MINUTES OF THE MEETING OF THE CHILDREN AND YOUNG PEOPLE'S SCRUTINY PANEL HELD ON TUESDAY 13TH DECEMBER 2016

PRESENT:

Councillors: Kirsten Hearn (Chair), Toni Mallett and Liz Morris

Co-opted Member: Luci Davin (Parent Governor representative)

18. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Mark Blake and Uzma Naseer (Parent Governor representative).

19. ITEMS OF URGENT BUSINESS

None.

20. DECLARATIONS OF INTEREST

Councillor Mallett stated that she was a governor at Broadwaters.

21. UPDATE ON RECOMMENDATIONS FROM THE OFSTED INSPECTION OF SERVICES FOR CHILDREN IN NEED OF HEALTH AND PROTECTION, LOOKED AFTER CHILDREN AND CARE LEAVERS AND REVIEW OF THE EFFECTIVENESS OF THE LOCAL SAFEGUARDING CHILDREN BOARD

Inspection on the Effectiveness of the Local Safeguarding Children Board (LSCB)

The Panel considered an update on progress with the implementation of the recommendations from the Ofsted inspection of 2014 on the effectiveness of the Local Safeguarding Children Board (LSCB). He reported that there were only four recommendations that directly concerned the LSCB and these had all been dealt with within a few months of the report.

He stated that participation from schools was much better, with Head Teachers attending meetings regularly. He met periodically with the Head Teachers Forum and, in addition, the LSCB had initiated specific pieces of work with schools. In respect of Child Sexual Exploitation (CSE), the LSCB's guidance had been in the process of being updated when OFSTED had visited. There was now a better understanding of the role of gangs within this. More work had also taken place on missing children.

A recent independent audit had assessed the LSCB as now being good. In particular, better systems were now in place. He was confident that were OFSTED to re-inspect now, they would say that the LSCB had addressed its previous recommendations fully.

In answer to a question regarding historical abuse, he stated that there were now systems in place to prevent abuse that had not been around 30 years ago. The priority was to ensure that perpetrators did not pose a risk to other people. In addition, consideration needed to be given to communication. Some schools still needed to undertaken further work on their safeguarding procedures but there was now a range of support that was available. Not all schools had their procedures on their websites but the numbers of those that did had improved. OFSTED had been very complimentary about safeguarding support by the LSCB for schools.

Support to those reporting historic abuse was the responsibility of the Police, who were able to signpost individuals to services. Reassurance was required for current parents and pupils in schools. There was a legal requirement to encourage whistle blowing and procedures were explained to staff in inductions. There had also been moves to make to a legal duty for staff to whistle blow.

In terms of sports clubs, safeguarding provision depended on a number of things. If an activity was on schools premises and organised by schools, the same procedures and protection applied as within school. If schools were letting their facilities, very similar provision applied and could be built into the contract. For sports clubs outside of school, there was a website that provided guidance to parents. Sports clubs had access to LSCB training. However, parents needed to exercise a degree of care and request assurance that coaches were DBS checked and that there were safeguarding procedures. It was nevertheless important that parts kept concerns in proportion and not unnecessarily restrict the activities of children and young people.

In answer to a question, he stated that young women had been involved in shaping policy and practice in respect of CSE and missing children through focus groups that had been arranged as part of the strategic review of Violence Against Women and Girls. Some were now being trained as peer supporters. The number of children and young people receiving return home interviews after going missing had gone up and this had helped to identify risk.

Tackling sexism should be inherent to safeguarding practice and at the heart of sex and relationship training. This was now more important than ever due to the increase in alternative sources of information that were available, particularly those on-line. Church schools had different guidelines in respect of sex and relationship training. Although every school had provision, its quality was not clear. One very important area was consent and guidelines needed to cover both the law and the individuals own perception.

Sir Paul felt that there were a number of values that kept young women safe and these included equality, respect, honesty, openness and valuing diversity. Empowerment was an issue that required particular attention though. It was sometimes forgotten that individuals were best placed to protect themselves.

In terms of feedback from return home interviews, the quality and truthfulness of this was variable. Not every child was referred and not all were honest in how they responded. It had not been possible yet to indentify any underlying themes.

Inspection of Services for Children in Need of Health and Protection, Looked After Children and Care Leavers:

The following updated that Panel on progress with the recommendations from the inspection of services for children in need of health and protection, looked after children and care leavers:

- Jon Abbey, the Director of Children's Services
- Neelam Bhardwaja, Assistant Director for Safeguarding and Social Care; and
- Carol Carruthers, Head of Children in Need of Support and Protection.

Mr Abbey reported that there had been 17 recommendations for the local authority. In addition to these, it had also been necessary to address service improvement and respond to changes in demand.

