



HARROW SAFEGUARDING
PARTNERSHIP
ANNUAL REPORT
2022/2023



Alison Renouf

HARROW SAFEGUARDING PARTNERSHIP MANAGER

1. Introduction.....	4
2. Report of the Chair of the Safeguarding Adult Board and Scrutineer for the Safeguarding Children Board.....	4
Introduction - June 2023.....	4
Context.....	4
Independent Scrutiny.....	5
The Six Steps for Independent Scrutiny.....	5
The three core partner leads are actively involved in strategic planning and implementation.....	5
Recommendations.....	6
The wider safeguarding partners (including relevant agencies) are actively involved in safeguarding children and adults.....	7
Recommendations.....	8
Appropriate quality assurance procedures are in place for data collection, audit and information sharing.....	8
Recommendations.....	8
There is a process for identifying and investigating learning from local and national case reviews.....	9
Recommendation.....	9
There is an active programme of multi-agency safeguarding training.....	9
Recommendations.....	9
Children, young people, families and service users are aware of and involved with plans for safeguarding children and adults with care and support needs.....	10
Working with Other Boards.....	10
Recommendation.....	10
Leadership.....	10
Recommendation.....	11
4. Areas for development 2023/24.....	11
Joint HSAB and HSCB.....	11
Adults.....	11
5. Learning from reviews.....	12
Audit - Safeguarding Adults Reviews A and B.....	12
Introduction.....	12
The Audit Process.....	12
Summary of self-assessment on understanding of SAR.....	12
Self-neglect.....	13

Sharing and Learning from Case Studies.....	13
Child Safeguarding Practice Review: Child M [2020].....	14
August 2022. Clinical Record Keeping: A Dip Sample of Groups and Relationships recording on System One	14
Background / Rationale	14
Aims & Objectives	14
Methodology.....	14
Conclusions.....	15
Recommendations	15
Was Not Brought Audit: RNOH	15
Introduction	15
Methodology.....	16
Findings.....	16
Recommendations	16
Learning Lessons Review [LLR]: Baby O	16
Introduction	16
The outcome of the Review: Recommendations	16
6. Training and Development	18
Introduction	18
Putting learning into practice	18
Multi-agency Training	18
Organisations attending the training	21
Who is delivering training?.....	21
Evaluation	22
Training Priorities	23
Safeguarding Adults Training	23
Voluntary and community sector safeguarding training.....	23
VAH – priorities	24
Single agency safeguarding training and development.....	24
LNWUH NHS Trust	24
CNWL	26
Safeguarding Adults	26
SAR training	26
Disaggregation of Local Authority and CNWL Mental Health Services Section 75 Agreement.....	26

Domestic Abuse	27
7. Allegations Against Staff and Volunteers - children's workforce	29
Profile of LADO Referral Activity & Analysis 1 st April 2022 - 31 st March 2023	29
<i>Contact and Referrals - Consultations</i>	29
Number of contacts/ referrals received - 1 st April 2022 to 31 March 2023.....	30
Professional Suitability & Personal Life.....	30
Where referrals came from between 1 st April 2022 to 31 March 2023.....	31
Referral Trends	31
Strategy and Evaluation Meetings	32
LADO Training and Development/ Consultation Sessions	32
Safer Recruitment	32
Outcomes of Allegation	32
Consultations Meeting/Not Meeting Threshold	33
Investigations	34
Conclusion	34
8. Appendices	35
HSSP Budget & Expenditure 2022-23	35
Meeting attendance	36
Harrow Safeguarding Partnership Structure	38
Children's social care - safeguarding data	39
Contacts	39
Sources of contacts	40
Top 10 presenting issues	41
Contact outcomes	41
Adult Social Care - Safeguarding Adults Data	42
Key facts	42
Concerns and Enquiries.....	42
Demand – Concerns, Enquiries and Concluded cases	42
Concerns – volume and change in types of abuse	43
Concerns and Enquiries: England Vs Harrow (Per 100K adult Population)	44
Concerns - Age groups and the types of abuse that affect them	45
Concluded Cases – Making Safeguarding Personal	45
Concluded Cases – Risks Identified.....	46

1. Introduction

This Harrow Safeguarding Annual Report covers the work of the partnership to safeguard both adults and children. This joint report reflects the integration of the support structures and funding for the Partnership as well as the joint work to strengthen awareness and understanding of safeguarding issues as they impact on all members of the family – so that children’s services are able to identify and refer safeguarding concerns to adult services and vice versa.

