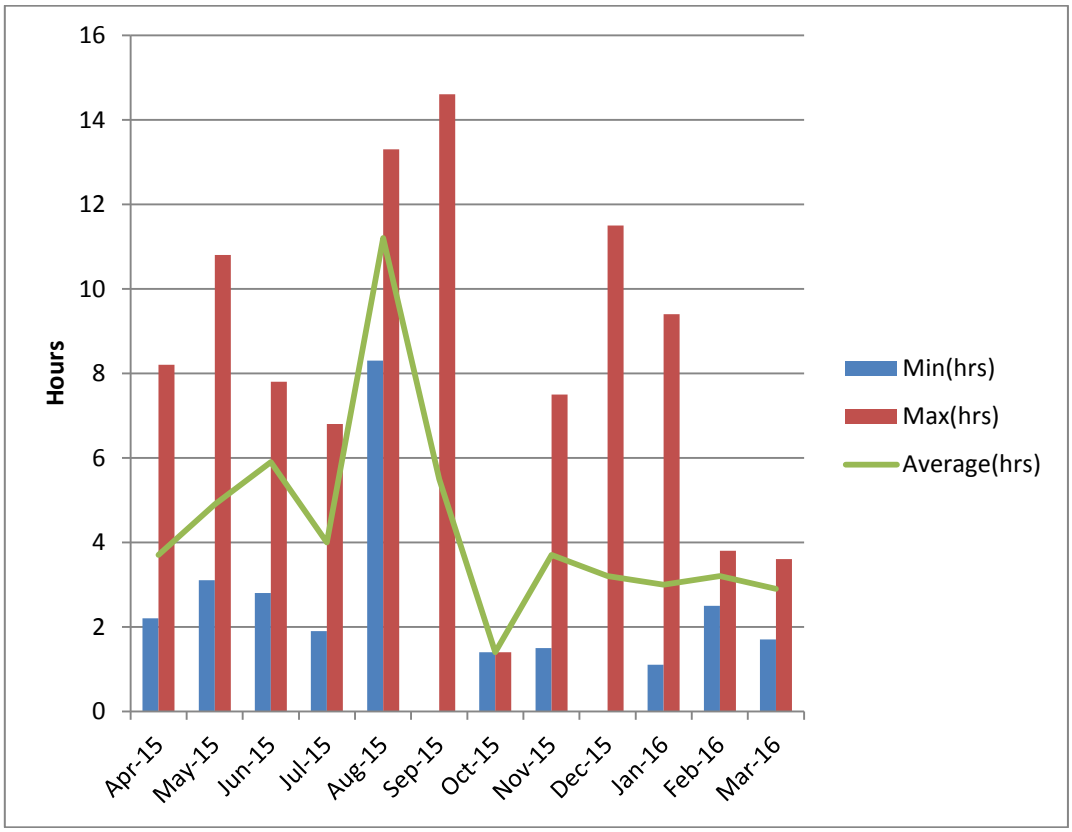

**Source: NSPIS Custody System**

**Figure 3: Average time spent in police custody by children and young people 2015/16**

| Year | Month | Time |
|---|---|---|
| 2015 | April | 7.2hrs |
| 2015 | May | 8.9hrs |
| 2015 | June | 9.8hrs |
| 2015 | July | 7.1hrs |
| 2015 | August | 11.8hrs |
| 2015 | September | 7.4hrs |
| 2015 | October | 2.4hrs |
| 2015 | November | 7.3hrs |
| 2015 | December | 7.7hrs |
| 2016 | January | 6.5hrs |
| 2016 | February | 5.1hrs |
| 2016 | March | 6.1hrs |

**Source: NSPIS Custody System**

**Figure 4: Minimum and maximum length of time spent whilst waiting for an appropriate adult**



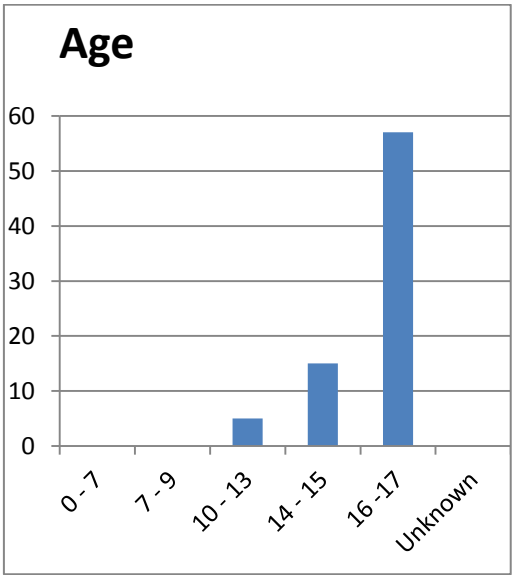

**Source: NSPIS Custody System**

**Figure 5: Average length of time spent awaiting an appropriate adult 2015/16**

| Year | Month | Time |
|---|---|---|
| 2015 | April | 3.7hrs |
| 2015 | May | 4.9hrs |
| 2015 | June | 5.9hrs |
| 2015 | July | 4hrs |
| 2015 | August | 11.2hrs |
| 2015 | September | 5.5hrs |
| 2015 | October | 1.4hrs |
| 2015 | November | 3.7hrs |
| 2015 | December | 3.2hrs |
| 2016 | January | 3hrs |
| 2016 | February | 3.2hrs |
| 2016 | March | 2.9hrs |

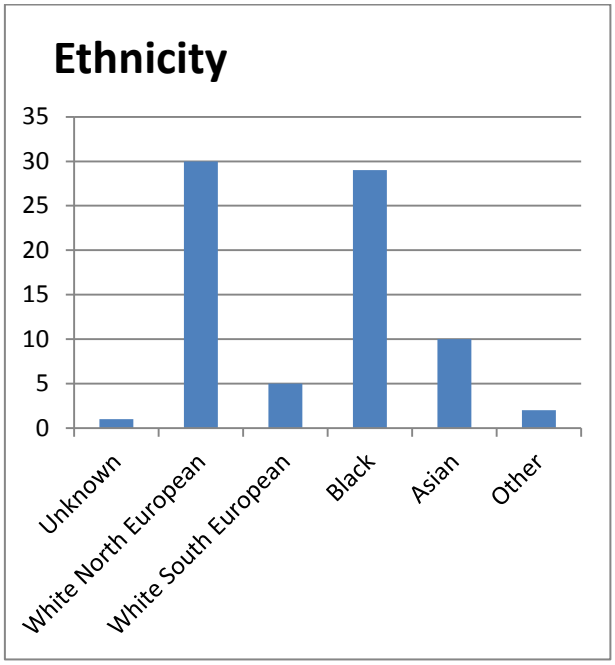
**Source: NSPIS Custody System**

**Figure 6: Children and young people in police custody by age 2015/16**



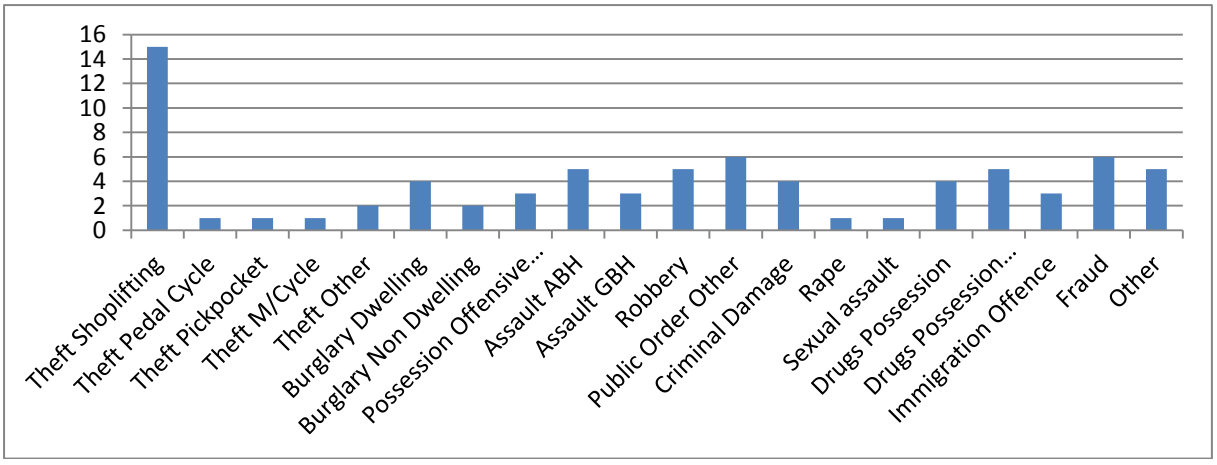

**Source: NSPIS Custody System**

**Figure 7: Children and young people in police custody by ethnicity 2015/16**




**Source: NSPIS Custody System**

**Figure 8: Offences for which children and young people held in police custody 2015/16**




**Source: NSPIS Custody System**

## Appendix 4 - Section 136 Mental Health Act 1983

**Figure 9 Age of people suffering Mental Health Crisis**

| 136 MHA 1983 during Apr 2015- Mar 2016 | 136 MHA |
|---|---|
| | |
| 18 and over | 126 |
| Under 18 | 2 |
| Unknown | 1 |
| | Total 129 |

**Source: CoLP Community Engagement**

**Figure 10 Method of transportation from scene of Mental Health Crisis**

| 136 MHA 1983 during Apr 2015- Mar 2016 | Number |
|---|---|
| | |
| Ambulance | 75 |
| Police Vehicle | 52 |
| Unknown | 2 |
| | Total 129 |

**Source: CoLP Community Engagement**

**Figure 11 Place of safety attended following Mental Health Crisis**

| 136 MHA 1983 during Apr 2015- Mar 2016 | |
|---|---|
| | |
| Hospital | 126 |
| Reception at police station | 2 |
| Private Home | 2 |
| | Total 129 |

**Source: CoLP Community Engagement**

### Background Documents

1) Use of Force Data (Showing Suspect Gender, Ethnicity and Age with Use of Force reason (between August 2015 - July 2016)
2) IPCC Report: Use of Force
3) NPCC Use of Force Monitoring Form: Guidance
4) NPCC Use of Force Monitoring Form

| **Committee(s)** | **Dated:** |
|---|---|
| Safeguarding Sub Committee | 17 November 2016 |
| **Subject:**<br>Annual Quality Assurance Report 2015 to 2016 | **Public** |
| **Report of:**<br>Director of Community and Children's Services | **For Information** |
| **Report author:**<br>Pat Dixon, Safeguarding and Quality Assurance Service Manager | |


**Summary**

This report reviews the quality assurance activity that has taken place within Children's Social Care between April 2015 and March 2016, identifying the themes, recommendations and progress that have been made in line with the quality assurance framework.

This report identifies considerable strengths in frontline practice and line of sight from the departmental Leadership Team and Members. Where there have been areas for further development, there is evidence that progress is being made and monitored through the Service Improvement Board.


**Recommendation(s)**

Members are asked to:

- Note the report.

**Main Report**

**Background**

1. In April 2015, a restructure of Children's Social Care took place, along with changes in staff within the social work team and management structure. Part of this restructure was the development of a new Safeguarding and Quality Assurance Service, which corresponded with the independent reviewing services being delivered by the City of London Corporation. The purpose of bringing the independent reviewing services in-house was to improve the quality of the service provided and to give independent scrutiny to frontline practice in the Children and Families Team.

2. The quality assurance framework has been revised and updated since April 2015 and the Annual Quality Assurance Report has reviewed the activity that has taken place since April 2015 through to April 2016 using this framework. The report reviews the quality assurance activity, establishing whether there has been compliance, and the impact this has had on frontline practice.

**Current Position**

3. The report identifies that there has been a considerable amount of quality assurance activity over the past year, indicating compliance with the framework. The following is a list of some of the activity that took place:

    - Early Help audits were completed in August 2015, November 2015 and February 2016.

    - Thematic audits were carried out in June 2015 in the following areas
      children in need
      child protection
      children looked after
      pathway plans
      compliance with guidance on children missing from care
      the range of interventions being used with families
      how care leavers are being supported around housing issues.

    - Aidhour audits were completed on all open cases and on eight closed cases in September 2015.

    - In July 2015, Action for Children carried out its annual consultation which focused on feedback from children looked after, children subject to a child protection plan, children in need and care leavers. There was also a consultation carried out in March 2016 on cases that had been closed between July and December 2015.

    - In September 2015 and February 2016, three multi-agency audits were completed through the City and Hackney Safeguarding Children's Board (CHSCB) with themes identified by the CHSCB quality assurance sub group. Themes explored in September 2015 included 'the journey of the child' and in February 2016 there was a focus on children with disabilities.

    - The Assistant Director People has oversight on case work and annual visits to children looked after in the City.

    - Quality assurance activity also took place through the top 3 forum, which explores cases that cut across services.

    - Line of sight on cases was also undertaken by the Director of Community and Children's Services and the lead Member.

**Overall strengths identified by audits**

- Overall, the outcomes for children and young people in the City of London are good, and at times outstanding.
- There is good evidence of multi-agency working on case files and the majority of assessments.
- The Assistant Director People writes annually to all the children looked after to arrange to see them in placement.
- Supervision is clear and concise, with timely actions; there is also evidence of case discussion and reflection.
- The in-house Independent Reviewing Officer (IRO) service has significantly improved the service for children looked after, and children subject to a child protection plan.
- Reports and plans for children and young people are child-focused and permanency plans are now in place.
- There is evidence of independent challenge from the IRO in reviews and conferences.
- Children and young people are seen by the IRO between reviews; recordings of these visits are child-focused and show a good relationship between the IRO and the young person.
- Staying put arrangements for care leavers are supported and encouraged; overall, placement stability is good.
- There are good examples of direct work with children by social workers and recordings of visits give a clear picture of the child.
- The majority of the assessments completed are good and show a child-focused approach.
- There is good support for children and young people in relation to their emotional and mental wellbeing. All young people are offered a Child and Adolescent Mental Health Services (CAMHS) assessment when coming into care.

**Overall areas for development**

- Review of templates for care planning to support an outcomes-focused approach: this has been actioned and a full review of templates completed.

- Life story work to be progressed with children looked after as soon as they come into care and with care leavers: this has been actioned and there is evidence that engagement in life story work between social workers and children looked after happens at early stage after children come into care.

- Ensure that in cases where statutory intervention is not required, but the engagement with the family or young person is proving difficult is clearly recorded in the case files; the recordings must set out the reasons why the children and family were not seen and the attempts that have been made to engage families.

- Thresholds for the step-up and step-down process in a small number of cases are not being applied appropriately when there are safeguarding concerns and consent has not been given by parents. Action linked to commissioning of research into work with affluent families.

- Ensure pathway plans are updated: this has been actioned following audit feedback.

- Ensure return interviews for children who go missing are commissioned and carried out within timescales: this has been actioned.

4. The Service Improvement Plan incorporates all the recommendations that have been identified from the quality assurance process, and these are progressed with the team through supervision and team meetings. There is oversight of this plan by Service Improvement Board, which is independently chaired; this board offers strategic oversight and challenge around improving the quality and standard of practice in the City of London.

**Conclusion**

5. This report identifies that there are considerable strengths in frontline practice and line of sight from the departmental Leadership Team and Members. The areas of development are being progressed through the Service Improvement Plan which is managed by the Children's Social Care and Early Help Service Manager. The Service Improvement Plan is reviewed and updated at the quality assurance meetings that take place on a quarterly basis. There is also strategic oversight of this plan by the independently chaired Service Improvement Board.

**Appendices**

- Appendix 1 – Annual Quality Assurance Report

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# Annual Quality Assurance Report

# April 2015 to April 2016

**Introduction**

In April 2015 a restructure of Children's Social Care took place, this corresponded with changes in staff within the social work team and management structure. Part of this restructure was the formation of a new Safeguarding and Quality Assurance Service, which corresponded with the independent reviewing service being delivered by the City of London. This provided independent scrutiny, as it separated this service from the Children and Families Team, which is a generic children's team that covers commissioned adoption services, early help, children in need, children with disabilities, child protection, children looked after and care leavers.

The total number of cases open to the Children and Families Team at and the end of April 2016 was 66. The average case load for a social worker is between 13 to 15 cases, and the case loads are varied, covering the full range of services offered by the team. This requires a good understanding of the legal framework that covers these services and the guidance that goes alongside.

This report will review the quality assurance activity that has taken place within Children's Social Care between April 2015 and March 2016, identifying strengths and areas for development in line with the quality assurance framework. Recommendations for service improvement have been fed back as part of the quality assurance cycle are noted within the identified areas for development set out in the report.

**Quality Assurance Activity**

For the purpose of this report I have reviewed the quality assurance activity that has taken place from April 2015 through to April 2016 in regard to the Children and Families Team, reviewing the outcomes and progress from the following audits and quality assurance activity that has taken place;

- Quarterly Early Help audits
- Thematic audits carried out in June 2015 on Children in Need, Child Protection, Children Looked After including pathway planning and Missing arrangements.
- Aidhour audit cycle completed on all open cases and 8 closed cases in quarter 3 2015.
- Multi- agency audits completed bi-annually through the City and Hackney Safeguarding Children's Board, (CHSCB) with theme's identified by the CHSCB quality assurance sub group.
- The Assistant Director of People's oversight of case work and annual visits to Children Looked After in the City.
- Information from the Director Community and Children's Services and Lead Member.