There was now a single point of access to children's social care. The Multi Agency Safeguarding Hub (MASH) was working effectively and there was now greater partner involvement, although it was recognised that there was still work to be done. The Early Help Service had now been launched and the effects of it were starting to be seen. Referrals were now being dealt with within the necessary time limits. Data was being managed effectively and the signs of safety policy had been implemented. The number of looked after children had gone down and was currently 437. Challenges still remained in respect of private fostering and the tracking of care leavers. In respect of the recruitment and retention of social care staff, the service had been able to recruit but had also lost staff as well.

The following responses were made to the Panel's questions:

The experiences and progress of children who need help and protection
children who need help and protection

- All schools now had a named family support worker, who was the first point of contact for advice and discussion. The service was structured to align with Networked Learning Community boundaries and each group was offered a termly briefing on the activity of the Early Help Service in their area and discussion how the schools offer could be developed further. Since October 2015, the Early Help service had seen a significant increase in the volume of requests from schools and had increased its reach to 90% of primary and infant schools and all secondary schools, The service would go to any school where need was identified.

- The Early Help Service was delivering its commitment to have a Family Support Worker in each Children's Centre and every site now had a named worker. The three directly managed Children's Centres were now part of the Early Help Service. Schools were helping to fund the service.

- Statistics held by the service indicated that the breakdown of the families being supported by the Early Help Service was as follows;
  - 42.4% Black/African/Caribbean/Black British, against a Haringey population of 28%;
  - 34.2% White, against a Haringey population of 46%;
  - 8.8% Other, against a Haringey population of 5%;

- 8% Mixed heritage, against a Haringey population of 12%; and
- 6.8% Asian/Asian British, against a Haringey population of 9%

The Black community was currently over represented but it was hoped that this would enable the service to prevent the need for a greater level of intervention arising.

- A strategy discussion was held whenever there was reasonable cause to suspect that a child was suffering, or likely to suffer, significant harm. It should be used to:
  - Share available information;
  - Agree the conduct and timing of any criminal investigation;
  - Decide whether an assessment under Section 47 of the Children Act 1989 should be initiated or consider such an assessment;
  - Plan how a Section 47 enquiry will be undertaken;
  - Agree what immediate action is required to safeguard and promote the welfare of a child and/or provide interim services and support;
  - Determine what information from the strategy discussion would be shared with the family; and
  - Determine if legal action was required.

- The attendance of agencies at strategy discussions or meetings was measured and this showed an improving picture. There was an escalation policy for the Chair to use if they felt that another agency was not contributing in the way that they should. It was felt that agencies contributed well in strategy meetings.

- Signs of safety was an evidence based practice model developed in Australia in the 1980's and was now used as an approach in a number of local authorities. It was a strengths based but safety focused approach, which was grounded in partnership and collaboration.

- There were currently no assessments that were out of timescale. The monthly completion rate was currently 93% but the overall annual rate was 72% due to a peak in demand that had occurred in the early summer. Since then, demand had levelled but remained higher than previously experienced. However, demand appeared to be rising again.

- A social care assessment framework was used, based upon the child's development, family and environmental issues and parenting capacity. There was statutory guidance on how assessments should be completed.

- Chronic neglect was characterised by domestic abuse, parental mental health issues and substance misuse. At the early stages, cases were picked up by schools, who involved Early Help services. When entrenched and severe neglect was identified, children were referred by schools and other agencies directly to children's social care.

- Good practice was identified in a number of ways through audits, compliments from partner agencies and by managers. Each team highlighted good practice in their team meetings and was starting to keep a good practice file and examples. Staff that were identified as good practitioners were written to by senior managers.

The Council was part of a quality performance network. In addition, further work was being undertaken to determine what good looked like.

- A private fostering arrangement was an arrangement between families for the care of a child under the age of 16 by someone other than a parent or close relative for 28 days or more that is undertaken without the involvement of the local authority.

- The need to identify privately fostered children had been communicated to the community through awareness raising and training for partner agencies. There was information on the Haringey website and it had also been referred to within the schools admissions forms. The issue remained a challenge though.

- The key message around privately fostered children was the need to for partners to understand what a private fostering arrangement was in order to be able to identify them and make referrals. Schools were normally the first to discover such arrangements and alert children's social care services. It was possible some additional work was required with schools in respect of this issue.

- In November, there were 5 child protection conferences out of 28 that were held outside of timescale. The reason for delay was often the non availability of families. It was important that families attended but they could be chaotic in nature which could make getting them to attend challenging.

- Child protection plans were produced following child protection conferences and aimed to reduce risk. Plans were individual to each child and family. The plan was implemented by a core group of professionals working with the family and child. The core group and the family met monthly to consider progress against the plan. Social workers visited fortnightly to progress the plan and ascertain the views of the children. Plans were reviewed formally at 3 months and at 6 monthly intervals subsequently.

- The "LADO" was the Local Authority Designated Officer. The LADO dealt with allegations against professionals. Their role was to manage investigations regarding professionals and ensure that adequate steps were taken to safeguard children and young people. They also provided awareness raising and training.

The experiences and progress of children looked after and achieving excellence

- It was not possible to give a figure for the cost of the contract for the recruitment of fosters carers as it was in the process of being negotiated. The previous contractor had been paid per assessment and on the approval of foster carers. Issues of both cost and quality were considered as part of the evaluation process.