It focuses on the activity of the Partnership carried out through the work of the sub-groups and the work of Board members to deliver Partnership objectives in their own services.

2. Report of the Chair of the Safeguarding Adult Board and Scrutineer for the Safeguarding Children Board

Introduction - June 2023

The Partnership is generally reflective and cooperative and demonstrates that it is capable of learning and improving. This report and the more in depth and focused JTAI review of Early Help both set the HSSP some questions about how they can ensure that their Arrangements remain effective.



Chris Miller
Independent Chair of and Scrutineer to
Harrow Safeguarding Children Partnership

Context

The Children and Social Work Act 2017 and Working Together 2018 (WT18) requires the three key Harrow Safeguarding partners - the North West Basic Command Unit of the Metropolitan Police, the North West London Integrated Care Board (ICB) and Harrow Council (the Partners) to establish in Harrow effective Multi-Agency Safeguarding Arrangements (for children). The Partners are also required to establish for Harrow a safeguarding adults board (HSAB).¹ The current safeguarding arrangements, which relate to both children and adults, **The Harrow Safeguarding Partnership Arrangements**² (the Arrangements) were originally published in June 2019³ and were revised in February 2022. The HSAB is required to publish an annual strategic plan. In common with many other safeguarding adults’ boards

¹ Care Act 2014 Sec 43 and Schedule 2.

² <https://www.harrowscb.co.uk/wp-content/uploads/2023/03/Harrow-Safeguarding-Children-Arrangements-Revised-Feb-2022-2-003.pdf>

³ As required by the Children Act 2004 sec 16 G (2)

HSAB, in 2021, published a three-year plan⁴. Annually the Partners are required to report both on what they have achieved in relation to their SAB strategic plan⁵ and also what they have achieved in relation to the Arrangement and how effective those arrangements have been⁶.

Independent Scrutiny

The partners are also required to provide for independent scrutiny of their Arrangements⁷. The Children Act does not describe how the Partners should go about providing independent scrutiny. They can provide this scrutiny how they see fit. The way that the Partners in Harrow provide for this is described at section 13 (page 20) of the Arrangements. Independent scrutiny should provide assurance about the effectiveness of the Arrangements and should include scrutiny of how the Partners identify and review serious child safeguarding cases. The independent scrutiny requirement is a feature of the Children Act but not of the Care Act but Harrow's partners have decided that where it is possible to do so the same scrutiny arrangements should apply to the safeguarding of adults as well.

The Six Steps for Independent Scrutiny⁸

This independent scrutiny report deals with the following six areas,

- The three core partner leads are actively involved in strategic planning and implementation
- The wider safeguarding partners (including relevant agencies) are actively involved in safeguarding children and adults.
- Appropriate quality assurance procedures are in place for data collection, audit and information sharing
- There is a process for identifying and investigating learning from local and national case reviews
- There is an active programme of multi-agency safeguarding training.
- Children, young people, families and service users are aware of and involved with plans for safeguarding children and adults.

The three core partner leads are actively involved in strategic planning and implementation

The Partners exercise oversight of and provide support to the safeguarding children board and the safeguarding adults board through its strategic safeguarding partnership. (HSSP) The Arrangements (page 13) describe the membership and function of this group and it meets three times a year. The HSSP is chaired on a rotational basis by the three strategic partners and attendance of the HSSP of all

⁴ <https://www.harrow.gov.uk/downloads/file/29124/hsab-strategic-plan-2021-24>

⁵ Care Act 2004 Schedule 2 (sec 4)

⁶ Children Act 2004 sec 16 G (7)

⁷ Children Act 2004 sec 16 G (3)

⁸ Taken from *Six Steps for Independent Scrutiny: Safeguarding Children arrangements*. Institute of Applied Social Research, University of Bedfordshire, Pearce, J (2019)

members of the core agencies is good, which demonstrates cooperative and active involvement in the delivery of the safeguarding function in Harrow. However, since the original publication (2019) and subsequent revision (2022) of the Arrangements the membership of the group, which for a strategic grouping was already large has grown even larger. Its strategic planning and implementation functions are not as distinct from the operation of the HSCB and HSAB as the Arrangements suggest they should be.