There is evidence through the above activity that the Quality Assurance Framework has been implemented and imbedded into practice.

The framework has been under constant review to ensure that it meets the needs of the service and the following amendments have been made:

- changes to the auditing tool being used, to support a clear and coherent analysis on frontline practice
- rationalising the auditing cycle to minimise the impact on frontline practitioners, whilst keeping a line of sight over practice.

Findings from audit form part of a continuous cycle of improvement. Case specific findings are fed back to social workers and the Team Manager in a timely fashion. Thematic findings are fed into the service improvement work led by the Children Families Service Manager via quarterly quality assurance meetings between the Safeguarding and Quality Assurance service and the Children and Families management team. Finally, thematic findings that form part of the service improvement plan are fed into the Children Services Senior Management Team, Departmental Leadership Team and the Service Improvement Board.

**Overall Strength Identified by Audits**

- Overall the outcomes for Children and Young People in the City of London are good, and at times outstanding.
- There is good evidence of multi-agency working on case files and the majority of assessments.
- The AD of People writes to all the children looked after annually to arrange to see them in placement.
- Supervision is clear and concise, with timely actions; there is also evidence of case discussion and reflection.

- The in-house IRO service has significantly improved the service for Children Looked After, and children subject to a Child Protection Plan.
- Reports and plans for children and young people are child focused and permanency plans are now in place.
- There is evidence of independent challenge from the IRO in reviews and conferences.
- Children and young people are seen by the IRO between reviews, recording s of these visits are child focused and show a good relationship between the IRO and the young person.
- Staying put arrangements for care leavers are supported and encouraged, overall placement stability is good.
- There are good examples of direct work with children by the social workers and recording of visits give a clear picture of the child.
- The majority of the assessments completed are good and evidence a child focused approach.
- There is good support for children and young people in relation to the emotional and mental wellbeing, all young people are offered a CAMHS assessment when coming into care.

**Overall Development Areas identified by Audits**

- Review of templates around care planning to support an outcome focused approach. This has been actioned with full review of templates completed.
- Life story work to be progressed with Children Looked After and Care Leavers as soon as coming into care; This has been actioned with evidence of engagement between Social Workers and CLA around life story happening at early stage after coming into care.
- Ensure that in CIN cases where engagement with families or young people are proving difficult and where statutory interventions are not required, case files to set out reasons clearly and attempts made to engage families. Action linked to commissioning of research into work with affluent families.
- Thresholds around the step up and step down process in a small number of cases are not being applied appropriately when there are safeguarding concerns and consent is not being given by parents
- Ensure Pathway Plans are updated. This has been actioned following audit feedback.
- Ensure return interviews for children who go missing are commissioned and carried out within timescales. This has been actioned**.**

**Five Early Help Audits**

Early help auditing takes place on a quarterly basis. Findings are reported to the EH Sub Group. Audits identified that overall, the offer of early help is strong. CAF activity is undertaken by the Early Help worker, and engagement from school and health is positive and has an impact on the lives of the children and families engaged in the process.

Areas for development included:

- Audits identified the need to ensure practice standards regarding CAF process were understood. This was actioned through development work carried out by the EH Coordinator.
- Information sharing and consent in respect of CAF quality assurance needed to be understood by partners. This was actioned via the EH sub group.

**Aidhour audit cycle in Quarter 3 and Quarter 4**
Aidhour were commissioned to complete audits on all the cases open and eight closed cases in Quarter 3 and 4. Audits were initially completed from data from Frameworki; revisions were made to some of the audits following discussion with the case workers. Follow up review of audits to check on progress was carried out end of Quarter3. Smaller audit was completed in Quarter 4.

The Children and Families service fully engaged in the audit and addressed audit findings in a timely fashion. Social workers fed back that they found the direct engagement with auditors helpful.

The areas of strength and development from these audits have been highlighted above. In addition to the findings, in terms of process the audit identified that on occasion information such as ethnicity and documents were not always uploaded onto Frameworki in a timely fashion. This could be improved by the improved use of the compliance and administration officer functions in the service thereby relieving pressure on social work time. As a result of this, the People Senior Management Team has commissioned an Administration Review to help improve efficiency and effectiveness of administration processes.

**Multi- Agency Audits**
The joint City and Hackney Safeguarding Children Board carry out multi-agency audits in the corresponding local authorities twice a year; these audits inform the board of the strengths of multi-agency practice and identify area of improvement, both in terms of practice and organisational leadership. Identified actions from these audits are then included onto an action plan and monitored through the QA sub group of the board.

**Overall Strengths**
- Evidence that agencies were contributing towards assessments and working together to meet the needs of the child.
- Agencies co-ordinated resources to support the family during a difficult time.
- Evidence of a “Think Family Approach” between adult and children’s services.
- Communication between partner agencies in supporting families’ engagement with agencies.
- The use of escalation procedures when required, resulting in the engagement of the agency in the child protection process.
- Agencies were able to balance the needs and vulnerabilities of the parent, whilst not losing focus on the child.

- Early identification of risk from partner agencies which contributed to a cohesive approach in supporting a mother and baby.
- Evidence of professional awareness around potential risks when managing domestic abuse.
- Professional going above and beyond their remit to ensure continuity to children and families, Health visitor support child until he was settled in school.

**Areas for Development**

- Surgeries to be aware and provide services for patients with a disability. This has been actioned by the Lead health professional who supported surgery in reviewing their practices in relation to patients with disabilities.
- Health Visitors are to be given a comprehensive handover on new cases. This has been actioned by the Lead health professional has reviewed the protocol in regard to cases and this is in place and being used.
- Staff need to receive monthly supervision which is clear in regard to decision making and timely. This has been progressed and is evidenced by auditing process.
- For professionals to know and understand the Child Protection Conference process and their role. This has been actioned by the service and CP chair.
- Not allowing litigious parents to distract the focus away from the children by making threats. Research by Goldsmiths commissioned to explore link between neglect and affluence and role of social work in tackling this. Report due summer 2016.

**Feedback from visits carried out by Assistant Director People**

The Assistant Director of People visited six young people in their placement, all those contacted knew who their social worker and how to contact them.

- All young people spoke very positively about their relationship with their social worker. It was clear that young people felt supported by their Social Worker.
- Several young people were able to immediately produce contact details for both their social worker and IRO wanting to demonstrate that they had their details on their phones. Nobody complained that they had difficulty contacting their social worker or IRO.
- All the looked after children knew of the Virtual School Head (VSH). There was less immediate recognition of the VSH compared to the social worker and IRO but again, when prompted all were able to say that they were aware of who the VSH was.
- They were also to reference the role of the VSH regarding PEPs and cited examples of the VSH attending college and schools for PEP meetings. Less young people knew how to contact the VSH compared to the social worker and IRO.
- In relation to foster carer's feedback, all knew how to contact the social worker, IRO and VSH. Several carers spoke very highly of the support provided by each professional for example, one carer stated that they had never had an IRO visit any of the children in placement in between reviews in the way the City IRO had done so.
- At the time of visiting all but 1 of the placements were stable. The young person in the less stable placement was going through a planned placement move. Despite the associated challenges in this case, the young person stated that they felt very much supported by their social worker.

**Additional interventions**
Following the visits further suggested interventions were fed back to the service including;

- Work experience was set up in the CoL Corporation Public Relations Office for 1 young person wanting to pursue a career in journalism.
- Cricket development opportunities were arranged via Lords/ MCC development training programme for 2 young people.
- Funding of extra tuition arrangements were addressed for 1 young person
- The IRO will be continuing to promote their role via work with the CiCC.

**Quality Assurance oversight Departmental Leadership Team**
The following activities have been undertaken by the Assistant Director People during Quarters 3 and 4 2015/16.

**Visits to Children Looked After**
The AD carried out a number of visits to CLA( 55% of CLA population) in their placements as part of the bi-annual programme of visits.

The visits form part of the AD's quality assurance activity and focus on exploring the quality of the relationship between the young person and the service as a corporate parent.

**Audit**
As part of the implementation of the QA strategy, the AD chaired 'Getting to Good' oversight improvement meeting of cases that were judged as Requires Improvement.

Following the 2015/16 quarter three audit programme, six cases were subject to review through this forum. Learning from this exercise included;

- An assurance report that confirmed the status of all CLA and Care Leavers having a Passport/ Birth Certificate/ NI number and actions required to ensure where applicable this documentation was available.
- The placement sufficiency strategy was reviewed. Confirmation that placement finding following disruption was robust and effective.
- Evidence that learning from case audits had been fed back into the management / supervision process.

**Performance Monitoring**
Fortnightly performance monitoring meetings chaired by the AD provided oversight of front door activity and provided basis to determine if caseloads are manageable, compliance against practice standards were met and decision making was timely and effective.

This forum has supported the need to build additional social work capacity to meet increasing CLA demand; monitored impact of front door oversight of non-City resident contacts and overseen partnership referral activity.

**Permanency Planning Tracking meetings**
On a quarterly basis, the AD People chairs the Permanency Planning Tracking meetings. This forum invites social workers to set out the permanency plans for all CLA, ensuring that drift is avoided and actions undertaken to secure permanency as soon as is possible.

Through the challenge and support provided via this forum, delaying issues in relation to a SGO process were identified and addressed. The learning from this supported the timely implementation of a second SGO for a City CLA.

**Director of Community and Children's Services and Lead Member**
The Director of Community and Children's Services has a clear line of sight on frontline practice, reviewing cases files on Frameworki on an ad hock basis. He has also reviewed two cases in depth, which has involved discussions with the allocated social workers.

The following meetings have also been observed by the Lead Member:

- The Multi-Agency Sexual Exploitation (MASE) meeting.
- A Child in Need Review, with the parents' consent.
- Observed a Child Protection Conference in May 2016.
- Attended Children's Executive Board.
- City Safeguarding Executive and the LSCB.

Members also receive regular updates in the Safeguarding subcommittee from the Children and Families Team and the Safeguarding and Quality Assurance Service on the performance and key priorities of Children's Social Care Service.

**Conclusion**

This annual report gives an overview of the quality assurance activity that has taken place between 2015 and 2016 in line with the Quality Assurance Framework. The report has focused on highlighting key strengths and areas of development that audit and quality assurance activity has identified.

As highlighted in this report, quality assurance activity has a demonstrable impact on the quality of work carried out by the Children and Families and partners. As previously noted, there is clear evidence that the findings from audits are being fed back to social workers and the Team Manager, and are being acted upon in a timely fashion. Furthermore, the thematic findings are fed directly into the Children and Families Service improvement plan which is monitored by the Children Services Senior Management Team, Departmental Leadership Team and the Service Improvement Board.

It is positive that as a result of audit activity, there has been evidence of improvement in respect of life story work, pathway planning and missing interviews. Future audit activity will include focus on ensuring that progress in these and the other areas identified for improvement are sustained.

This report identifies considerable strengths around frontline practice and line of sight from the Departmental Leadership Team and Members. In terms of supporting potential improved efficiency and effectiveness of practice, an administration review will be undertaken that will potentially relieve admin burdens on social workers and ensure that admin process and documentation management do not detract from the core business of social workers carrying out high quality direct work with their children and families.

**Pat Dixon**
**Safeguarding and Quality Assurance Service Manager**
**May 2016**

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| **Committee:** | **Dated:** |
|---|---|
| Safeguarding Sub Committee | 17 November 2016 |
| **Subject:**<br>Self-Neglect (and Chronic Hoarding) Protocol | **Public** |
| **Report of:**<br>Director of Community and Children's Services<br><br>**Report author:**<br>Marion Willicome-Lang,<br>Service Manager, Adult Social Care | **For Information** |


**Summary**

This report summarises the City and Hackney Safeguarding Adults Board Self-Neglect (and Chronic Hoarding) Protocol, and describes its operational implementation through the City of London Multi-Agency Self-Neglect and Hoarding Panel which has met monthly since January 2016.


**Recommendation(s)**

Members are asked to:

- Note the report and accompanying Self-Neglect Protocol.

**Main Report**

**Background**

1. The Care Act 2014 formally recognised self-neglect as a category of abuse and neglect, and has brought self-neglect within the statutorily constituted functions of the City and Hackney Safeguarding Adults Board (CHSAB).

2. A Self-Neglect Protocol was approved by the CHSAB in December 2016, and applies to all partner agencies represented on the CHSAB.

3. The City of London set up a Self-Neglect and Hoarding Panel in January 2016, chaired by the Service Manager Adult Social Care (ASC).

**Current Position**

The Panel

4. The Panel meets monthly and seeks to provide a person-centred and effective multi-agency response to situations where the person referred has been assessed as at a high level of risk as a result of complex self-neglect issues.

5. The Panel seeks to ensure that all relevant agencies work together to provide a co-ordinated and accountable response to the person presenting issues/risks.

6. The Panel, wherever possible, will focus on the outcomes that the person wants to achieve, given their individual circumstance and risks, including their mental capacity and right to make an unwise decision (if they have been assessed as having mental capacity), unless there is a clear risk of significant harm to that person or others. This work is carried out at all times in the least restrictive way possible.

7. The Panel will provide update reports to the CHSAB as requested, presenting high-risk issues and the number of referrals to the Panel, and reporting fully through the annual reporting process.

8. The City of London Panel has a core membership which comprises,

    - City of London Adult Social Care
    - City of London Housing
    - City of London Environmental health
    - City of London Public Health
    - City and Hackney Clinical Commissioning Group (CCG) or Tower Hamlets CCG GP (specific to case )
    - City of London Legal
    - MRS Independent Living (a voluntary organisation commissioned by One City Hackney)
    - City of London Fire Brigade

    Other agency representatives may be required on a case-by-case basis, such as City of London Police, Tenancy Sustainment and Wellbeing co-ordinators, Drug and Alcohol services, Trading Standards etc.

9. Due to the complex and diverse nature of self-neglect, responses by a range of organisations are seen to be more effective than a single agency response. Sharing information between organisations will usually require the person's consent and each organisation must consider when it is appropriate to share information without the person's consent, for example if there is a public or vital interest.

The Protocol

10. The Protocol sets out the presenting difficulties of self-neglect and hoarding and seeks to give a range of explanations for these behaviours, including mental health and mental capacity; it also sets out good practice guidance for multi-agency practitioners.

11. The Protocol identifies the often difficult balance to be struck between respecting an individual's autonomy and having a duty of care. It is important to understand each individual's situation. Both the Care Act and *Making Safeguarding Personal* (Local Government Association, 2014) emphasise the importance of involving the person, wherever possible, in decision making and focusing on the outcomes that the person wants to achieve. If there is an assessed risk of significant harm to others, or if the person lacks the capacity to make the relevant decisions, the Protocol refers to the professionals' duty of care that may require them to override an individual's right to exercise choice and control.

12. Any restrictions imposed for the protection of the person or others must have the proper lawful authorisation, such as a decision by the police or a court order.

13. The Protocol goes on to describe the role of each service, examines the risks, and sets out the processes for practitioners to follow, which illustrate the pathway to a case being referred to the Panel.

14. The Protocol also sets out a useful legislative guide (appendix 4), listing all the multi-agency laws that can be enacted in relation to specific cases.

15. Appendix 6 of the Protocol is the London Fire Brigade's Clutter Image Rating, which has become a nationally recognised tool for assessing the extent and level of risk around hoarding and self-neglect.

16. Adult Safeguarding plays a crucial role within the City of London. As partners of the CHSAB, we have signed up to the Protocol and implemented the Panel which, since January 2016, has discussed five cases with successful ongoing plans of action for four of them. This has involved a full multi-agency response and full attendance at all monthly panels to date. Future performance information on the impact of the Protocol will be presented as part of the performance reporting to this Sub Committee.

**Corporate & Strategic Implications**

17. Safeguarding is priority 1 of the Department of Community and Children's Services Business Plan. The City of London is fully legally compliant with the statutory safeguarding requirements as set out in the Care Act 2014.

**Conclusion**

18. This report sets out how the new Protocol is being applied within the City of London.

**Appendices**

- Appendix 1 – The City and Hackney Safeguarding Adults Board Self-Neglect (and Chronic Hoarding) Protocol 2016

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City and Hackney
Safeguarding Adults Board

# SELF- NEGLECT
# (INCLUDING CHRONIC HOARDING)
# PROTOCOL

# Contents

## 1) Partners to the protocol

The London Borough of Hackney Council
The Metropolitan Police (City of London and Hackney)
The City of London Corporation
The London Fire Brigade
The London Probation Service
Hackney Council for Voluntary Services
Homerton University Hospital NHS Foundation Trust
East London NHS Foundation Trust
City and Hackney Clinical Commissioning Group
Care Quality Commission
Barts Health NHS Trust
Hackney Healthwatch
City of London Healthwatch
London Ambulance Service

## 2) Introduction

"***Self-neglect covers a wide range of behaviour - neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding."***
***(Department of Health, 2014)***

Self-neglect often involves an interplay between mental, physical, social and environmental factors. There is no clear point at which lifestyle patterns become self-neglect, and the term can apply to a wide range of behaviour and different degrees of self-neglect. Social and environmental factors and physical health issues such as visual impairment and restricted mobility often contribute towards self - neglect and hoarding. Key triggers include: disability, poverty, lack of physical space in the home, and inequalities in terms of access to health and social care services.