- Careful consideration had been given to the option of delivering the service in-house. However, previous experience had suggested that this might be challenging. There would be a need to set up fully an in-house facility in advance whilst the previous contractor had been paid only once assessments had taken place. It was therefore felt to be risky due to the up front costs that would be incurred.

- One local authority was giving a discount on Council Tax as an incentive to foster carers. Providing incentives for Haringey foster carers was something that could be looked at but this would need to be balanced against the Council's current financial position. Foster parents valued the support provided by the Council and it was the reason why some of them joined the in-house scheme from agencies.

- The appointment of a permanent head of service had helped to improve the percentage of young people with a pathway plan. This had led to an increased focus on the figures and regular scrutiny of performance. Sometimes work demands and the availability of key people could hinder progress but efforts were made to ensure outstanding plans were completed as soon as possible.

- The completion of life stories could be challenging for the more historical cases. It was felt important that all children knew where they came from and life stories also needed to be kept up to date. Work had been undertaken to address the historical cases and the focus was now on current cases. Training had been provided on this issue.

- There were no set time scales for the completion of risk assessments but they needed to be done at the beginning of involvement and after a change in circumstances, if necessary. They were undertaken as an integral part of assessments and pathway plans and shared. However, not all relevant information may have been shared with carers in the past and it had previously been identified as an area of weakness. Improvements had since been made though.

- The categories of missing children were those missing from home, education or care. In respect of missing from care, performance was good with only two currently missing. Weekly reports were provided on children missing from care and all appropriate steps taken to find them. Other missing children were monitored on a three weekly basis, with assistance from relevant partners. It was often found that children missing from school had moved but the family had failed to tell the school. Systems for addressing missing children were now much more robust. Any patterns that were found were referred to the Missing and Child Exploitation (MACE) Panel. The increase in the number of missing children was due to many things and similar to the situation elsewhere across the country. Professionals were acutely aware of their responsibilities.

- The acronym "SPOC" referred to "single point of contact" and person with special responsibilities (i.e. coordinating child death responses).

- "Drift and delay" referred to when a proposed outcome within a care plan for a looked after child was not achieved within the desired timescale. The Independent Reviewing Officers (IRSs) and statutory reviews had a key role in ensuring that this was avoided. Reports of the IRO were shared with parents, team managers, social workers and other professionals. There was a team of IROs and their role was defined in legislation.

- The acronym "S&W" referred to safety and welfare (vulnerabilities risk).

- Haringey Youth Justice Partnership Board had responded to the Panel's recommendations on disproportionality with an agreed set of actions for their implementation. The Youth Justice Partnership Board would monitor the implementation of each of the actions and report progress in implementation and impact of these actions to both Haringey's Health and Wellbeing Board and Haringey's Community Safety Partnership.

- There could be a number of reasons for dips in performance in areas that had improved due to a consistent focus but had since dipped. Performance was monitored on a frequent basis the service was now able to identify downward trajectories in a more agile way. There would nevertheless be variations but action was being taken to try to reduce these.

- Practical and logistical factors, such as moving away or lack of contact details, were the predominant challenges in keeping in touch. However, the Council had obtained support from the European Social Fund for two posts to build relationships and increase the number that kept in touch. The Panel noted that once young people turned 18, there was not legal requirement to keep in touch and some young people chose not to do so.

- The service was implementing Viewpoint, which was a piece of IT software which children and young people registered with in order to participate and share their views. The service kept abreast of the market in order to identify suitable apps. Engagement with young people also took place through a number of different means, including discussions with Aspire and the Haringey Youth Council, but it was acknowledged that the service needed to work hard on this.

- There was a Designated Nurse for all Looked After Children with responsibility for ensuring that health histories were communicated to looked after children. 83% had received their health records by the end of August.

Leadership, management and governance

- Performance was tracked and recorded in a number of ways using graphs and charts to illustrate progress towards goals, comparing performance against statistical neighbours and track trends in relation to practice, including checks and balances on quality of practice as well as the quantitative issues. The Priority 1 dashboard was an important tool from which the service could create transparency and engage the community in understanding performance in key areas. The dashboard had had over 1,500 unique page views since it was launched. The trajectories looked at past, present and projected performance towards key targets and RAG rated performance according to targets. Performance was also tracked against the Ofsted recommendations. In addition, the service also undertook self evaluation and would be staging a mock inspection in the new year.

In answer to a question regarding how the needs of different communities were taken into account, Ms Bhardwaja reported that this could be a challenge. One particular issue was physical chastisement of children and the norms that existed within different communities. There could be a need to talk to parents in some circumstances and

there had been some cases that had required Police intervention. Mental health was another issue and the thresholds set for access to services were now very high.

Mr Abbey commented that access to good schools for looked after children had improved considerably. There were also better and different offers available for post 16.

AGREED:

That a report be submitted to a future meeting of the Panel on private fostering.