The Joint Targeted Area Inspection (JTAI) of Services for Children and Families who need Help,⁹ which took place in the performance year (albeit the letter reporting the JTAI findings was published outside the reporting year) discovered weaknesses in the oversight function of the HSSP in relation to Early Help.

Whether an inspection of HSSP's oversight of other aspects of multi-agency safeguarding would deliver a concurring finding is moot, but the recent JTAI offers an opportunity for HSSP to restate and review its strategic function.

The Arrangements rely heavily on the work of three subgroups to deliver multi-agency oversight. The chairing and management of the subgroups is shared by a range of partners, but unlike the HSSP this responsibility is not rotated among the partners. Retaining the same chair and management regime for the subgroups provides helpful stability but does not necessarily lead to shared understanding and ownership. HSSP does not have a work plan with milestones for delivery. Some sort of forward planner that provides a calendar of future reports and scheduled activities would provide purpose and focus to the HSSP. Historically the funding for the support of the Arrangements by the three core partners has lacked equity and transparency. Harrow Council have borne the burden of this by contributing the lions' share of the funding. This has been raised in independent scrutiny and other annual reports for a number of years and remains unresolved.

Recommendations

- The HSSP reviews its membership and its frequency of meeting (see para 18) so that it better reflects its strategic oversight function.
- The HSSP reviews the chairing arrangements of the subgroups to ensure that continuity is retained while sharing the responsibility fairly.
- The HSSP develops a forward work programme/ planner to enable the group to structure its work.
- The HSSP agrees a multi-agency budget, to support the Arrangements which is equitable and transparent.

⁹ Accessed at <https://files.ofsted.gov.uk/v1/file/50217932>

The wider safeguarding partners (including relevant agencies) are actively involved in safeguarding children and adults.

The Arrangements¹⁰ describe a wide range of relevant and other agencies who contribute to the safeguarding function in Harrow. Their attendance at the HSCB and HSAB is generally good and many agencies are involved in the sub groups. One of the sub groups is chaired by a school colleague and another by a Health provider trust. The involvement of schools and colleges in the work of the partnership is strong, and the designated safeguarding leads group for schools is a key network for informing, consulting and working with a key partner. The serious incident group, which brings together schools, businesses, the Council, the Metropolitan Police and other relevant agencies to review incidents involving school age children is a strong expression of continued multi agency innovative working.

The Harrow Social Workers in Schools project which began in September 2020 is one of 21 similar projects across England and Wales and brings significant benefits to schools. It is now being extended. It demonstrates good cross sector working between partners and is warmly welcomed by schools.

One of the ways in which the Partners discharge their responsibility in relation to the active participation of other agencies in safeguarding is to conduct a section 11 /42 audit¹¹, which enables organisations to assess themselves as to their effectiveness at safeguarding. This process is very resource intensive and its value from time to time is questioned. HSSP should review this audit arrangement to see whether it provides the necessary engagement of other agencies and reasonable assurance as to those other agencies' safeguarding competence and capacity.

Harrow does not have a named GP for adult safeguarding, nor does it have a designated doctor for child death. This has been a longstanding situation that needs to be addressed by the HSSP. It does have a named GP for child safeguarding and there is good liaison between the primary care network and local GPs through the work of the that named GP.

The Arrangements describe a range of voluntary, sports and religious agencies¹² who as relevant agencies are important contributors to safeguarding. Through the work of Voluntary Action Harrow, the safeguarding partners have good contact with the local voluntary network. The HSAB and the HSCB are both attended by a range of third sector bodies.

There is little engagement with the religious sector or sports associations/ bodies. Other local partnerships have developed a variety of ways of engaging faith and sporting bodies, and these may be worth exploring.

¹⁰ Appendix 1

¹¹ Named after sec 11 Children Act 2004 and sec 42 Care Act 2014, which both describe how agencies are required to cooperate with the safeguarding function

¹² Appendix 1

Recommendations

- The HSSP reviews the sec 11 and sec 42 audit process.
- The HSSP reviews the arrangements for the provision of named and designated safeguarding professionals and ensures that the required posts are filled.
- The HSSP reviews the contribution to the Arrangements made by sports and religious bodies locally and take appropriate steps to ensure that their involvement is proportionate to the part they play in local safeguarding

Appropriate quality assurance procedures are in place for data collection, audit and information sharing

The past year has seen little multi agency audit of safeguarding activities. This was once a strength of the partnership but has been highlighted by JTAI now as a weakness. An audit of Child Sex Abuse cases is currently in train and the Quality Assurance Group, which previously focused on examination of data has been repurposed as an audit group. This repurposing of the sub group was a pragmatic decision in the face of the difficulties of obtaining staff to conduct multi agency audits in addition to their other sub group responsibilities. It generally falls to the same staff who attend the QA group to participate in audits. It does mean that how and when data is scrutinised at a partnership level is now less certain.