Sometimes professional concerns do not match the individual's own perception of their situation. Adults that self-neglect usually have longstanding, recurring, complex needs and/or present with particular behaviours that mean they are difficult to work with.

Some people are difficult to engage with because of presenting behaviours associated with diagnosed or undiagnosed mental health problems, substance misuse/dependency issues, cognitive impairments or other anti-social behaviours.

Working with adults who self-neglect can be very time consuming and stressful for staff as there are no straightforward and proven approaches available to follow. In most instances of self-neglect the person is assessed as having the mental capacity to make relevant decisions in relation to their self-neglect. However, their behaviour may include not wishing to engage with services to make any changes to their

situation. Risks as a result of this lack of engagement include: social isolation, verbal abuse, homelessness and a risk to health and wellbeing.

Research (*Self-neglect and adult safeguarding: findings from research, SCIE report 46, 2011)* suggests that a multi-agency, multi professional and multidisciplinary approach to self-neglect is the most effective one.

The Care Act 2014 has formally recognised self-neglect as a category of abuse and neglect and has brought self-neglect within the statutorily constituted functions of the City and Hackney Safeguarding Adults Board (CHSAB). This protocol is issued by the CHSAB and applies to all agencies represented on the CHSAB. It is outcome focused and outlines who is best placed to engage with the vulnerable person who self-neglects and how a coordinated multi-agency/multi-disciplinary/multi-professional approach should assist in achieving the best possible result. It offers clear guidance to operational staff and managers on how the needs or presenting problems of difficult to engage vulnerable adults who self-neglect should be addressed.

## 3) Aims of the protocol:

- to improve the management of adults who self-neglect
- to engage with, and support, those in the local community such as friends, relatives and neighbours who are often best placed to work with the person who is self-neglecting
- to facilitate appropriate outcome focused, solution-based intervention and support
- to facilitate people to remain in their own homes and reduce the risk of homelessness as a result of self –neglect issues such as hoarding and rent arrears
- to improve the co-ordination of services between agencies in taking responsibility for the management and support of adults who self –neglect
- to establish best practice guidance
- to improve knowledge of the relevant legislation.

## 4) Key Principles of the protocol

This protocol is based on the following principles:

1. the most effective approach to self-neglect is to use consensual and relationship-based approaches. These may be more effective if carried out by, or in partnership with, non-statutory parties including family members, friends, housing officers, charities and voluntary sector organisations

2. the rights of individuals under the Human Rights Act (1998) should be supported and consensual, least restrictive interventions should be made unless there is evidence that a clear risk of significant harm exists to the person or others, which may require a non-consensual intervention

3. given the subjective nature of clutter, disarray and the value of possessions and life-styles, it is necessary to use an objective rating scale to assist communication and understanding of the level and impact of hoarding

4. risk of harm should always be considered in terms of harm to the individual and of harm to other people, for instance, neighbours

5. because of the heterogeneous nature of hoarding and self-neglect, it is necessary to co-ordinate interventions across multiple organisations when concerns of risk of harm arise and to do this, a lead organisation has to be identified

6. Particularly high risk is present where:
    a. multiple organisations are involved, but their actions are not coordinated and there is no clear oversight and direction

    b. a person who hoards or self-harms is of concern to numerous different organisations but does not meet their threshold criteria.

## 5) Sharing information

Due to the complex and diverse nature of self-neglect responses by arrange of organisations are likely to be more effective than a single agency response. Sharing information between organisations will usually require the person's consent and each organisation must consider when it is appropriate to share information without the person's consent, for example, if there is a public or vital interest.

## 6) Presenting problems of self-neglect

The presenting problems related to self-neglect can be wide ranging. For example:

- a person 'hoards' excessively and this impacts on the living environment causing health and safety concerns for them and for their neighbours

- signs of serious self-neglect are regularly reported by the public or other agencies but no change in the person's circumstances occur

- a person's actions/inactions indicate a high risk of fire
- a person's personal or domestic hygiene exacerbates a medical condition and could lead to a serious health problem
- the accommodation becomes filthy (including problems associated with cats/dogs and their excrement) and verminous causing a health risk or possible eviction
- the person has no heating or water and refuses to move to alternative accommodation
- the person appears unkempt and/or exhibits extreme weight loss
- there are structural problems with the property and the person cannot afford repairs or refuses to consider alternative accommodation
- financial debt issues which may lead to rent arrears and the possibility of eviction
- there are health and safety issues around gas or electricity and the person refuses or cannot afford to get the appliances repaired
- anti-social behaviour intimidates neighbours and causes social isolation
- the conditions in the property cause a potential risk to people providing support or services e.g. paid carers.

This list is not exhaustive and there may be other areas of concern or a mixture of the above that highlight a difficulty for the vulnerable person and those trying to assist them.

It is important to recognise that assessments of self-neglect are grounded in, and influenced by, personal, social and cultural values and workers should always reflect on how their own values might affect their own judgements.

## 7) Hoarding

For the purposes of this protocol, hoarding is considered as an element of self – neglect. Hoarding refers to the acquisition of items with an associated inability to discard things that appear to others to have little or no monetary value to the point where it interferes with use of their living space or activities of daily living. Hoarding can include new items that are purchased and hoarded. It can also include food items, items of no monetary value, refuse and animals.

It is important to distinguish between overcrowding and hoarding. The impact of overcrowding in a small living space may appear to workers as a hoarding issue when it is in fact a lack of living space for necessary possessions which is the presenting issue.

Hoarding Disorder has now been identified as a distinct diagnosis in the DSM 5 (American Psychiatric Association, 2013) but does not appear in the ICD 10 (World Health Organisation, 2010). Individuals may benefit from mental health intervention and should be encouraged to accept referral by their GP to psychological therapies or other relevant secondary mental health professionals for support.

**Signs of hoarding**:

Conditions of extreme clutter, especially where bathroom facilities, food storage, oven, heating sources, and entry and exits are blocked, inability to throw things away that may seem to be, or actually are, rubbish, empty food containers, or papers stacked up in the living space.

## 8) Reasons for self–neglecting behaviour

There are a range of explanations for self-neglect (*Self-neglect and adult safeguarding: findings from research, SCIE report 46, 2011)* and a reluctance to accept intervention, including:

- psychiatric aetiology
- underlying personality disorder, depression, dementia, obsessive-compulsive disorder, trauma response, severe mental distress
- diminishing social networks and/or economic resources
- attempts to maintain continuity and control
- physical and nutritional deterioration
- personal philosophy such as pride in self-sufficiency
- a sense of connectedness to place and possessions
- in some cases, shame and efforts to hide state of residence from others.

Unpaid carers may self-neglect as a result of their caring responsibilities and workers should be aware of the impact that caring for a vulnerable person might have on the carer and ensure that a carer's assessment is carried out and appropriate support offered.

## 9) Working with those who self-neglect

Challenges to practitioners working with self –neglect issues include:

- divergent agency thresholds for triggering concern and involvement
- competing value perspectives e.g. duty of care versus choice and control
- understanding complex family relationships
- dealing with the emotional effect of self-neglect on those experiencing it
- care management workflow arrangements
- care management models that do not recognise the amount of time required to build relationships and engage in what are often long, slow negotiations
- the need for legal literacy (knowledge of all relevant legislation, including the Mental Capacity Act 2005 and the Mental Health Act 1983)
- the need for creative interventions which are flexible, negotiated and proportionate.

## 10) Mental Capacity and self-neglect

If concerns are raised by anyone about self-neglect, the statutory agency must be clear about the person's mental capacity in respect to the key decisions that may require intervention.

If there are any doubts about the person's capacity especially with regard to their ability to 'choose' their living conditions or refuse support, then where possible a mental capacity assessment should be undertaken. There may be circumstances in which it is useful to involve therapists in capacity assessments, for example, where the decision is around managing the home environment or where the person has communication difficulties and speech and language therapists could be helpful.

Capacity assessments may not take full account of the complex nature of capacity. *Self-neglect and adult safeguarding: findings from research, SCIE report 46* highlights the difference between capacity to make a decision (decisional capacity) and capacity to actually carry out the decision (executive capacity). However, this distinction does not currently exist in policy or guidance. Good practice should involve considering whether the person has the capacity to act on a decision that they have made (executive capacity).

Strong emphasis needs to be placed by practitioners on the importance of inter-agency communication, collaboration and the sharing of risk. The autonomy of an adult with capacity should be respected including their right to make what others might consider to be an "unwise decision". However, this does not mean that no

further action regarding the self-neglect is required. Efforts should be directed to building and maintaining supportive relationships through which services can in time be negotiated.

If the person is assessed as not having capacity to make decisions in relation to their self-neglect, then any decisions should be made following the best interests process, which includes taking into account the person's views and taking the least restrictive action. Additionally, consideration should be given as to whether an Independent Mental Capacity Advocate (IMCA) should be instructed. IMCAs may be instructed in Safeguarding regardless of the level of involvement of family or friends.

## 11) Good practice

Good practice when working with self-neglect *(Self-neglect policy and practice: key research messages, SCIE, 2015)* is:

- taking the time to build rapport and a relationship of trust, through persistence, patience and continuity of involvement. The theme that emerged most consistently in the research carried out by Braye, Orr and Preston Shoot in 2014 was the importance of establishing a relationship to secure engagement and achieving interventions that could make a difference

- trying to 'find' the whole person and to understand the meaning of their self-neglect in the context of their life history, rather than just the particular need that might fit into an organisation's specific role

- engaging with the individual's family/friends/support network (with the person's consent). Their knowledge and understanding of the person may assist with understanding the reasons for self-neglect and they may be best placed to provide support

- working at the individual's pace and being able to spot moments of motivation that could facilitate change, even if the steps towards it are small

- offering choices and having respect for the individual's judgements on the most appropriate form of help even when coercive measures are being taken. The degree to which the person is treated with respect can go a long way in creating a beneficial outcome

- ensuring an understanding of the nature of the individual's mental capacity in respect of self-care decisions

- being honest, open and transparent about risks and options

- having in-depth understanding of legal mandates providing options for intervention

- making use of creative and flexible interventions, including family members and
  community resources where appropriate

- engaging in effective multi-agency working to ensure inter-disciplinary and specialist perspectives, and coordination of work towards shared goals. If there are children living in the home of someone who self-neglects then children's services should be informed and from part of the multi-agency response.

In order for good practice to occur there is a need for:

- flexibility (to fit individual circumstances)

- negotiation (of what the individual might tolerate)

- proportionality (to act only to contain risk, rather than to remove it altogether, in
  a way that preserves respect for autonomy).

The worker should:

- show humanity

- be reliable

- show empathy

- demonstrate patience

- be honest

- work at the individual's own pace.

## 12) Autonomy versus a duty of care

There is often a difficult balance to be struck between respecting an individual's autonomy and having a duty of care.

Balancing choice, control, independence and wellbeing calls for sensitive and carefully thought through decision-making. It is important to understand each individual's situation and to try and find a way of working effectively with them. Both the Care Act and Making Safeguarding Personal emphasise the importance of involving the person in decision making and focusing on the outcomes that the person wants to achieve.

If there is a doubt about an individual's capacity to make a decision then a mental capacity assessment must be carried out. As referred to in section 10, the fact that an individual may be assessed as having capacity to make decisions around their lifestyle does not mean that professionals should withdraw from the situation. Individuals have the right to make what others may consider to be an "unwise" decision. However, where there are concerns about the impact of these decisions on the person's health and well-being or the health and well-being of others then professionals should continue to try and work with the person and people close to them (with their consent) to negotiate creative solutions. This requires appropriate and sensitive engagement by those involved with the person. Consideration should be given as to whether the person meets the requirement for a Care Act Advocate

In certain circumstances coercive action may be imposed by organisations such as the housing department even when the person has the capacity to make a decision, for example, eviction from the property. In a life or limb situation the police would have powers to intervene.

If there is an assessed risk of significant harm to others, or to the person themselves if they lack the capacity to make the relevant decisions, then the professional's duty of care may require them to override the individual's right to exercise choice and control. Any restrictions imposed must be necessary to prevent harm, and proportionate to the risk of that harm. Any restrictions imposed for the protection of others must have the proper authorisation, e.g. the decision of a police officer or a court order. The individual and their supporter/advocate should be kept informed of any decisions made and actions to be taken and solutions acceptable to the person sought wherever possible.

## 13) Key agencies and their roles

**Environmental health service (EHS)**

The EHS has a range of powers to intervene where a property is in a condition that is prejudicial to health, or where the premises is materially affecting neighbouring premises. EHS is a frontline agency in raising alerts and early identification of cases of self-neglect and hoarding. Where properties are verminous or pose a statutory nuisance EHS will take a leading role in case managing the necessary investigations and determining the most effective means of intervention.

Where the individual is residing in conditions that only pose a threat to their own welfare, the powers available to EHS may have limited or no effect. In cases involving persistent hoarders the powers may only temporarily address and/or contain the problem. Therefore utilising powers under public health legislation in isolation may not be the most effective use of resources, particularly where a coordinated approach could provide immediate protection of the individual and others and also promote a long term solution.

**Housing department**

Under Part 1 of the Housing Act 2004, the housing department has powers to take enforcement action where there is any risk of harm to the health or safety of an actual or potential occupier of a dwelling or house of multiple occupation which arises from a deficiency in the dwelling or house of multiple occupation or in any building or land in the vicinity (whether the deficiency arises as a result of the construction of any building, an absence of maintenance or repair, or otherwise). The housing department can require access to residential premises in their district to assess if such a hazard exists.

The duty to inspect the property is restricted to where there is an official complaint made either to the Justice of the Peace or local council. However, where there is evidence that there is imminent risk of serious harm to the health and safety of the occupier, the local authority has emergency power to serve a remedial action notice or emergency probation notice prohibiting the use of the property.

There are also powers to serve a deferred action notice and take emergency remedial action. There is no requirement that the property is owned by the local authority, nor is the capacity of the inhabitant relevant to the exercise of these powers. However, use of these powers in isolation will have limited effect on those who have persistent behaviours. The Housing Act powers cannot be used to remove hoarded items or address any health and safety problems that are the result of the owner's actions.

**Private landlords/housing associations/registered social landlords**

Private landlords/housing associations and registered social landlords have an obligation to ensure that their properties are in a good state of repair and are fit for human habitation. Where the tenant is responsible for the disrepair the landlord has a right of action, including ultimately seeking possession of the premises. The role of the landlord/housing association and powers afforded to them means that they have a key role in alerting the statutory authorities to particular cases and that consideration should always be given to their inclusion within multi-agency discussions.

**Adult social care**

Adult social care will initially co-ordinate the multi-agency approach. In the majority of cases the usual community care assessment procedures will be the best route to provide an appropriate intervention. If assessed as having mental capacity to make informed decisions on the issues raised, then the person has the right to make their own choices. However, the assessor must ensure that the person has fully understood the risk and likely consequences if they refuse services. Involvement with the person should not stop at this point and efforts should be made to engage the person in the management of risks and to form a relationship with them to do this.

If the person is assessed as not having capacity to make the relevant decisions then care should be provided in line with “best interest” principles (s.4 MCA). If any proposed care package might amount to a deprivation of liberty consideration must be given as to whether it would be necessary to obtain authorisation under the DoLS procedure or an order from the Court of Protection.

Assessment of self-neglect should include assessment of any health issues such as impaired sight and mobility, pain issues, or long term conditions that may be contributing towards the self-neglect.

**Mental health services**

Mental health services will be the lead agency where the individual is eligible or believed to be eligible for mental health services. Mental health services will also have a crucial role within many investigations under this protocol as for many individuals hoarding or self-neglect are the manifestations of an underlying mental health condition. Powers conferred by the Mental Health Act 1983 (MHA) to Approved Mental Health Professionals (AMHP) enable the mental health service to take such steps as they consider necessary and proportionate to protect a person form the immediate risk of significant harm.

**Police**

The police have powers of entry and so may be pivotal in gaining access to conduct assessments if all else fails. Under section 17 (1) (a) of the Police and Criminal Evidence Act 1984, the police have the power to enter without a warrant if required to save life or limb; or prevent serious damage to property; or to recapture a person who is unlawfully at large whilst liable to be detained.

**Primary health services**

In some cases of chronic or persistent self-neglect individuals who are reluctant to engage with adult social care may engage with primary health care services such as their GP, district nursing service etc. GPs and district nurses carry out home visits to vulnerable older people and may be the first people to notice a change in the person’s home environment. Alternatively, failure to keep health appointments or to comply with medication may indicate self-neglect. As well as raising alerts and providing information, primary health services can be very effective in forming a relationship with the person and in addressing underlying concerns.

Primary health services should monitor those individuals who are engaged with their service and show signs of self-neglect or hoarding. Monitoring might include a regular check in with, and offer of intervention to, someone who is reluctant to engage. If deterioration is such that risks to the person or to others are assessed as high by the health professional then a multi-agency response will be required.

**Acute and community health services**

Therapists who work in acute wards may observe hoarding and other self-neglect related behaviours when undertaking access visits or home visits to help inform the discharge planning process. Community based therapists and nursing staff are often

the first people to observe hoarding and self-neglect related problems. These professionals are key to identifying triggers and changes in behaviour which are then fed into the multi-disciplinary team. Therapists can assess and report on how a client's self-neglect or environment impacts on their overall ability to be safe at home and help determine the level of risk posed to the client and others (family members, neighbours etc).

**London fire brigade (LFB)**

LFB is best placed to work with individuals to assess and address any unacceptable fire risk and to develop strategies to minimise significant harm caused by potential fire risks. LFB will also raise alerts when called to addresses repeatedly or where homes have significant damage because of a fire and the individual continues to live at that address. LFB will raise alerts, carry out fire risk assessments and offer advice to individuals assuring them of the necessity of fire protection and prevention. LFB may gain entry where home access is refused to other services.

**Utility companies/building and maintenance workers**

Utility companies/ building and maintenance workers have an important role in the identification of hoarding and self -neglect as they visit people's homes to read meters, carry out inspections or carry out building/maintenance work. Engagement of utility companies and other companies/workers who enter peoples' homes is therefore important so that reports of hording and self-neglect can be received and appropriate action taken.

**Domiciliary care providers**

Care agencies are commissioned by the London Boroughs of Hackney and City of London to provide support to people in their own homes and are also commissioned directly by people who fund their own care. They have a role in both identifying people who self-neglect and hoard and in working with them.

## 14) Self –neglect and risk

### Low level risk

It is vital that low level risk is addressed in order to ensure that the self-neglect does not escalate and result in high level risk.

At a low level of risk the most effective approaches to self-neglect are based on a long-term approach. This involves developing a relationship with the person who hoards or self-neglects, sensitively raising the problems their behaviour causes for them or for others and working with them to find solutions and providing assistance to put these into action. It may include working with someone close to the person who is able to assist the person to achieve change due to a long standing relationship with them.

Low-key monitoring of wellbeing may be the only form of assistance that is acceptable to the person. This may involve community-based voluntary organisations providing specific services such as visiting, floating support,

befriending or support in managing finances, and will often involve members of the individual's social network. Support may also be provided to address mobility issues etc.

Interventions may include de-cluttering or cleaning, although any changes are likely to be temporary unless carried out in conjunction with other interventions such as relationship building with a worker from an appropriate agency e.g. floating support, or specialist psychological intervention.

Such approaches respect the legal right of people with mental capacity to have their autonomy respected, while still taking steps to assist with their safety and wellbeing.

Actions to help with daily living may help to build up relationships of trust. These actions might involve the provision of key items of furniture, or white goods such as fridges and microwaves. Ensuring that the person has medical attention to deal with specific health conditions is another way to build trust while acting to address concerns about wellbeing.

It is important to put a plan into place so that change can be maintained. This might take the form of a care package to ensure that help is provided on a regular basis, or involvement in meaningful activity that could replace but serve the same purpose as the person's previous lifestyle. For example, people who hoard could be linked into workshops or groups that make use of the hobbies or collecting passions that had led them to hoard in the first place. Recognition should be given to the attachment that people often have to their possessions or surroundings, and the need to replace what is being given up with forward-looking interventions focusing on lifestyle, companionship and activities.

During any intervention, it is essential that those involved remain alert to risk factors, especially fire. A referral should always be made for a fire safety check. If the person persistently self - neglects/hoards and, whilst currently the living conditions may not be posing a significant risk they would do if left unaddressed, then environmental health services (or the landlord if appropriate) should be involved.

Some situations deteriorate rapidly and may require urgent escalation. If the person's self-neglect does not pose a statutory nuisance and the risk of harm is low, then the key agencies that need to be involved with the individual should be notified of the concerns and requested to monitor or signpost to relevant support.

It is important that approaches are coordinated to avoid situations where activity takes place without any specific aim, or actually conflicts with the interventions of other organisations and so it is important that a lead agency is identified to ensure coordination. The lead agency will not necessarily be responsible for implementing action or interventions but will monitor the actions and interventions of the agencies involved. The lead agency in Hackney is Hackney adult social care and in the City is the City of London adult social care.

## Significant risk

Where significant risks of harm have been identified at the point of referral or when low level risk has increased following failed interventions from a single agency, a multi-agency response is required. Options should be explored at a multi-agency meeting and a plan of action agreed specifying what will be done, by whom and by when.

## High level risk

If there is a high risk of serious harm then a referral should be made to the community MARAC (London borough of Hackney only). This panel will meet monthly but can be convened on an extraordinary basis if an immediate response is required due to the urgency of the situation. Options should be explored and a plan of action agreed specifying what will be done, by whom and by when.

Statutory interventions may include, but are not limited to, using Public Health legislation, sectioning or removing the person to a place of safety under the Mental Health Act or obtaining Court of Protection approval to remove someone from their home under the Mental Capacity Act.

# 15) Process for practitioners

**Identification and referral**

1. Cases of hoarding, self-neglect may be raised by members of the public or by professionals.

2. If the person referred is not previously known to the agency referred to, the first step by the agency receiving the referral is to obtain as much information as possible and ascertain which, if any, agencies are already involved with the person.

3. A referral should be made to either Hackney or City of London adult social care as the initial lead agencies in relation to cases of self-neglect or other risk behaviour by vulnerable adults.

   *Hackney adult social care only:*

   - the information and assessment team will establish whether the person is known to adult social care or mental health services

   - if the person is known then the information and assessment team will establish who is best placed to take on the work

   - if the person is not known to adult social care or mental health services then the information and assessment team will carry out a screening assessment and take any appropriate actions. This may include referring on to a specialist service such as the mental health service.

**Assessment**

Sensitive and comprehensive assessment is of critical importance and should include an accurate assessment of the individual's mental and physical health status, family dynamics and family coping patterns and cultural beliefs.

The professional carrying out the assessment should:

1. ensure that the assessment is multi-agency/ multi-disciplinary and includes:
    - a detailed social and medical history
    - whether the presenting issue is self-neglect or is the result of underlying illness/disease
    - a historical perspective of the person and the situation
    - the person's perception of the situation, willingness to accept support, observation and self-reporting
    - liaison with family members and people in the individual's network such as friends and neighbours
2. carry out a risk assessment to determine the level of seriousness of each identified risk. This should include observation of the individual and the home, activities of daily living, functional and cognitive abilities, nutrition, social supports and the environment
3. share information with other relevant professionals who may have a contribution to make in managing or monitoring the risks
4. use the "assessment tool guidelines" (see appendix 7) and the clutter image scale guidelines (see appendix 6) to explore the extent and the impact of the presenting problem
5. carry out a Mental Capacity Act assessment, if justified under the Mental Capacity Act. This will inform the actions taken
6. make a decision in liaison with the Safeguarding Adults Manager (SAM) as to whether a safeguarding enquiry is required. Under the Care Act a safeguarding enquiry is required if the person concerned is unable to protect themselves due to a support need. For example, if the person's mental health status or lack of capacity to make a relevant decision is causing or impacting on the self-neglect or other risk behaviours. If all efforts to work with a person in minimising risk are failing and the level of risk is assessed as significant then a safeguarding enquiry may be appropriate.

Operationally, there is a need for flexibility and proportionality in the allocation of self-neglect cases to adult social care or specialist teams. Also, in deciding whether or not to follow the safeguarding process. Decisions will depend on the complexity of the case and the nature of the self-neglect or other risk taking behaviour being presented.

**Actions to make the person safer**

**Level 1 Signposting/referral/low level monitoring**

Where the risk assessment identifies low level risk (for hoarding, images 1-3 on the clutter scale), a judgement will have to be made on whether or not any intervention is

necessary. At this stage the best intervention is likely to be consensual, utilising friends, neighbours, family, health care assistants, district nurses, estate officers or the voluntary sector to engage and support the individual.

Signposting may include advising the individual to contact relevant organisations that may assist with repair and maintenance, or removal and cleaning or a professional making contact with these organisations themselves. A referral for a fire safety check should always be made if not already carried out. All decisions made and actions taken must be recorded.

**Level 2 Refer for a multi-agency meeting**

If the self-neglect is assessed as being significant (for hoarding, images 4-6 on the clutter scale) then a multi-agency meeting should be called to consider and co-ordinate any multiagency involvement. The involved worker should discuss the case with their line manager who will advise whether a multi-agency meeting should be convened.

The best intervention is still likely to be a consensual, collaborative one, utilising the person's support network. A fire safety check must always be considered and if there is a risk of fire or carbon monoxide poisoning, then an urgent multi-agency meeting must be arranged. Environmental health and housing input may be necessary.

The person at risk should be informed by the worker that a meeting will be taking place and why and this communication should be followed up in writing.

When the worker and the manager (from any organisation) have agreed that the situation requires a multi-agency approach, a multi-agency meeting should be convened, with all relevant agencies invited.

**A manager should chair the multi-agency meeting**

The meeting will aim to arrive at the "best possible decision" possible as it is acknowledged that in many circumstances there are no easy solutions. It is important that the meeting is accurately recorded so that the thinking and processes used in reaching the decisions made/action points are clear. Where a key person is identified to take the lead in engaging with the person at risk it is important that appropriate support is provided from relevant professionals when needed.

Before the multi-agency meeting concludes, any ongoing needs for the individual or their family and carers should be clearly identified and communicated to the relevant agencies. If the agency was not part of the intervention the chair of the meeting should take responsibility for conveying the ongoing needs to the relevant agency.

It may be necessary to build a relationship with the person that self neglects before they can be encouraged to accept any practical help. Consideration should be given as to whom would be best placed to build that relationship.

**Level 3 Urgent community MARAC**

If there is high risk as identified by the risk assessment or "assessment tool guidelines" (images 7 – 9 on the cluster image rating) then it will be necessary to

refer to the community MARAC to ensure the safety of the individual or others who may be affected.

Timescale: The community MARAC will meet monthly but can be convened on an extraordinary basis in an urgent situation.

**Potential triggers of referral to the community MARAC are:**

1. repeated problems of self – neglect. When an agency's usual way of engaging with a vulnerable person has not worked and
   (a) no other options appear available, or
   (b) enforcement is being considered using statutory powers

2. serious concerns for health and wellbeing (of the person or others) that require an immediate response

The community MARAC will consider and agree:

- whether or not urgent action needs to be taken
- whether or not a consensual approach is possible
- the legal remedies that are available
- who will implement any actions
- timescales for action
- monitoring arrangements.

The core members of the community MARAC are:

- housing
- adult social care
- mental health services
- CCG
- CVS
- police
- other as appropriate e.g. One Hackney, fire brigade, ambulance service, trading standards.

A consensual, collaborative approach is still the most effective response and anyone who is able to get through the front door should be considered to be a key link. If there is high level risk then the meeting should consider whether or not coercive intervention is necessary, and if so, how it can be applied lawfully and quickly. The meeting should consider risk to others as well as to risk to the person themselves and consider whether there is the need for action to save life and limb. It is essential that a mental capacity assessment has taken place to determine how any intervention should be applied.

Where an individual is already in receipt of adult social care, known to the service or appears eligible for adult social care support the relevant social work team manager will ensure an allocated social worker is assigned to complete necessary assessments, including of the individual's mental capacity, community care or health

needs. The allocated worker will act as lead in co-ordinating any plan for intervention.

**Financial considerations**

The financial implications of any agreed actions should not be a factor at the community MARAC in order to focus on the best outcome for the person at risk. Debates and disputes around funding should be resolved outside of the meeting.

## 16) Appendices

## Appendix 1

# Questions to ask about self-neglect and hoarding

**Hoarding and self-neglect guidance for practitioners**

The following is a list of questions to ask where you are concerned about someone's safety in their own home and where there may be a risk of self- neglect or hoarding.

Each question may lead to further questions such as finding out when the event occurred and what the outcome was.

1. How do you get in and out of your property, do you feel safe living here?
2. Have you ever had an accident, slipped, tripped up or fallen, how did it happen?
3. How have you made your home safer to prevent this (above) from happening again?
4. How do you move safely around your home (where the floor is uneven or covered, or there are exposed wires, damp, rot, or other hazards)
5. How do you get hot water, lighting, heating in here? Do these services work properly? Have they ever been tested?
6. How do you manage to keep yourself warm? Especially in winter?
7. Do you have an open bar fire or a convection heater?
8. When did you last go out in your garden? Do you feel safe to go out there?
9. Are you worried about other people getting in to your garden to try and break-in? Has this ever happened?
10. Are you worried about mice, rats or foxes, or other pests? Do you leave food out for them?
11. Have you ever seen mice or rats in your home? Have they eaten any of your food? Or got upstairs and be nesting anywhere?
12. Can you prepare food, cook and wash up in your kitchen?
13. Do you use your fridge? Can I have look in it? How do you keep things cold in the hot weather?
14. How do you keep yourself clean? Can I see your bathroom? Are you able to use your bathroom and use the toilet ok? Have a wash, bath? Shower?
15. Can you show me where you sleep and let me see your upstairs rooms? Are the stairs safe to walk up? (if there are any)
16. Where do you sleep? Are you able to change your bed linen regularly? When did you last change them?
17. What do you do with your dirty washing?
18. How do you keep yourself warm enough at night? Have you got extra coverings to put on your bed if you are cold?
19. Are there any broken windows in your home? Any repairs that need to be done?
20. Have you experienced weight loss recently? How long ago?

21. When did you last see your GP?
22. Do you drink at home?

The following are questions regarding the imminent risk of fire. If the answer to any of these questions is yes, then this must be reported as a matter of urgency to the fire brigade and raised urgently through your line management system.

**Significant danger**

23. Has a fire ever started by accident?
24. Do you ever use candles or an open flame to heat and light here or cook on a camping gas or a barbeque inside your home?
25. Do you use your gas cooker to heat your home?
26. Do you smoke at home e.g. in bed?

# Appendix 2

## Terms of reference for the Community MARAC panel

### Purpose of the panel

To provide a person-centred, timely and effective multi-agency response to situations where the person referred has been assessed at a high level of risk as a result of complex self - neglect issues or other high risk issues. To ensure that all relevant agencies work together to provide a co-ordinated and accountable response to the person's presenting issues/risks. To focus on the outcomes that the person wants to achieve to the greatest extent possible given the individual circumstances and risks. To feed up to the City and Hackney Safeguarding Adults Board (CHSAB) on presenting high risk issues and the number of referrals to the community MARAC.

### Objectives

1. To share information to increase the safety, health and well-being of adults with care and support needs who have been assessed at high levels of risk.

2. To explore all options to minimise risk and ensure that all interventions possible are taken to maintain the safety of those who are assessed as being at a high level of risk due to issues of self –neglect or other risk taking behaviours.

3. To identify agencies that need to be involved to mitigate identified risks.

4. To ensure that any work undertaken with the person is in the least restrictive way possible to achieve their safety.

5. To ensure that the person has been made aware of all relevant information/options.

6. To ensure that any decisions made/proposed actions involve the person (and with their consent anyone close to them) to the greatest extent possible and that their view has been taken into account in the decision making process.

7. To be aware of a person's right to make an unwise decision if they have been assessed as having mental capacity to make this decision unless there is a clear risk of significant harm to that person or others.

8. To ensure that the person is aware of the implications of any decisions/proposed actions.

9. To ensure that appropriate measures (including coercive measures) are taken if there is a clear risk of significant harm to that person or others. These should always be the least restrictive measures possible in the circumstances.

10. To provide clear professional advice to the relevant agencies involved.

11. To review actions taken by the member agencies on specific cases at the next panel meeting.

12. To monitor the implementation of local policies in relation to specific cases.

13. To identify policy issues arising from casework and raise these through the appropriate channels.

14. To contribute to the development of best practice.

15. To provide feedback to the City and Hackney Safeguarding Board (CHSAB) via the Task and Finish Group on presenting high risk issues and number of referrals to the community MARAC etc.

**Core membership**

- Hackney adult social care
- Hackney Homes/private sector housing
- East London foundation trust
- Hackney CCG
- Hackney GP
- Hackney CVS
- Hackney metropolitan police

*Other agency representatives may be required on a case by case basis e.g. HUH, LFB, LAS, drug and alcohol services, trading standards etc*

**Responsibilities of the core member agencies**

1. The named member to attend all community MARAC meetings.

2. If the named member is unable to attend, an appropriate person in the agency must replace them.

3. To ensure that all referrals from their agency have been signed off by a manager and meet the threshold for the community MARAC.

4. To check their agencies records on all cases discussed at the community MARAC prior to the meeting.

5. To contribute to community MARAC discussions.

6. To make decisions on behalf of their agency and agree actions to be taken by their agency.

7. To follow up on actions agreed for their agency and provide feedback on the progress of these actions to the community MARAC co-ordinator.

8. To promote good practice within their agencies through updating colleagues about the community MARAC, addressing any issues about the quality of their agency's community MARAC referrals and supporting colleagues through the community MARAC process.

**Responsibilities of the community MARAC co-ordinator**

1. To collate the referrals to the community MARAC.

2. To record the referrals onto a community MARAC spreadsheet.

3. To invite non-core agencies to the community MARAC if requested to do so by the community MARAC chair.

4. To set up community MARAC meetings, including room bookings, sending out invites and papers. The papers should include the minutes of the last meeting, the agenda for the meeting and the completed referral forms.