The data scrutinised by the Partners is not a balanced data set. Local Council data is rich and plentiful and there is also a reasonable amount of health data. There is currently no regular police data set. It is reported that the MPS has almost completed a safeguarding data set which it will share with partners. This will be a significant step forward, but the real value from a blended data set will come from analysis and commentary. The HSSP will need to resource this function.

In relation to information sharing a separate scrutiny exercise during the year found some weaknesses in the workforce's understanding of why it is often inappropriate to seek consent before sharing information. If consent is inappropriately sought then either the sharing is delayed or it may not happen at all. In any event seeking consent inappropriately potentially misleads the data subjects about the status of their information.

The JTAI found that although there were good examples of information well used and properly shared there were also weaknesses in this aspect of professional practice. Given the frequency with which the failure to share information arises in safeguarding reviews this is an issue that the HSSP needs to keep under review.

Recommendations

- The HSSP develops a plan for multi-agency audits and the scrutiny of partner data, including how these activities can be resourced.
- The HSSP notes the findings of the Harrow scrutiny report into information sharing and the JTAI observations on information sharing and takes the necessary steps to ensure that professional practice in this regard meets the requirements of WT 18 (p 18ff) and Care Act Guidance (sec 14)

There is a process for identifying and investigating learning from local and national case reviews

In the past year the Partnership concluded a SAR that had been commissioned in the previous year and conducted a rapid review into an infant death. The requirement for reviews tends to be highly unpredictable and whereas in the two previous years the case review group was continuously engaged in assessing cases for review, commissioning reviews, conducting rapid reviews and acting on the learning, in the past year far fewer cases have been referred for consideration for review.

The two previous years have shown the Partnership in a good light in this regard. The JTAI also comments favourably on the implementation of learning from reviews. However, the HSSP should review whether the lack of cases referred for review in the past 12 months is a statistical “blip” or is the result of a change in behaviour by staff.

Recommendation

- HSSP satisfies itself that partner agencies are referring for review all appropriate serious safeguarding cases.

There is an active programme of multi-agency safeguarding training

The Partnership have offered 18 different multi agency courses in the past year. A large number of different agencies have attended. Schools are particularly good attenders. The take up by third sector bodies, non-school educational providers and various council departments is also quite high. The Police and the Health Service (save for Central and North West London NHS Foundation Trust (CNWL)) are less frequent attenders. This is common in many partnerships. This is something for the HSCB and the HSAB to review.

The courses that are offered (apart from the standard introductory and advanced safeguarding courses) arise from case reviews, local requests and national themes. A good example of a course arising from a review was the offering of a course on adverse childhood experiences, which was initiated following the completion of SARs A and B, both of which explored this issue.

The Learning and Delivery group run surveys to assess the extent to which training changes the workforce’s level of knowledge and the way they carry out their duties. The JTAI identified little by way of multi-agency training for matters concerned with Early Help. The HSSP will want to explore this.

Recommendations

- HSCB and HSAB reviews regularly the attendance of staff at multi agency training.
- HSSP commissions the L and D group to develop a multi-agency training programme for Early Help that is consistent with the Arrangements.

Children, young people, families and service users are aware of and involved with plans for safeguarding children and adults with care and support needs Harrow has a strong record (noted also by the JTAI) of consulting and communicating with service users, children and families.

The HAY ¹³ survey provides the Partners with a rich data set that helps them understand the need for services and the impact that those services are having. The Partnership has strong representation of the third sector in both boards, but particularly on the HSAB. This means that the representative voice of the service user is heard by the Harrow Safeguarding Partners.

Another way in which families and service users could impact the quality and design of services would be to involve them in the audit process suggested above.

Working with Other Boards

WT 18 says: *'To be effective, these arrangements should link to other strategic partnership work happening locally to support children and families. This will include other public boards including Health and Wellbeing Boards, Adult Safeguarding Boards, Channel Panels, Improvement Boards, Community Safety Partnerships, the Local Family Justice Board and MAPPAs.'*

There is a degree of join up in Harrow in relation to the interoperability of the various multi agency boards as described in WT 18. This is partly because many of the attendees of these various boards are the same individuals. However, the JTAI identified a gap between what might be expected from a series of partnership boards attended by many of the same staff and the reality of how well the HSSP is supplied with the information it needs. As an illustration of this the Health and Wellbeing Board in its 2022-2030 Health and Wellbeing Strategy has allocated joint oversight of its "Start well" strategy¹⁴ to the HSCB without previously flagging that to the HSCB. Preventing this strategic gap is relatively easily achieved and mapping out how the HSSP links with these other boards would reap strategic dividends.

Recommendation

- The HSSP maps its relationship with other strategic multi agency boards and describes what information needs to flow between the various and the mechanism for achieving that.

Leadership

There has been significant leadership churn among the key partner agencies over the reporting period. This has led to a degree of drift and delay in the direction of the Partnership. It may be that meeting three times a year is too infrequent a schedule to ensure the necessary resilience.

¹³ **How Are You** is a survey of 6000 young people in Harrow conducted as a collaboration between the Young Harrow Foundation, CNWL and Public Health Harrow.

¹⁴ The first 1000 days of a child's life

Recommendation

- The HSSP reviews the frequency of its meeting schedule to ensure resilience and continuity in the Partnership

4. Areas for development 2023/24

Joint HSAB and HSCB

- Work more closely with Community Safety and related Boards to consider areas of joint interest ensuring we maximise the use of resources.
- Review the effectiveness of the children and adults safeguarding arrangements.

Adults

- Review progress on the priorities in the Strategic Plan
- Work with partners to develop a new three-year Strategic Plan for 2024/27 and associated draft action plan.
- Work with partners to develop a SAB Risk Register.
- Establish a task and finish group to review safeguarding adult data and intelligence.
- Review mechanisms to ensure learning from SARs is embedded in practice.
- Prepare for the CQC Framework

5. Learning from reviews

Audit - Safeguarding Adults Reviews A and B

Introduction

Annie Ho, an independent auditor was commissioned to carry out a review following the completion of SAR A and SAR B. SAR A highlighted the need for learning in relation to the response to hoarding; working with resistant service users [or involuntary clients]; elective home education; young carers and perplexing presentations. SAR B highlighted the need for learning in regard to professionals understanding of the Mental Capacity Act and the impact of adverse childhood experiences on carers.

The audit focused on the following identified themes:

- The use of mental capacity assessments where citizens are refusing care and/or treatment.
- The allocation of self-neglect and hoarding cases to experienced staff and supervision support
- Multi-agency decision making in cases of resistant citizens.
- A safe process for closing cases where there is non-engagement with citizens.

The Audit Process

The audit process includes 2 stages.

Stage 1: two-part Self-assessment Tool [SAT]

Stage 2: one-day Partnership Audit Workshop [29/09/2022]

Attendance at the workshop: Harrow ASC – PSW and Safeguarding; Harrow ASC – Learning and Development; NWLUHT; CNWL; CLCH; Housing; Police

Summary of self-assessment on understanding of SAR

- Most partners understand all agencies have a duty to make a SAR referral, but not everyone is aware that anyone (including the public) can make a SAR referral.
- Most partners are aware that it is the SAB's duty to carry out a SAR, but the mixed responses from partners appear to indicate an assumption that the local authority takes the lead in decision making.
- Most partners understand the criteria for making a SAR referral, for people who died from known or suspected abuse or neglect, but not everyone is aware that a SAR referral can be made for people who are alive and have experienced known or suspected serious abuse or neglect.
- Most partners are aware of the referral and decision-making process via the case review group. Some partners who are 'distant' from the case review group are unclear about frontline staff's access to the SAR referral form.
- Apart from Harrow ASC, most partners were unable to provide details of specific learning or improvement action from SAR A. Generic responses included raising awareness about self-neglect and promoting good information sharing.

- Apart from Harrow ASC, most partners were unable to provide details of specific learning or improvement action from SAR B. Generic responses included improving partnership working including using the escalation policy and promoting professional curiosity.
- ASC shared SAR specific responses including new training on hoarding/self neglect and ACE, the specialist team, the self-neglect protocol and the self-neglect and hoarding panel, although some partners are not aware of / have not accessed the relevant training courses, policies and processes.