5. To distribute an attendance sheet at each meeting.

6. To take minutes of the meeting and send these out to all Community MARAC members.

7. To check and record that agencies have completed their agreed actions.

8. To record any actions fed back by the community MARAC members onto the community MARAC spreadsheet.

9. To provide any data required for reporting purposes.

**Responsibilities of the community MARAC chair**

1. To read the referrals one week prior to the meeting and inform the co-ordinator if an agency which isn't a core member of the panel needs to attend e.g. the LFB.

2. To double check the referrals to ensure that that are appropriate for the community MARAC.

3. To emphasise confidentiality/information sharing agreement at the beginning of each meeting.

4. To manage the order of cases presented at the meeting.

5. To agree any actions to be taken.

**Frequency of meetings**

The community MARAC will sit monthly for the duration of a 6 month pilot.

**Chair of the community MARAC**

The chair of the community MARAC is the ASC service manager for long term services.

**Referral process**

1. The person referred (and if applicable, their advocate/informal carer/ someone close to them) should be informed that their case is being referred to the community MARAC.

2. Referrals are via the community MARAC Referral Form.

3. Referrals must be submitted by the manager of the allocated worker.

4. Referrals should be sent to: trisha.brooks@hackney.gov.uk

5. Referrals should be sent one week before the next community MARAC meeting. Referrals will be considered at shorter notice in exceptional circumstances.

**During the MARAC meeting**

1. All attendees will sign an attendance sheet and provide details of their contact number and email address.

2. The Chair will set out the confidentiality/information sharing agreement and the purpose of the community MARAC.

3. Any outstanding follow-up actions from the previous MARAC will be highlighted and new deadlines / actions agreed.

4. The Chair will go through the running order, enabling visiting agencies with no involvement on other cases to present cases before any cases being presented by core members.

5. Cases will be presented by the lead agency working with the person at risk. The allocated worker may be invited to present the case.

6. Cases will be presented verbally and in a clear way, focused on relevant facts, areas where there are gaps in knowledge and setting out the risk of harm. The adult at risk's experience/perspective will be represented.

7. All core member agencies will share information held by them on the person at risk

8. On all cases the Chair will invite professional opinion and actions from agencies and formulate a plan to reduce the risk. The Chair will agree specific and timed actions on each case including who will update the person at risk.

9. The community MARAC co-ordinator will take minutes during the meeting and will clarify any actions agreed with the Chair before the next case is heard.

**Confidentiality**

The community MARAC is not a public forum and attendance is limited to those agencies who are able to provide a contribution with regard to listed cases. All cases discussed at the community MARAC are strictly confidential and the information discussed should not be passed on to any individual or agency without the agreement of the Chair, with the following exception:

under the Criminal Procedure and Investigations Act 1986 (CPIA), if/when an individual is charged with an offence the police are required to disclose the existence of all material created as part of the investigation. As a result the existence of the community MARAC referral will be disclosed to the defence. However this will be listed as 'sensitive information' and will only be fully disclosed if a judge deems it absolutely necessary in the interests of justice. Even on the rare occasion when this may happen the defence will be issued with the following instructions:

*'This material is disclosed to you in accordance with the provisions of the CPIA 1986, and you must not use or disclose it, or any information recorded in it, for any purpose other than in connection with these criminal proceedings. If you do so without the permission of the court, you may commit an offence.'*

It is the duty of referring agencies and core members to store and communicate information pertaining to the community MARAC safely.

**Appendix 3**

# Community MARAC referral form

| **DETAILS OF PERSON AT RISK** | | | | | | | |
|---|---|---|---|---|---|---|---|
| NAME | | | | | MOSAIC/User ID | | |
| Address | | | | | | | |
| AGE | | DOB | | | GENDER | | |
| USER GROUP<br>Tick any appropriate user group | | Learning Disability | | | | Mental Health | |
| | | Older People | | | | Physical & Sensory | |
| | | Substance Misuse | | | | Other vulnerable people | |
| ETHNIC ORIGIN | | White British | | White Irish | | Other White | |
| | | White Traveller of Irish Heritage | | White Gypsy/Roma | | | |
| | | Black Caribbean | | Black African | | Other Black | |
| | | Indian | | Pakistani | | Bangladeshi | |
| | | Chinese | | Other Asian | | Mixed White and Black Caribbean | |
| | | Mixed White and Black African | | Mixed White and Asian | | Mixed White and Chinese | |
| | | Other | | | | | |

| | | | | |
|---|---|---|---|---|
| DATE & TIME OF REFERRAL | | | | |
| TENURE | Home Owner | | Lessee | |
| | Council Tenant | | Private rented | |
| | Housing Association Tenant | | Temporary Accommodation | |
| | Other | | | |
| SOURCE OF INITIAL REFERRAL | Neighbour | | GP | |
| | Estate Officer | | Floating Support Worker | |
| | Social Worker/ Community Nurse | | Police | |
| | Fire Service | | Other | |

| **DETAILS OF THE PERSON COMPLETING THIS FORM** | | | |
|---|---|---|---|
| NAME | JOB TITLE / PROFESSION | CONTACT DETAILS | DATE |
| | | | |

| **DETAILS OF THE MANAGER AUTHORISING THIS REFERRAL** | | | |
|---|---|---|---|
| NAME | JOB TITLE / PROFESSION | CONTACT DETAILS | DATE |
| | | | |

| Up to date background information on the person at risk |
|---|
| |

| |
|---|
| |
| Briefly outline the assessed high level risks (e.g. there is a likely risk of serious harm) to the person or others and their views of the identified risks. If no high level risks are identified **do not** refer to community MARAC at this point |
| |
| Results of formal mental capacity assessment (including “executive capacity” i.e. the ability of the person to implement the decision) |
| |
| Has the safeguarding adult’s process been started and what stage is it at? If not started, why not? |
| |
| What are the protective factors in the person’s life? e.g. home care, placement, support from neighbours (if there are protective factors, briefly outline why a referral to the community MARAC is still required) |
| |

| |
|---|
| Briefly outline the interventions that have already been tried and what the outcomes were |
| |
| Has a multi-agency meeting already taken place? (if no, outline why this referral needs to go straight to the community MARAC) |
| |
| Does the person engage with services? (If yes, explain why a referral to the community MARAC is required) |
| |
| What outcomes are you seeking from this referral? |
| |
| Has your manager approved this referral to the community MARAC (if not, then do not proceed with referral) |
| YES/NO |

# Appendix 4

## Legislation

**Care Act 2014**

The Care Act 2014 sets out a statutory framework for adult safeguarding which stipulates local authorities' responsibilities, and those with whom they work, to protect adults at risk of abuse or neglect. It includes self-neglect as a category of abuse and neglect. There are new responsibilities for the Director of Public Health in relation to infection which may involve neglect. The Act does not contain powers to enter a person's property.

**Public Health Act 1936**

Contains the principal powers to deal with filthy and verminous premises.

**Section 83 - Cleansing of Filthy or Verminous Premises:**

i. where a local authority (LA), upon consideration of a report from any of their officers, or other information in their possession are satisfied that any premises –

a) are in such a filthy or unwholesome condition as to be prejudicial to health, or
b) are verminous

ii. the local authority (LA) shall give notice to the owner or occupier of the premises requiring him to take such steps as may be specified in the notice to remedy the condition of the premises

The steps which are required to be taken must be specified in the notice and may include:

- cleansing and disinfecting
- destruction or removal of vermin
- removal of wallpaper and wall coverings
- interior of any other premises to be painted, distempered or whitewashed

There is no appeal against a Section 83 notice and the LA has the power to carry out works in default and recover costs. The LA also has the power to prosecute.

**Section 84 Cleansing or Destruction of Filthy or Verminous Articles:** -

Applies to the cleansing, purification or destruction of articles necessary in order to prevent injury, or danger of injury, to health.

**Section 85 Cleansing of Verminous Persons and Their Clothing: -**

The person themselves can apply to be cleansed of vermin or, upon a report from an officer, the person can be removed to a cleansing station. A court order can be applied for where the person refuses to comply.

The Local Authority cannot charge for cleansing a verminous person and may provide a cleansing station under Section 86 of the Public Health Act 1936.

The Public Health Act 1936 Section 81 also gives Local Authority's power to make bylaws to prevent the occurrence of nuisances from filth, snow, dust, ashes and rubbish.

## The Public Health Act 1961

The Public Health Act 1961 amended the 1936 Act and introduced:

**Section 36 Power to Require Vacation of Premises During Fumigation: -**

Makes provision for the Local Authority to serve notice requiring the vacation of verminous premises and adjoining premises for the purposes of fumigation to destroy vermin. Temporary accommodation must be provided and there is the right of appeal.

**Section 37 Prohibition of Sale of Verminous Articles: -**

Provides for household articles to be disinfested or destroyed at the expense of the dealer (owner).

## Housing Act 2004

Allows Local Authorities to carry out a risk assessment of residential premises to identify any hazards that would likely cause harm and to take enforcement action where necessary to reduce the risk to harm. If the hazard is a category 1 there is a duty by the Local Authority to take action. If the hazard is a category 2 then there is a power to take action. However an appeal is possible to the Residential Property Tribunal within 21 days.

## Building Act 1984

Section 76 is available to deal with any premises which are in such a state as to be prejudicial to health. It provides an expedited procedure i.e. the Local Authority may undertake works after 9 days unless the owner or occupier states intention to undertake the works within 7 days.

There is no right of appeal and no penalty for non-compliance.

There is further legislation that relates specifically to people – both the living and the deceased.

## Environment Protection Act 1990

Section 79(a) refers to any premises in such a state as to be prejudicial to health or a nuisance. Action is by a Section 80 abatement notice and the recipient has 21 days to appeal.

## Prevention of Damage by Pests Act 1949

Local Authorities have a duty to take action against occupiers of premises where there is evidence of rats or mice. They have a duty to ensure that its District is free from rats and mice.

**Public Health (Control of Disease) Act 1984**

Section 46 imposes a duty on the Local Authority to bury or cremate the body of any person found dead in their area in any case where it appears that no suitable arrangements for the disposal of the body have been made. Costs may be reclaimed from the estate or any person liable to maintain the deceased.

**Mental Health Act**

**Admission for assessment (section 2)**

Duration of detention: 28 days maximum.

Application for admission: by an Approved Mental Health Practitioner (AMHP) or the patient's nearest relative. The applicant must have seen the patient within the previous 14 days.

**Procedure:** two doctors must confirm that:

(a) the patient is suffering from a mental disorder of a nature or degree that warrants detention in hospital for assessment (or assessment followed by medical treatment) for at least a limited period; and

(b) he or she ought to be detained in the interest of his or her own health or safety, or with a view to the protection of others.

**Discharge:** by any of the following:

Responsible clinician

Hospital manager

The nearest relative, who must give 72 hours' notice. The responsible clinician can prevent him or her discharging a patient by making a report to the hospital managers

MHT. The patient can apply to a tribunal within the first 14 days of detention.

**Admission for treatment (section 3)**

Duration of detention: up to six months, renewable for a future six months, then for one year at a time.

Application for admission: by nearest relative, or AMHP in cases where the nearest relative does not object, or is displaced by County court, or it is not 'reasonably practicable' to consult him or her.

**Procedure:** two doctors must confirm that:

(a) the patient is suffering from a mental disorder (see above) of a nature or degree that makes it appropriate for him or her to receive medical treatment in hospital; and

(b) appropriate medical treatment is available for him or her; and

(c) it is necessary for his or her own health or safety, or for the protection of others that he or she receives such treatment and it cannot be provided unless he or she is detained under this section.

**Renewal:** under section 20, the responsible clinician can renew a section 3 detention if the original criteria still apply and appropriate medical treatment is available for the patient's condition. The responsible clinician must consult another person of a different profession who has been professionally concerned with the patient's treatment.

**Discharge:** by any of the following:

Responsible clinician

Hospital managers

The nearest relative, who must give 72 hours' notice. If the responsible clinician prevents the nearest relative discharging the patient, by making a report to the hospital managers, the nearest relative can apply to an MHT within 28 days.

MHT. A patient can apply to a tribunal once during the first six months of his or her detention, once during the second six months and then once during each period of one year. If the patient does not apply in the first six months of detention, his or her case will be referred, automatically, to the MHT. After that, the case is automatically referred when a period of three years has passed since a tribunal last considered it (one year, if the patient is under 18).

**Admission for assessment in cases of emergency (section 4)**

**Duration of detention**: 72 hours maximum.

Application for admission: by an AMHP or the nearest relative. The applicant must have seen the patient within the previous 24 hours.

**Procedure:** one doctor must confirm that:

a) it is of 'urgent necessity' for the patient to be admitted and detained under section 2 and

b) waiting for a second doctor to confirm the need for an admission under section 2 would cause 'undesirable delay'

Note: the patient must be admitted within 24 hours of the medical examination or application, whichever is the earlier, or the application under section 4 is null and void.

**Guardianship (sections 7-10)**

**Duration of guardianship order**: up to six months, renewable for a further six months, then for one year at a time.

Application for reception into guardianship: by an AMHP or nearest relative.

**Procedure**: two doctors must confirm that:

(a) the patient is suffering from a mental disorder (see above) of a nature or degree that warrants reception into guardianship; and

(b) it is necessary in the interests of the patient's welfare or for the protection of others.

Note: the patient must be over 16. The guardian must a local social services authority, or person approved by the social services authority, for the area in which he or she (the guardian) lives. A guardian has the following powers

- to require a patient to live at a place specified by the guardian
- to require a patient to attend places specified by the guardian for occupation, training or medical treatment (although the guardian cannot force the patient to undergo treatment)

- to ensure that a doctor, social worker or other person specified by the guardian can see the patient at home.

**Discharge:** by any of the following

Responsible clinician

Local social services authority

Nearest relative

MHT. The patient can apply to a tribunal once during the first six months of guardianship, once during the second six months and then once during each period of one year.

**Warrant to search for and remove patients (section 135)**

**Duration of detention: 72 hours maximum**.

**Procedure**: if there is reasonable cause to suspect that a person is suffering from mental disorder and

(a) is being ill-treated or neglected or not kept under proper control; or

(b) is unable to care for him or herself and lives alone a magistrate can issue a warrant authorising a police officer (with a doctor and AMHP) to enter any premises where the person is believed to be and remove him or her to a place of s

**Mentally disordered persons found in public places (section 136)**

Duration of detention: 72 hours maximum

Procedure: if it appears to a police officer that a person in a public place is 'suffering from mental disorder' and is 'in immediate need of care or control', he or she can take that person to a 'place of safety', which is usually a hospital, but can be a police station.

Section 136 lasts for a maximum of 72 hours, so that the person can be examined by a doctor and interviewed by an AMHP and 'any necessary arrangements' made for his or her treatment or care.

**Anti-Social Behaviour Orders**

Anti-social behaviour is defined as where there is persistent conduct which causes or is likely to cause alarm, distress or harassment or an act or situation which is, or has the potential to be, detrimental to the quality of life of a resident or visitor to the area.

Questions about whether an application for an Anti-Social Behaviour Order would be appropriate should be made to the Police Inspector responsible for Hate Crime and Anti-Social Behaviour or the Anti-Social Behaviour Officer.

Consider inviting the relevant Neighbourhood Policing Team to participate in multi-agency work for individual cases.

**Misuse of Drugs Act 1971**

Section 8

A person commits an offence if, being the occupier or concerned in the management of the premises, he knowingly permits or suffers any of the following activities to take place on those premises:

S8 (a) Producing or attempting to produce a controlled drug

S8 (b) Supplying or attempting to supply a controlled drug to another or offering to supply a controlled drug to another

S8 (c) Preparing opium for smoking

S8 (d) Smoking cannabis, cannabis resin or prepared opium

**Mental Capacity Act 2005**

"A person is not to be treated as unable to make a decision merely because he makes an unwise decision"

There are five underpinning principles of the Mental Capacity Act.

You must:

1) Assume the person has capacity unless proved otherwise

2) Do not treat people as incapable of making a decision unless you have tried all practicable steps to try to help them.

3) Allow people to make what may seem to you an unwise decision (if they have capacity)

4) Always do things, or take decisions for people without capacity in their best interest

5) Ensure that when doing something to someone, or making a decision on their behalf you choose the least restrictive

**The two- stage test of capacity**

You must use the following test to assess if the person has capacity:-

is there an impairment of, or disturbance in the functioning of the person's mind or brain? If so,

is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision at a given time (capacity is decision specific)

The person is able to make a decision and therefore has capacity if they:

a. understand the information relevant to the decision,

b. retain the information,

c. use or weigh that information as part of the process of making the decision, or

d. communicate his/her decision either by talking, signing, or any other means

It is very important to consider "executive capacity" – that is the ability of the individual to implement the action.

**Best Interest Checklist**

Where a person lacks capacity all decisions must be made in their best interest. The checklist below gives some common factors that you must always take into account where a decision is being made, or an act is being done for the person who lacks capacity.

- involve the person who lacks capacity
- be aware of the persons past and present wishes and feelings
- consult with others who are involved in the care of the person
- do not make assumptions based solely on the person's age, appearance, condition or behaviour
- is the person likely to regain capacity to make the decision in the future?