Self-neglect

Top challenges in self-neglect cases

- Embedding learning from SARs
- MCA literacy and application
- Including the person's view and ensuring that intervention is person-led
- Attendance and engagement of appropriate partners at meetings, including, in particular, the GP
- Sharing burden of risk management and decision making
- Multi-agency collaboration and exercising powers to intervene

Improvements in self-neglect work

- Review of self-neglect policy and guidance
- More robust overview of self-neglect cases
- Consideration of a think-family approach
- Employment of a floating support worker

Sharing and Learning from Case Studies

The case studies demonstrated good single-agency management of complex cases, but this appears to have been hampered by multi-agency level barriers.

- The 'surprises' in these cases illustrate that self-neglect/hoarding behaviours could apply to different people including, for example, a highly skilled medical consultant. Professional curiosity was clearly demonstrated by a staff member's observations of P's appearance, odour and low-level concerns over a period of time.
- The assessment of mental capacity with regards to executive functioning is challenging. One case study illustrates the impact of alcohol on the person's behaviours. One partner shared his 'surprise' about how intelligent P was when not intoxicated.
- The 'satisfaction' came from supporting P in their wishes, e.g. regaining contact with family, returning home.
- In cases where it was difficult for professionals to engage with P, 'satisfaction' came from one 'good relationship' between P and one worker. The staff member was able to spend time with P exploring their past and engage with them in a meaningful way.
- The 'dissatisfactions' in the case studies appear to indicate barriers to effective multi-agency work.
- Housing shared their learning from a safeguarding (non self-neglect) case. Partners learned that Housing holds a vulnerable adults list which includes

people who have mobility needs, disability, have debits on their accounts or have not initiated contact for repairs. People on the list have a 6-monthly review.

Child Safeguarding Practice Review: Child M [2020]

August 2022. Clinical Record Keeping: A Dip Sample of Groups and Relationships recording on System One

Background / Rationale

It was identified at the Child M, safeguarding practice review that within a child's SystemOne records, 'Groups and relationships' had not been maintained or updated, leading to a poor overall assessment of the child, the wider family and that child's place within the family. A recommendation from the safeguarding practice review was to merge SystemOne systems across a broad section of children's community health services.

Aims & Objectives

The aim of the audit is:

- To ensure compliance with relevant national, regional, professional and local clinical record keeping requirements.

The objectives of the audit are:

- To give evidence-based assurance that clinical record keeping standards and best practice is being carried out within the service.
- To identify any areas of concern within clinical record keeping practices.
- To ensure a consistent approach to clinical record keeping practices.
- To highlight areas of good practice that can be shared with other services.
- To identify areas of concern and develop an action plan. This was an outcome of a safeguarding practice review within the Harrow partnership in 2021.
- To identify gaps or areas for future training.

Record keeping is a tool for professional practice that aids the care process. Records form a permanent account of the patient/client journey (BMJ. January 2014). Health records are also created and maintained as evidence for legal purposes. With this in mind, our audit was originally going to look at the broader spectrum of all aspects of record keeping, but in light of the findings and recommendations of the safeguarding practice review in to Child M in 2021, we extended the section on 'Groups and relationships'.

Methodology

This was a randomised and anonymised review of records held on the SystemOne database for the Harrow 0-19 service. A total of 58 records were reviewed from both the health visiting and school nursing services universal plus and universal partnership plus caseloads.

Conclusions

Whilst the majority of records were clearly written and elements of the process are being completed, it is clear from the data that, overall, practitioners are not compliant with the requirements in the Trust's Clinical Record Keeping Policy (auditing of patient records) and related policies and procedures.

The findings of the audit are also in line with the observations made by Safeguarding Advisers during the composition of chronologies, completion of MASH checks and during supervision sessions.

The audit highlights that there is an obvious need for further training in order to ensure that all staff involved in clinical record keeping have an increase awareness of the relevant requirements, professionalism and efficiency in these processes.