You must formally record your decision e.g. by completing the Mental Capacity Act Checklist template and store this within the service user's electronic or paper file.

# Appendix 5

LONDON FIRE BRIGADE

For the London Borough of Hackney only:

All referrals from Hackney Social Care will carry the source code **Hackney P1 – 01**

**External: neareacfsteam@london-fire.gov.uk**

**Urgent Queries**
Graham Scawthorn
NE Area Admin Team - CS
Operations Prevention and Response
London Fire Brigade
Rear of Stratford fire station
2 Ferns Road
Stratford E15 4LX

Tel: 020 8555 1200 Extn 35716
Mob: 07827 896 174
e-mail: graham.scawthorn@london-fire.gov.uk

**OUT OF HOURS**
0208 555 1200 Extn 88111

**Appendix 6**

**Clutter Image Rating**

# Clutter Image Rating: Kitchen

1

2

3

4

5

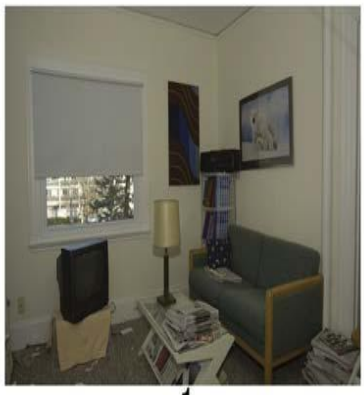
6

7

8

9

Clutter Image Rating:Living Room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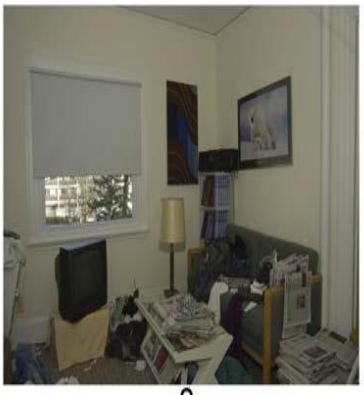
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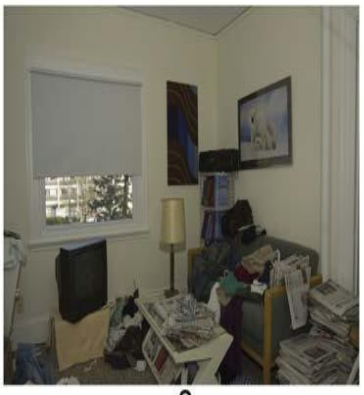

3


4


5


6


7


8

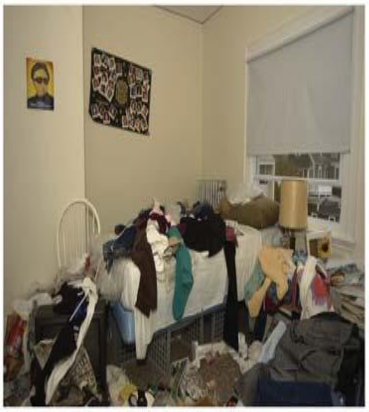

9

Clutter Image Rating: Bedroom

1

2

3



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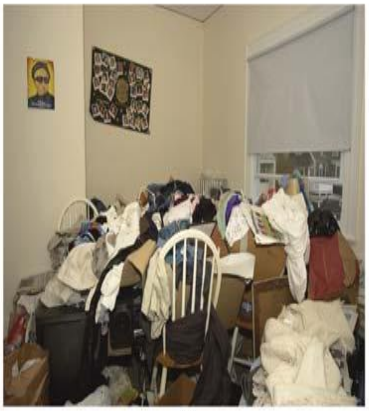

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# Clutter Image Rating

Using the 3 series of pictures (CIR: Living Room, CIR: Kitchen, and CIR: Bedroom), please select the picture that best represents the amount of clutter for each of the rooms of your home. Put the number on the line below.

Please pick the picture that is closest to being accurate, even if it is not exactly right. If your home does not have one of the rooms listed, just put NA for "not applicable" on that line.

| **Room** | **Number of closest corresponding picture (1-9)** |
|---|---|
| Living Room | _____ |
| Kitchen | _____ |
| Bedroom #1 | _____ |
| Bedroom #2 | _____ |

*Also, please rate other rooms in your house that are affected by clutter on the lines below. Use the CIR: Living Room pictures to make these ratings.*

| | | |
|---|---|---|
| Dining room | _____ | |
| Hallway | _____ | |
| Garage | _____ | |
| Basement | _____ | |
| Attic | _____ | |
| Car | _____ | |
| Other Please specify: | _____ | Please specify: _____ |

# Appendix 7

## Assessment Tool Guidelines

| | |
|---|---|
| **1. Property structure, services & garden area** | □ Assess the access to all entrances and exits for the property. (Note impact on any communal entrances & exits). Include access to roof space.<br>□ Does the property have a smoke alarm?<br>□ Visual Assessment (non-professional) of the condition of the Services (NPVAS) within the property e.g. plumbing, electrics, gas, air conditioning, heating, this will help inform your next course of action.<br>□ Are the services connected?<br>□ Assess the garden. size, access and condition. |
| **2. Household Functions** | □ Assess the current functionality of the rooms and the safety for their proposed use e.g. can the kitchen be safely used for cooking or does the level of clutter within the room prevent it.<br>□ Select the appropriate rating on the clutter scale.<br>□ Please estimate the % of floor space covered by clutter<br>□ Please estimate the height of the clutter in each room |
| **3. Health and Safety** | □ Assess the level of sanitation in the property.<br>□ Are the floors clean?<br>□ Are the work surfaces clean?<br>□ Are you aware of any odours in the property?<br>□ Is there rotting food?<br>□ Does the resident use candles?<br>□ Did you witness a higher than expected number of flies?<br>□ Are household members struggling with personal care?<br>□ Is there random or chaotic writing on the walls on the property?<br>□ Are there unreasonable amounts of medication collected? Prescribed or over the counter?<br>□ Is the resident aware of any fire risk associated to the clutter in the property? |
| **4. Safeguard of Children & Family members** | □ Do any rooms rate 7 or above on the clutter rating scale?<br>□ Does the household contain young people or children? |
| **5. Animals and Pests** | □ Are the any pets at the property?<br>□ Are the pets well cared for, are you concerned |

| | |
|---|---|
| | about their health?<br>□ Is there evidence of any infestation? e.g bed bugs. rats, mice, etc.<br>□ Are animals being hoarded at the property?<br>□ Are outside areas seen by the resident as a wildlife area?<br>□ Does the resident leave food out in the garden to feed foxes etc. |
| **6. Personal Protective Equipment (PPE)** | □ Following your assessment do you recommend the use of Persona Protective Equipment (PPE) at future visits? Please detail<br>□ Following your assessment do you recommend the resident is visited in pairs? Please detail |

| | |
|---|---|
| Level 1<br>***Clutter image rating 1 - 3*** | Household environment is considered standard. No specialised assistance is needed. If the resident would like some assistance with general housework or feels they are declining towards a higher clutter scale, appropriate referrals can be made subject to age and circumstances. |
| **1. Property structure, services & garden area** | 1. All entrances and exits, stairways, roof space and windows accessible.<br>2. Smoke alarms fitted and functional or referrals made to fire brigade to visit and install.<br>3. All services functional and maintained in good working order.<br>4. Garden is accessible, tidy and maintained |
| **2. Household Functions** | 1. No excessive clutter, all rooms can be safely used for there intended purpose.<br>2. All rooms are rated 0-3 on the Clutter Rating Scale<br>3. No additional unused household appliances appear in unusual locations around the property<br>4. Property is maintained within terms of any lease or tenancy agreements where appropriate.<br>5. Property is not at risk of action by Environmental Health. |
| **3. Health and Safety** | 1. Property is clean with no odours, (pet or other)<br>2. No rotting food<br>3. No concerning use of candles<br>4. No concern over flies<br>5. Residents managing personal care<br>6. No writing on the walls<br>7. Quantities of medication are within appropriate limits, in date and stored appropriately. |
| **4.Safeguard of Children & Family members** | 1. No Concerns for household members |
| **5. Animals and Pests** | 1. Any pets at the property are well cared for<br>2. No pests or infestations at the property |
| **6. Personal Protective Equipment (PPE)** | 1. No PEP required<br>2. No visit in pairs required. |
| **Actions** | **Level 1** |
| Referring Agency | □ Discuss concerns with resident<br>□ Raise a request to the Fire Brigade for a home safety fire check<br>□ Refer for support assessment if appropriate.<br>□ Refer to GP if appropriate |

| | |
|---|---|
| Environmental Health | □ No Action |
| Social Landlords | □ Provide details on debt advice if appropriate to circumstances<br>□ Refer to GP if appropriate<br>□ Refer for support assessment if appropriate.<br>□ Provide details of support streams open to the resident via charities and self help groups.<br>□ Provide details on debt advice if appropriate to circumstances<br>□ Ensure residents are maintaining all tenancy conditions |

| Level 2<br>***Clutter Image Rating 4 – 6*** | **Household environment requires professional assistance to resolve the clutter and the maintenance issues in the property.** |
|---|---|
| **1. Property structure, services & garden area** | 1. Only major exit is blocked<br>2. Only one of the services is not fully functional<br>3. Concern that services are not well maintained<br>4. Smoke alarms are not installed or not functioning<br>5. Garden is not accessible due to clutter, or is not maintained<br>6. Evidence of indoor items stored outside<br>7. Evidence of light structural damage including damp<br>8. Interior doors missing or blocked open |
| **2. Household Functions** | 1. Clutter is causing congestion in the living spaces and is impacting on the use of the rooms for their intended purpose.<br>2. Clutter is causing congestion between the rooms and entrances.<br>3. Room(s) score between 4-5 on the clutter scale.<br>4. Inconsistent levels of housekeeping throughout the property<br>5. Some household appliances are not functioning properly and there may be additional units in unusual places.<br>6. Property is not maintained within terms of lease or tenancy agreement where applicable.<br>7. Evidence of outdoor items being stored inside |
| **3. Health and Safety** | 1. Kitchen and bathroom are not kept clean<br>2. Offensive odour in the property<br>3. Resident is not maintaining safe cooking environment<br>4. Some concern with the quantity of medication, or its storage or expiry dates.<br>5. No rotting food |

| | |
|---|---|
| | 6. No concerning use of candles<br>7. Resident trying to manage personal care but struggling<br>8. No writing on the walls |
| **4.Safeguard of Children & Family members** | 1. Hoarding on clutter scale 4 -7 doesn't automatically constitute a Safeguarding Alert.<br>2. Please note all additional concerns for householders<br>3. Properties with children or vulnerable residents with additional support needs may trigger a Safeguarding Alert under a different risk. |
| **5. Animals and Pests** | 1. Pets at the property are not well cared for<br>2. Resident is not unable to control the animals<br>3. Animal's living area is not maintained and smells<br>4. Animals appear to be under nourished or over fed<br>5. Sound of mice heard at the property.<br>6. Spider webs in house<br>1. Light insect infestation (bed bugs, lice, fleas, cockroaches, ants, etc) |
| **6. Personal Protective Equipment (PPE)** | 1. Latex Gloves, boots or needle stick safe shoes, face mask, hand sanitizer, insect repellent.<br>2. VIP required |
| **Level 2** | **Actions** |
| Referring Agency | □ Refer to landlord if resident is a tenant<br>□ Refer to Environmental Health is resident is a freeholder<br>□ Raise an alert to the Fire Brigade and request a HSFV<br>□ Provide details of garden services<br>□ Refer for support assessment<br>□ Referral to GP<br>□ Referral to debt advice if appropriate<br>□ Refer to Animal welfare if there are animals at the property.<br>□ Ensure information sharing with all agencies involved to ensure a |

| | |
|---|---|
| Level 3<br>Clutter image rating<br>7 - 9 | Household environment will require intervention with a collaborative multi agency approach with the involvement from a wide range of professionals. This level of hoarding constitutes a Safeguarding alert due to the significant risk to health of the householders, surrounding properties and residents. Residents are often unaware of the implication of their hoarding actions and oblivious to the risk it poses. |

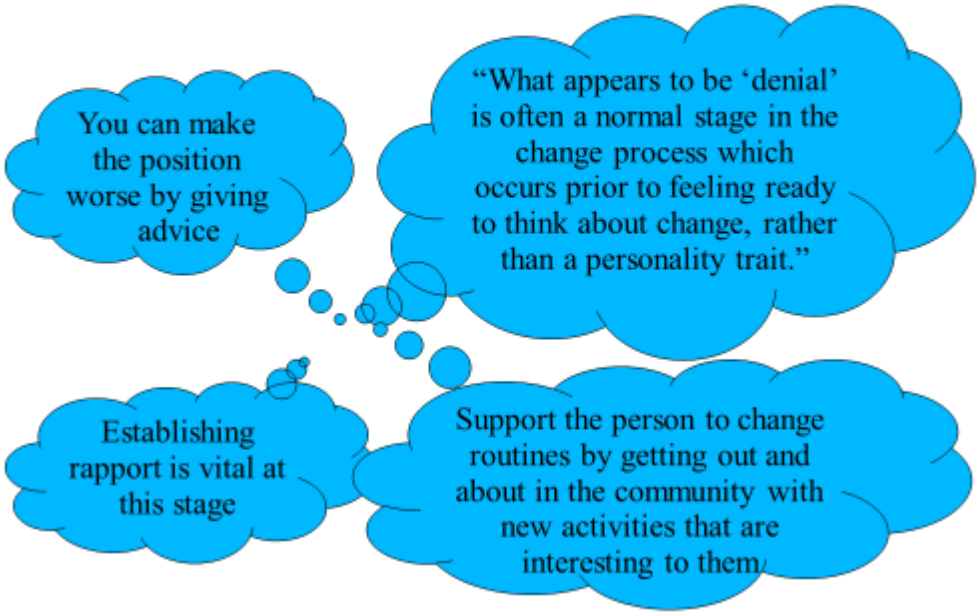
| | |
|---|---|
| **1. Property structure, services & garden area** | 1. Limited access to the property due to extreme clutter<br>2. Evidence may be seen of extreme clutter seen at windows<br>3. Evidence may be seen of extreme clutter outside the property<br>4. Garden not accessible and extensively overgrown<br>5. Services not connected or not functioning properly<br>6. Smoke alarms not fitted or not functioning<br>7. Property lacks ventilation due to clutter<br>8. Evidence of structural damage or outstanding repairs including damp<br>9. Interior doors missing or blocked open<br>10. Evidence of indoor items stored outside |
| **2. Household Functions** | 1. Clutter is obstructing the living spaces and is preventing the use of the rooms for their intended purpose.<br>2. Room(s) scores 7 - 9 on the clutter image scale<br>3. Rooms not used for intended purposes or very limited<br>4. Beds inaccessible or unusable due to clutter or infestation<br>5. Entrances, hallways and stairs blocked or difficult to pass<br>6. Toilets, sinks not functioning or not in use<br>7. Resident at risk due to living environment<br>8. Household appliances are not functioning or inaccessible<br>9. Resident has no safe cooking environment<br>10. Resident is using candles<br>11. Evidence of outdoor clutter being stored indoors.<br>12. No evidence of housekeeping being undertaken<br>13. Broken household items not discarded e.g. broken glass or plates<br>14. Concern for declining mental health<br>15. Property is not maintained within terms of lease or tenancy agreement where applicable<br>16. Property is at risk of notice being served by Environmental Health |
| **3. Health and Safety** | 1. Human urine and or excrement may be present<br>2. Excessive odour in the property, may also be evident from the outside<br>3. Rotting food may be present<br>4. Evidence may be seen of unclean, unused and or buried plates & dishes.<br>5. Broken household items not discarded e.g. broken glass or plates<br>6. Inappropriate quantities or storage of |

| | |
|---|---|
| | medication.<br>7. Pungent odour can be smelt inside the property and possibly from outside.<br>8. Concern with the integrity of the electrics<br>9. Inappropriate use of electrical extension cords or evidence of unqualified work to the electrics.<br>10. Concern for declining mental health |
| **4. Safeguard of Children & Family members** | 1. Hoarding on clutter scale 7-9 constitutes a Safeguarding Alert.<br>2. Please note all additional concerns for householders |
| **5. Animals and Pests** | 1. Animals at the property at risk due the level of clutter in the property<br>2. Resident may not able to control the animals at the property |

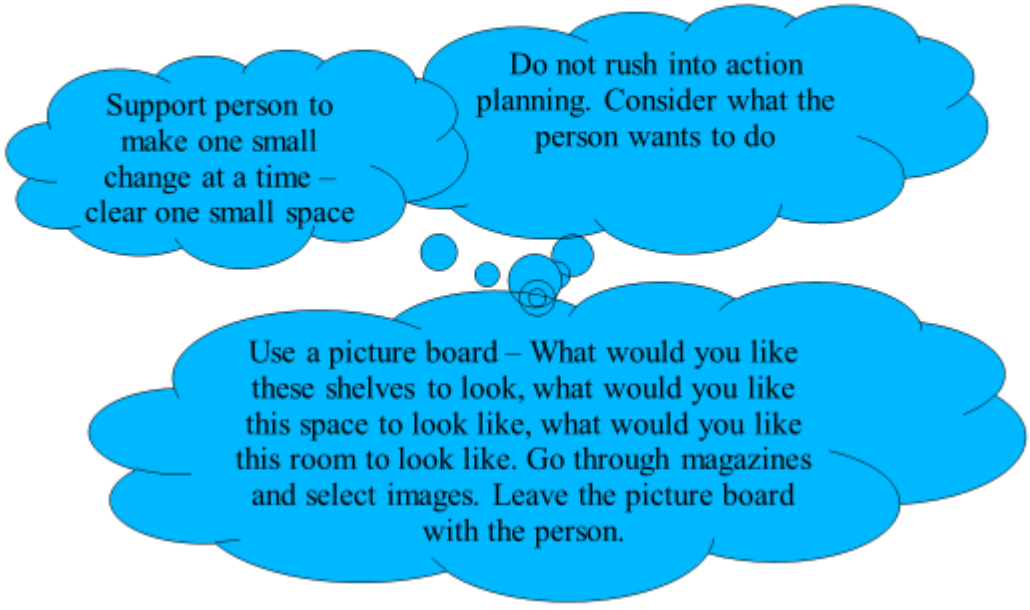
**Appendix 8**

# Supporting change

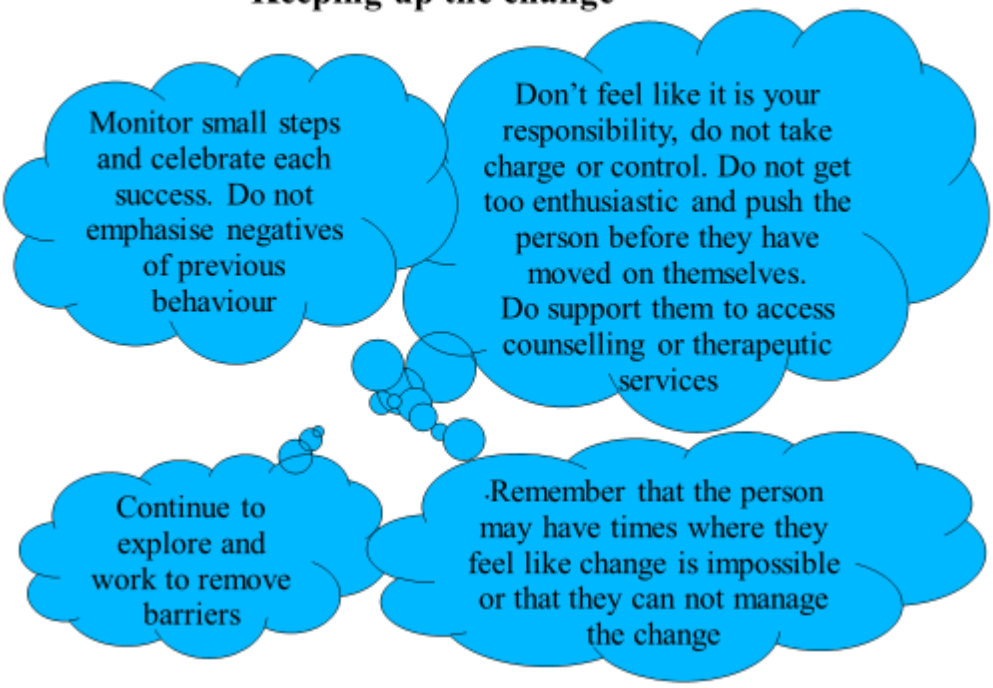
## When a person is not considering change




## Starting to consider change



## Keeping up the change




## Maintenance skills

Most useful:

- Be aware when support may still be required and when to let go
- Build regular support for the new behaviour
- Positive feedback on progress
- Affirm and praise
- Build new skills/behaviours
- Plan for coping and lapse
- Reinforcement of longer term goals

Fuller and Taylor 2005

**Maintenance skills (cont.)**

Least useful:

- Let go too early
- Over emphasise exploring previous behaviour
- Hold them in dependency
- A person is likely to have periods of relapse. If this happens start the process again building on the strengths gained – no blame

Fuller and Taylor 2005

## When talking to someone who hoards

## DO:

**Imagine yourself in that persons shoes.** How would you want others to talk to you to help you manage your anger, frustration, resentment, and embarrassment?

**Match the person's language.** Listen for the individual's manner of referring to his/her possessions (e.g. "my things", "my collections") and use the same language (i.e. "your things", "your collections").

**Use encouraging language.** In communicating with people who hoard about the consequences of hoarding, use language that reduces defensiveness and increases motivation to solve the problem (e.g. "I see that you have a pathway from your front door to your living room. That's great that you've kept things out of the way so that you don't slip or fall. I can see that you can walk through here pretty well by turning sideways. The thing is that somebody else that might need to come into your home, like a fire fighter or an emergency responder, would have a pretty difficult time getting through here. They have equipment they're usually carrying and fire fighters have protective clothes that are bulky. It's important to have a pathway that is wide enough so that they could get through to help you or anyone else who needed it. In fact, the safety law states that [insert wording about exits/ways out must be clear], so this is one important change that has to be made in your home".

**Highlight strengths.** All people have strengths, positive aspects of themselves, their behaviour, or even their homes. A visitor's ability to notice these strengths helps forge a good relationship and paves the way for resolving the hoarding problem (e.g. "I see that you can easily access your bathroom sink and shower," "What a beautiful painting!", "I can see how much you care about your cat.")

**Focus the intervention initially on safety and organisation of possessions and later work on discarding.** Discussion of the fate of the person's possessions will be necessary at some point, but it is preferable for this discussion to follow work on safety and organisation.

## When talking to someone who hoards

## DO NOT:

**Use judgmental language.** Like anyone else, individuals with hoarding will not be receptive to negative comments about the state of their home or their character (e.g. "What a mess!" "What kind of person lives like this?") Imagine your own response if someone came into your home and spoke in this manner, especially if you already felt ashamed.

**Use words that devalue or negatively judge possessions.** People who hoard are often aware that others do not view their possessions and homes as they do. They often react strongly to words that reference their possessions negatively, like "trash", "garbage" and "junk".

**Let your non-verbal expression say what you're thinking.** Individuals with compulsive hoarding are likely to notice non-verbal messages that convey judgment, like frowns or grimaces.

**Make suggestions about the person's belongings.** Even well-intentioned suggestions about discarding items are usually not well received by those with hoarding.

**Try to persuade or argue with the person.** Efforts to persuade individuals to make a change in their home or behaviour often have the opposite effect – the person actually talks themselves into keeping the items.

**Touch the person's belongings without explicit permission.** Those who hoard often have strong feelings and beliefs about their possessions and often find it upsetting when another person touches their things. Anyone visiting the home of someone with hoarding should only touch the person's belongings if they have the person's explicit permission

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| Committee(s) | Dated: |
|---|---|
| Safeguarding Sub Committee | 17 November 2016 |
| **Subject:** Sufficiency and Commissioning Strategy for Children in Care | **Public** |
| **Report of:** Director of Community and Children's Services | **For Information** |
| **Report author:** Pat Dixon, Safeguarding and Quality Assurance Service Manager | |


**Summary**

This report will provide Members with the current context to the sourcing of placements for the City of London's children looked after population, summarising the proposed commissioning strategy for placements in the future. It explains how this will ensure that there are sufficient placements, with the capacity to meet the diverse cultural and ethnic needs of the City of London's children looked after population.

This report identifies the options available to ensure that there will be sufficient placements in the future, advising of potential strengths and risks in relation to these options and taking into consideration the needs analysis of our current children and young people looked after and how this will be reviewed.


**Recommendation(s)**

Members are asked to:

- Note the report.

**Main Report**

**Background**

1. The City of London has one generic children's team which provides services including adoption, early help, children with disabilities, children in need, child protection, children looked after and care leavers. The number of City of London resident children who have become looked after is very low, usually three or four children at any one time. The majority of children who are looked after in the City are unaccompanied asylum seeking children (UASC); on average, the number of these children looked after at any one time ranges from seven to twelve.

2. Due to the low numbers of children looked after in the City of London, placements for children have been provided by independent fostering agencies (IFAs) through the Pan London Consortium, of which the City is a part. Local authorities within the Consortium come together under a single contractual arrangement with IFAs to ensure that there is an agreed standard and cost for placements.

3. This does not preclude the need for individual contractual arrangements with IFAs, but there is a certain assurance as to the quality and consistency of the services being provided. There is also a wider pool of diverse foster carers which offers more choice when finding a placement. The majority of local authorities use the Pan London Consortium when they have exhausted their own placements, or where they have a child who requires more specialist care which cannot be provided in-house.

4. The risks in relation to this strategy are that the quality of the placements can be variable. City of London children and young people can also be placed over a wide geographical area when establishing the best match in regard to ethnic and cultural needs, which can be isolating for the children and young people involved. There is also some concern that the consortium may be disbanded due to a lack of interest/participation on the part of other local authorities.

**Other placement options**

5. The following options will be considered to ensure that sufficient placements are available to meet the needs of children looked after in the City of London.

**Option 1**

6. This option would be to bring fostering services in-house, with foster carers being recruited and supported by the City of London. The strength of this strategy would be that the City would have more control over the quality of services being offered, training foster carers in the specific needs of the City. It would also enable the recruitment of foster carers from in and around the locality of the City, making it possible for children and young people to remain near their homes; however, as previously identified, the majority of the City's children are UASC. In-house foster carers would support the children's and young people's identities in being connected to the City, and local resources would be available.

7. The risk in relation to this strategy would be a smaller pool of foster carers to call upon; this could restrict the City's capacity to meet the diverse needs of the City of London's children looked after population. Consideration would also need to be given to the current structure of Children's Social Care to support a fostering service. This strategy could have considerable resource implications, due to the infrastructure required to deliver in-house fostering services.

**Option 2**

8. This option would be to have direct contractual arrangements with one or two IFAs, to provide fostering services for the City. The strengths of this strategy would be similar to those of option 1, in that the City would have more control over the quality and costs of the provision through individually negotiated agreements directly with the providers. Unlike option I, the City would not be required to increase the infrastructure of Children's Social Care to accommodate the fostering service.

9. The potential risks in relation to this strategy could be the restricted number of foster carers available, and their lack of diversity to meet the needs of the City's children looked after population. When commissioning the service, consideration would have to be given to placement disruption and the potential deterioration of the quality of the IFA in order to ensure that the City could minimise the disruption for young people, while retaining good to outstanding services. However, this could be resolved through putting robust contractual and monitoring arrangements in place which would quickly identify areas of concern, and working with the IFAs to resolve any performance issues.

**Option 3**

10. This option would look at commissioning fostering placements from another local authority. Given the low numbers of children looked after, this could provide a sustainable option that is likely to offer the diversity needed. The strength in using this strategy would be the potential to have children and young people placed near the City in neighbouring boroughs. It could also give children and young people the opportunity to link into local services in the area in which they are placed. This option has been pursued in the past; however, there was limited response from other local authorities due to the pressures they were already experiencing on their placements from their own children looked after population.

11. These potential concerns could be resolved through the commissioning strategy used: for example, exploring the option of funding additional foster carers, by contributing to training costs for foster carers and supporting the recruitment of additional carers. The potential risks in relation to this strategy would be the availability of placements when required, and whether there would be enough diversity within the foster placements to meet the needs of the children and young people.

**Conclusion**

12. The Sufficiency and Commissioning Strategy analyses the needs of children and young people looked after in the City of London, and the impact that this data has on our future placement requirements. We need to explore the strengths of this strategy and the potential areas for development to ensure that children and young people feel connected and central to the strategic planning of future services.

13. A key area of development has been to bring both City of London resident children and UASC together to ensure that they have a say in the development of services for children. This has been achieved through the Children in Care Council (CiCC) which offers opportunities for children in care and care leavers to be involved in the monitoring of commissioned services.

14. We are currently reviewing the feasibility of the various options put forward to ascertain the most suitable resources for the City of London's children looked after population. It may well be that a range of options will be used to reduce the potential risks.

**Appendices**

- Appendix 1 – Sufficiency and Commissioning Strategy for Children in Care in the City of London 2015 to 2017

**Pat Dixon**
Safeguarding and Quality Assurance Service Manager

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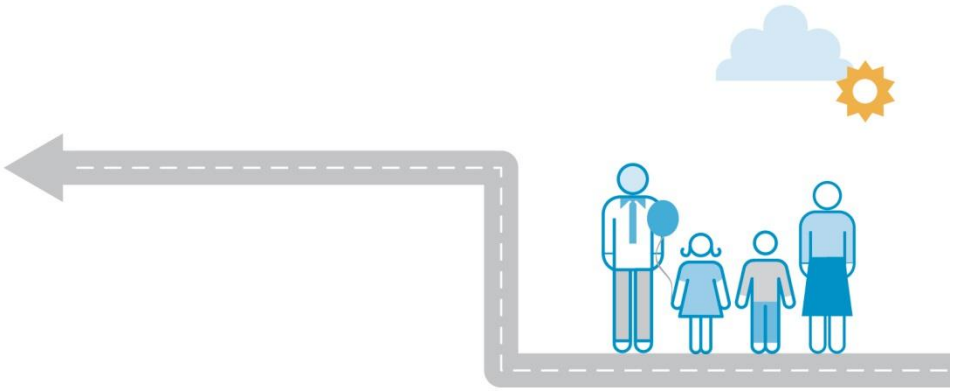


**APPENDIX 1**

# Sufficiency and Commissioning Strategy for Children in Care in the City of London 2015 to 2017

# About this document

| | |
|---|---|
| Title | Sufficiency and Commissioning Strategy for Children in Care in the City of London. |
| Purpose | The Sufficiency Strategy has been produced to set out how Family Operations will meet its duty of sufficiency. This version of the document includes the mid-term review. |
| Updated by | Pat Dixon |
| Approved by | |
| Date | |
| Version number | 1.3 |
| Status | Final |
| Review frequency | Three-yearly with mid-term review. |
| Next review date | |

# Table of Contents

# 1. Introduction

**1.1.** The City of London's Sufficiency and Commissioning Strategy for Children in Care draws together the findings from research into the needs of children and young people in care in the City of London.

**1.2.** All local authorities have a statutory duty to ensure that there are sufficient placements within their geographical area to meet the needs of children and young people in care. The City of London covers only one square mile and there are currently no foster carers within this geographic area. Due to the number of children residing in the City of London, which is currently standing at approximately just under 900 it has not been considered feasible to provide an in-house fostering service.

**1.3.** The City of London has one generic children's team which provides services from adoption, early help; children with disabilities, children in need, child protection, children looked after and care leavers. The number of City of London resident children who have become looked after is very low, ranging from approximately three to four children at any one time. The majority of children who are looked after in the City are unaccompanied asylum seeking children, on average the number of children looked after at any one time ranges from seven to twelve.

**1.4.** The Sufficiency and Commissioning Strategy analyses the needs of children and young people in care in the City of London and the impact that this data has on our future placement requirements. Exploring the strengths of this strategy and the potential areas for development, to ensure that children and young people feel connected and central to the strategic planning for future services

# 2. Legal Context

**2.1** Since the implementation of the Children Act 1989 local authorities have been required to take steps that secure, so far as is reasonably practicable, sufficient accommodation for children looked after within their local authority area (Section 22G Children Act 1989). This section of the 1989 Act was also inserted into Section 9 of the Children and Young Persons Act 2008. This is now referred to as 'the sufficiency duty'.

**2.2** The Statutory Guidance on securing sufficient accommodation for children looked after provides examples of best practice in securing sufficiency that include the following:

- That all children are placed in appropriate placements with access to the support services they require in their local authority area, except where this is not consistent with their welfare;

- That the full range of universal, targeted and specialist services work together to meet children's needs in an integrated way in the local area, including children who are already looked after, as well as those at risk of care or custody;

- Where it is not reasonable or practical for a child to be placed within her/his local authority area, there are mechanisms in place to widen the range of provision in

neighbouring areas, or region which is still within an accessible distance, while still being able to provide the full range of services to meet identified needs;

- That partners, including housing, work together to secure a range of provision to meet the needs of those who become looked after at the age of 16 and 17 years, and support the continuity of accommodation beyond the age of 18 years;

- And in addition to meeting relevant national minimum standards, services are of high quality to secure the specific outcomes identified in the care plans of children looked after;

**2.3** The Statutory Guidance states that 'Local authorities must be able to show that at a strategic level they are taking steps to meet the sufficiency duty, so far as is 'reasonably practical'.' It further explains what is meant by 'reasonably practical', and it includes the following:

- that it is a general duty that applies to strategic arrangements, rather than to the provision of accommodation to a particular, individual child;

- it does not require local authorities to provide accommodation within their area for every child they look after;

- there may be a significant minority of children for whom it is not 'reasonably practical' to provide a certain type of accommodation within the area;

- in accordance with section 22C (5) of the 1989 Act, the overriding factor is that the placement must be the most appropriate placement available;

- the local authority must give preference to a placement with a friend, relative or other person connected with the child and who is a local authority foster parent [section 22C (7) (a)];

**2.4** The term 'looked after children' as defined in the 1989 Act refers to all children and young people being 'looked after' by the local authority. These may be subject to Care Orders or Interim Care Orders; placed or authorised to be placed, with prospective adopters; voluntarily accommodated including unaccompanied asylum seeking children and LAC Placement Sufficiency Strategy 2014-2017 5 finally those subject to court orders with residence requirements i.e. a secure order or remanded to local authority accommodation.