Recommendations

- Record keeping training being offered on a 6-weekly basis.
- Chronology training being offered on a 6-weekly basis.
- Record keeping discussed at both group and individual safeguarding supervision sessions, team meetings and forums.
- Record keeping to be discussed at Level 3 training.
- Ad-hoc record keeping training to be offered if required.
- It is anticipated that this audit will be revisited in early 2023 to review and evaluate the impact and effectiveness of the training delivered by the safeguarding team to the Harrow 0-19 service.

The findings from the audit will be discussed and presented at:

- Health visiting and school nursing team meetings
- Health visitor and school nursing forums
- Harrow safeguarding team meetings
- Safeguarding supervision group session
- Internal CNWL meetings
- Harrow Safeguarding Partnership Board meetings

The above recommendations form the basis of the audit action plan.

Was Not Brought Audit: RNOH

An action from the Child M C SPR was for health agencies to remind professionals of their organisation's 'Was Not Brought' policy and the importance of compliance. RNOH carried out an audit of compliance with their 'Was Not Brought' policy

Introduction

- A Was Not Brought Appointment (WNB) is defined as a scheduled appointment that is missed without prior arrangement by the parent/carer.
- When the child is not brought to an appointment it is the parent/carer who does not attend.

- To minimise the risk to children, if a parent chooses not to attend, there should be consideration around the risk to the child.
- All children have the right to have their health needs met. When children are not brought to appointments this may represent a risk of harm which could be significant.

Methodology

- On the day of the data collection, all Was Not Brought appointments for children and young people under the age of 18 years, for the month of June 2022, were extracted from Insight.

Findings

- This small spot audit indicates a lack of consistency when it comes to following the current Was Not Brought Policy.
- The Safeguarding Children Team and / or GP were not routinely informed following a second consecutive Was Not Brought appointment or when a Vulnerable Child was not brought to appointment.

Recommendations

- Sharing and communication of WNB Policy through supervision and presenting findings at the Trust Audit and Paediatric Audit days to ensure staff awareness of the following:
 - What to do when a child is not brought to appointment
 - When to involve the safeguarding children team
 - Use of WNB letter templates
 - Re-audit of WNB process in 12 months following sharing and communication of the current policy.
- Share audit findings at the Safeguarding Sub Committee and Integrated Governance Risk Committee

Learning Lessons Review [LLR]: Baby O

Introduction

Baby O tragically died shortly after birth as a result of severe abnormalities. The decision was made to carry out a LLR because the young mother, who was homeless and in temporary accommodation, had not engaged with ante-natal care and, hence, the abnormalities were not identified pre-birth prior to the baby being born and no planning was therefore possible for the birth. The LLR sought to understand if anything could have been done differently to engage the mother in antenatal care.

The LLR” was presented, with a series of recommendations, to the HSSP [21.2.23] and the HSCB [3.3.23]. The Report was reviewed and discussed, and the recommendations accepted. They continue to be progressed.

The outcome of the Review: Recommendations

- A pathway is developed for un-booked pregnancies.

- The London CP Procedures are amended to emphasise the risk to women being un-booked in pregnancy
- Draft amendments to be proposed to the Editorial Board of the London Child Protection Procedures.
- That a midwifery outreach service is set-up to support vulnerable women with their pregnancies
- That the mother is offered support and accommodation on a long-term basis
- A multi-borough service is developed for women at risk of repeat removals
- CSC To review the decision to NFA the police referral in March 2022 that the mother was pregnant again
- To encourage dialogue between adult and children's services
- The partnership to review the NHS Patient Safety Incident Response Framework with a view to implementing it, as appropriate, across agencies
- Housing – safeguarding training and engagement in CP processes
- That senior leaders in Housing are engaged in complex cases to allow, where appropriate, for normal processes to be over-ruled in the best interests of a child [unborn in this instance].
- Housing to review job roles and determine what level of safeguarding children and adults' training is required for assessment officers; housing prevention and solutions officers; and other relevant roles [Managers to have a higher level of training]

6. Training and Development

Introduction

The Learning and Development Officer for the Safeguarding Partnership ensured that a comprehensive training programme was provided for the workforce. The programme was aimed at supporting the needs identified from local and national Child Safeguarding Practice Reviews (CSPRs), Safeguarding Adult Reviews (SARs) and the Harrow Safeguarding Partnership (HSP) priorities:

- Domestic Abuse
- Contextual Safeguarding
- Mental Health

Attendance on the day has improved, however, some courses have only just had sufficient attendance to go ahead and some courses have had to be cancelled because of poor attendance.