**2.5** The term 'care leavers' as defined in The Children (Care Leavers) Act 2000 refers to eligible, relevant and former relevant children:

- Eligible children are those young people aged 16 and 17 who are still in care and have been 'looked after' for (a total of) at least 13 weeks from the age of 14 and including their 16th birthday; Relevant children are those young people aged 16 and 17 who have already left care, and who were 'looked after' for (a total of) at least 13 weeks from the age of 14, and have been 'looked after' at some time while they were 16 or 17;

- Former relevant children are those young people aged 18, 19 or 20 who have been eligible and/or relevant.

# 3. Local Context for Children Looked After

**3.1** The City of London is committed to ensuring that children and young people are able to remain safely within their own families wherever this is consistent with maintaining and promoting their wellbeing. This is supported through a "Think Family" approach, whereby all services involved with the family work together to prevent children coming into care.

**3.2** We are also improving the range of support services available to children with disabilities and their families, again to ensure that this group of children and young people remain within their families wherever possible. This is achieved through supporting children and families in accessing targeted and early help services, in addition to "short breaks".

**Fig 1**

| Snapshots @ 31 March | Entity | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|---|---|---|---|---|
| Number of Looked After Children @ 31 March | **LA** | 12 | 14 | 9 | 6 | 7 | 7 | 8 | 11 |
| LAC at 31 March - Rate per 10,000 CYP population (<18yo) | **LA** | 207.00 | 224.00 | 133.00 | 102.00 | 88.00 | 84.00 | 84.00 | 115.18* |
| LAC at 31 March - Rate per 10,000 CYP population (<18yo) | **SN** | 59.70 | 60.40 | 57.60 | 56.70 | 52.50 | 48.90 | 48.70 | Not yet available |
| LAC at 31 March - Rate per 10,000 CYP population (<18yo) | **England** | 54.00 | 57.00 | 58.00 | 59.00 | 60.00 | 60.00 | 60.00 | Not yet available |

** 2016 rate per 10,000 currently using the ONS 2014 Mid-Year population projection for < 18 year olds, awaiting the 2015 projection*

**3.3** We ensure that only those children and young people for whom care is essential come into care while enabling all others to be supported to remain within their extended families. Where children and young people need to come into care for their own safety and protection, we will seek to ensure that they remain placed as close as possible to their home, community and school, when this is in accordance with their best interests. For young children who are unable to safely return to their birth or extended families, we will seek permanency for them through adoption wherever possible. Adoption is associated with the best outcomes for children unable to remain within their own birth families, where this isn't possible the City has sought to achieve permanency through a Special Guardianship Order.

**3.4** As can be seen by Fig 1 the number of City resident children who become looked after has always remained low, the majority of the City's children looked after are unaccompanied asylum seeking children (UASC). This is in contrast to other local authorities, where the majority of the children looked after are residents in the local authority, this brings its own unique challenges in finding suitable placements that meet the diverse cultural needs of the City's children looked after.

**Fig 2 Ethnic diversity of Children Looked After Population April 2016**

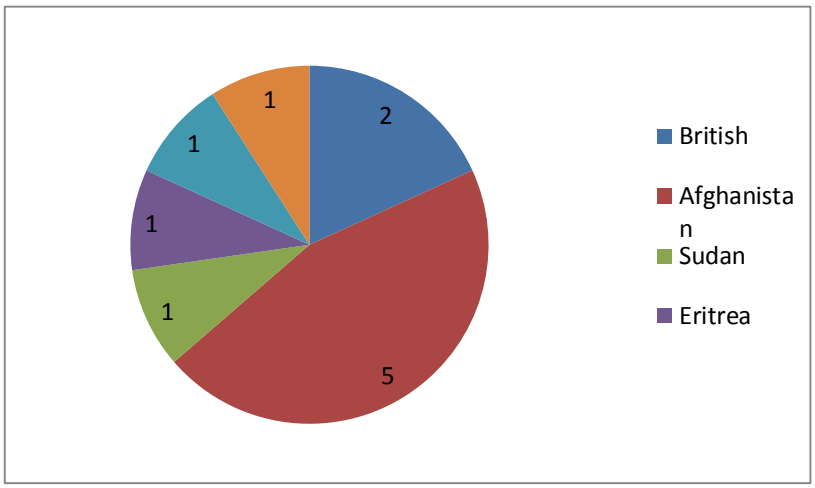
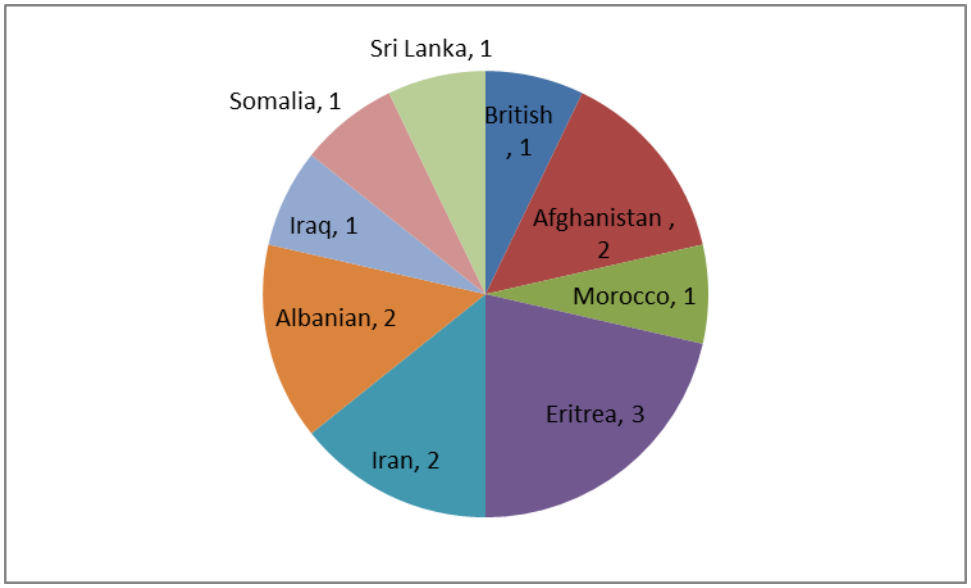



**Fig 3 Ethnic diversity of Care Leaver Population April 2016**




**3.5** Fig 2 and 3 shows the ethnic diversity of the children looked after and care leaver population in the City of London. Integral to this strategy is how we meet the diverse needs of our children and young people, ensuring that they have the support and familiarity of foster carers who know and understand their needs and journey. Key to achieving this is ensuring that we have achieved the best match for the young person in relation to their placement, so that they can feel safe and secure. This is achieved

through reviewing a wide range of carers with similar backgrounds to the young people. Working closely with the commissioning team in setting up individual contractual arrangements with the Independent Fostering Agencies, so there is consistency around the quality of the placements, which achieves best value. This approach supports placement stability and the learning and development of our young people.

# 4 Needs Analysis and Commissioning Intentions

In terms of the looked after children population data from 1 April 2014 to 31 March 2015 shows that;

**4.1** The age and gender profile of the City's children looked after reflects the dominance of children who are UASC. Among this group seven of the eleven children looked after in 2014/15 were UASC, as were three of the four children who came into care during this year. Nationally, 89% of UASC children are male and 76% are aged over 16 years

**4.2** 36% of children looked after in 2014/15 in the City of London were from white ethnic backgrounds. This is less than would be expected because 58% of the general population aged 0-19 years old are from white ethnic backgrounds. 18% of the children looked after population are from mixed ethnic backgrounds which are reflective of the 14% of children from mixed ethnic background in the general population. 36% are from Asian ethnic backgrounds. Asian children are over represented in the population of children looked after; only 17% of the general population are Asian. These proportions should however be treated with caution due to the very low numbers involved.

**4.3** Due to the diverse nature of the City of London's children looked after population it is important that we have a range of carers from varied backgrounds, given the size and demography of the City of London it may prove difficult to meet these needs within the one square mile. As can be seen from Fig 2 the highest proportion of people living in the City are White/ British, with Asian Bangladeshi being the second highest. In relation to care leavers considerable support is offered by City of London Housing, through supported tenancy arrangements in the City and on estates owned by the City of London in other Local Authorities.

**4.4 Options**

The following options have been considered to support City of London children who are looked after;

**Option 1**

This option would be to bring fostering services in-house; with foster carers being recruited and supported by the City of London. The strength of this strategy would be that the City would have more control of the quality of services being offered, training foster carers in the specific needs of the City. It would also enable the recruitment of foster carers from in and around the locality of the City, making it possible for City children and

young people to remain near to their homes; however as previously identified the majority of the City's children are UASC. In-house foster carers would support the children and young people's identity in being connected to the City, and local resources available.

The risk in relation to this strategy would be a smaller pool of foster carers to call upon; this could restrict the City's capacity in meeting the diverse needs of the City of London's children looked after population. As can be seen by the data in fig 4, white British are the highest ethnic group in the City of London at 57.5. When this is seen in relation to the majority of the children looked after in the City, who unaccompanied children seeking asylum, with only a small proportion are being City residents it could prove difficult to meet the diverse needs of our CLA population.

Consideration would also need to be given to the current structure of Children's Social Care in relation to supporting a fostering service. To ensure that the fostering service met National Minimum Standards and the supervisory role for foster carers employed by the City of London. This strategy could have considerable resource implications, due to the infra-structure required to deliver in-house fostering services. There is also the risk that with a smaller selection of carers the City might not be able to meet the diverse needs of our children looked after population.

**Option 2**

This option would be to have direct contractual arrangements with one or two Independent Fostering Agencies, to provide fostering services for the City. The strengths of this strategy would be similar to those of option 1, in that the City would have more control over the quality and costs of the provision through individually negotiated agreements directly with the providers. Unlike option I the City would not be required to increase the infra-structure of Children's Social Care to accommodate the fostering service. The potential risks in relation to this strategy could be the restricted number of foster carers available, and the diversity to meet the needs of the City's children looked after population. Consideration would also need to be given in regard to placement disruption and the potential deterioration of the quality of the IFA when commissioning the service, to ensure that the City can minimise the disruption for young people, whilst retaining good to outstanding services. However this could be resolved through robust contractual and monitoring arrangements being in place, which will quickly identify areas of development, working with the IFA's to resolve any performance issues.

**Option 3**

This option is the current option being used by the City of London. The City is part of the Pan London Consortium, which is where Local Authorities in London have come together under one contractual arrangement with IFA's to ensure that the there is an agreed standard and cost for placements from IFA's. This does not preclude the need for individual contractual arrangements with the IFA's, but there is a certain assurance as to the quality and consistency as to the services being provided. There is also a wider pool of diverse foster carers to choose from, which enable more choice when finding a placement. The majority of Local Authorities use the Pan London Consortium when they have exhausted their own placements or where they have a child who requires more specialist care which cannot be provided in-house.

The risks in relation to this strategy are that the quality can be variable in regard to the placements. City of London children and young people can also be placed over a wide demographic area when establishing the best match in regard to ethnic and cultural needs, which can be isolating for the young people. There have also been some concerns that the consortium may be disbanded due to the lack of interest/participation from other Local Authorities.

The options identified are being reviewed on a regular basis to ensure that the most suitable model is used to meet the needs of the children looked after and care leavers in the City of London. It may be that the City will use more than one option, this would minimise the potential risks in utilising just one of the options available. The main priority of the City is to ensure that children and young people have the best possible opportunities to reach their full potential. A key factor in achieving this is placement stability and appropriate support and care, therefore the priority of this strategy is to meet needs of children and young people, to do this they will need to be the central focus to any commissioning arrangements

**Fig 4**

| City of London Ethnicity Source 2011 census | |
|---|---|
| White British | 57.5 |
| Black African | 1.3 |
| Black Caribbean | 0.6 |
| Turkish/ Turkish Cypriot | 0.2 |
| Asian Indian | 2.9 |
| Asian Bangladeshi | 3.1 |
| White Irish | 2.4 |
| Asian Chinese | 3.6 |
| White Polish | 0.5 |

**4.5** The current preferred option for the City's children looked after is to commission Independent Fostering Agencies (IFA) through the Pan London consortium, to which the City of London belongs to;

- This ensures that the City has access to a culturally diverse number of foster carers, which match the needs of our children looked after population.

- The City ensures that when children are placed with IFA they are only placed with agencies that have been judged as good or outstanding by Ofsted.

- IFA's are monitored every 6 months by the Safeguarding and Quality Assurance Service Manager to ensure that agencies are meeting national minimum standards.

- City of London provides additional free training for foster carers caring for City looked after children.

- Children and young people have a high level of support in placement from their social worker and independent reviewing officer.

This strategy has led to placement stability for City of London children and young people, many of whom often take up the opportunity to "stay put" in placement post 18 years

# 5 Reviewing this Strategy

**5.1** This strategy sets out our commissioning intentions to ensure that we have sufficient placements to meet the needs of children and young people in care within the City of London.

**5.2** Central to this strategy is children and young people and the support that they need to thrive and develop to reach their full potential. To achieve this consideration will need to be given to their health, education, and emotional wellbeing when reviewing how we meet their placement needs.

**5.3** Part of the review of this strategy is for children and young people to have their views taken into consideration; this can be achieved through feedback and through consultation with the Children in Care Council (CiCC).

**5.4** The strategy will be under review to ensure that the commissioning intentions are meeting the needs of children looked after in the City of London. Part of this review will take into consideration any complaints or complements that have been received in regard to placements.

**1.5.** This strategy runs until 2017, and has now been subject to a mid-period review.

# 6 Concluding Remarks

**6.1** The sufficiency and Commissioning Strategy for children in care sets out the City's intentions in providing fostering services for children looked after in the City, which meets their needs in relation to quality and diversity. The uniqueness of the demography in the City is not currently conducive in meeting these needs and therefore the City commission's independent fostering agencies through the Pan London agreement.

**6.2** The City is providing preventative services through Early Help to prevent children and young people coming into care, this has supported the City in maintaining low numbers of City children coming into care. A significant proportion of the City of London's looked after population are unaccompanied asylum seeking children (UASC). A key area of development has been to bring both City of London resident children and UASC together to ensure that they have a say in the development of services for children in care. This has been achieved through the Children in Care Council (CiCC) and opportunities for children in care and care leavers to be involved in the monitoring of commissioned services.

Fostering Monitoring Form

**Fostering Provision**……**Date seen**……...

**Present**……
……

**Contract Review**

Pan London/ Organisational contract in place……..…Yes/No

Individual child contract in place ……Yes/No

Last Reviewed……Date……

Last Monitoring Meeting……....Date……

**Ofsted Inspection**

Last Ofsted Inspection Outcome…….....Date……

Outstanding Actions Progress…….Date……

**Children Placed**

Name…….Date Placed……Foster Carers……...

Name…….Date Placed……Foster Carers……...

Name…….Date Placed……Foster Carers……...

Name…….Date Placed……Foster Carers……...

Name…….Date Placed……Foster Carers……...

**Current Placement Costs/ Reviewed**

Cost……..Reviewed……

Cost……..Reviewed……

Cost……..Reviewed……

Cost……..Reviewed……

**Finance Review/ Comment**……
……
……
……
……
……

| Placement | Evidence | Checked By | Comment |
|---|---|---|---|
| Is there someone that the child can speak to if they are worried or concerned? | | | |
| How do foster carers promote the child identity and individual needs? | | | |
| What support and training do staff have in promoting positive behaviour and relationships? | | | |
| Safeguarding Children – Training, LADO procedures and reporting mechanisms. | | | |
| Does the agency have clear policy and procedures in place in relation to children missing from care/ are foster carers aware, | | | |
| How often are placements checked/reviewed in regard to Health and safety, what training is available for foster carers? | | | |
| Placement suitability in regard to leisure, contact and supporting educational needs. | | | |
| Feedback from children and young people on placement, provider and commissioned service. | | | |
| Promoting independence and moves to adulthood and leaving care- How is this supported. | | | |
| Recruiting, selection and assessing of foster carers. | | | |
| Information on agency decision maker and fostering panel. | | | |
| Fostering agencies statement of purpose and children's guide. | | | |
| Stability of work force, safer recruitment processes | | | |
| Learning and development of foster carers, sample of training opportunities available, and frequency. | | | |
| Supervision and support for foster carers. Out of normal working hours support. | | | |
| Handling of professional allegations and suspicions of harm. Policy and procedures. | | | |
| Notification of significant events LA's, Social Worker, Safeguarding Board. | | | |

**CSE / Radicalisation and Prevent agenda (obtained from LSCB/Police)**

**Intelligence on prevalence where children and young people placed;**

CSE…….Yes/No (delete as required)

Radicalisation……. Yes/No (delete as required)

**Foster Carers have had training on**;

CSE…….Yes/No (delete as required)

Radicalisation……. Yes/No (delete as required)

**Actions outstanding/ review date**

**……**
**……**
**……**
**……**
**……**
**……**

**Copy of Form sent to agency…Yes/ No……..Date……..**

**Next Review Date……**

**Signed……..Date……**

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