In October 2021 the partnership moved to SS4e as the booking system for HSCB courses. This has taken some time to embed and for practitioners to create accounts, however, in the last year, 466 delegates have attended HSCB courses via this booking system.

Putting learning into practice

The HSP needs assurance that training is making a difference to working practice, especially learning, which has been identified in CSPRs and SARs. Initial course feedback has been received electronically and similarly impact evaluation. Impact evaluation is the area that we would most like to strengthen.

Multi-agency Training

2022/23 had 466 delegates attending 23 HSCB courses promoted via SS4e (Appendix A). There has also been training commissioned from external agencies such as YGAM and the Child Sexual Abuse [CSA] Centre not included within the above figures. Two CSA events in December 2022 and March 2023 had a total of 81 delegates attending.

Date	Training course	Organisation/setting attendance	No. attended
Dec 12 th 2022	Harrow CSA Training www.csacentre.org.uk	Schools 18 Health 18 Harrow People Services 2 Charities/Voluntary 2	40
March 8 th 2023	Harrow CSA Training www.csacentre.org.uk Kingston and Richmond Safeguarding Children Partnership HOST	Cafcass 2 Health 1 CYPS (including MASH/CIN/Keeping Families Together/1 st Response) 33 Adolescent Safety Team 4 Probation 1	41

Each term the Designated Safeguarding Lead (DSL) forum continues to attract a high number of delegates. The success of these events is due to the active participation of, school DSLs, the support from bespoke presenters/experts and regular attendees including:

- Metropolitan Police Service NW BCU safer schools and engagement team
- Harrow Social workers in school team
- Virtual school
- MASH education lead

A range of topics have been covered over the year including:

- Child Q: Lessons Learned
- Online Safety Bill
- Mind in Harrow
- Core CAMHs, an overview of the service and processes (CAMHS Mental Health Support Team)
- Virtual School update
- Professional Supervision (Public Health)
- Service Introduction from NW London Clinical Commissioning Group
- Information Sharing
- Supporting parents to accept appropriate help to support their child's additional needs
- An introduction to Young Gamers & Gamblers Education Trust
- HAY Children and Young People Survey – next steps
- Social Workers in Schools projects and next steps

In response to DSL feedback, the learning and development team designed a bespoke refresher training package for the February 2023 forum, attended by 42 delegates. This training included:

- Child/Young person disclosure – What you should know
- Domestic Abuse Guidance
- Updates in Keeping Children Safe in Education.
- Victim Blaming – Direct and Indirect
- How to challenge Victim Blaming
- Online Safety – What should you be asking?
- Threshold – Continuum of Need Matrix (London Child Safeguarding Procedures Update)
- Child Protection Chair – Updates
- Learning from Child Q – Guidance on Searches in Schools
- Safer Schools Officer – Guidance to police
- Learning from Child Safeguarding Practice Reviews
- Safeguarding Concerns and allegations against staff
- Harrow Challenge and Escalation Procedure
- Information Sharing

The theme for the 2023 safeguarding conference “Adverse Childhood Experiences” was chosen following consultation and feedback from 72 practitioners. The

cancellation of the 2023 conference was disappointing but, due to the support from Harrow Early Help team a workshop did go ahead - “How Adverse Childhood Experiences (ACEs) Fuel Conflict - Parental Conflict Through a Trauma Lens” with 46 practitioners attending.

15 training events, (these courses do not feature in the figures), were cancelled due to;

- 8 trainer not available
- 6 insufficient delegate numbers

Courses cancelled due to trainer availability (often due to illness or extreme weather conditions without technology access) included:

- perplexing presentations
- modern slavery
- LADO training
- child mental health
- digital exploitation training

Courses where there were insufficient practitioner numbers included:

- drug awareness
- safer recruitment
- child mental health
- click path to protection (online sexual abuse)
- digital exploitation

Despite requests for online abuse training there were insufficient practitioner numbers for some of these sessions. The reasons for the low numbers should be explored by the partnership.

Across all courses there were 541 bookings, 75 delegates did not attend. The most common reason for delegate cancellations were work commitments or sickness absence. (HSCB have a cancellation policy whereby failure to attend without notice is liable for charges).

Name	Delegate No	Attended	Not Attended
HSCB Introduction to Multi-Agency Safeguarding and Child Protection A Shared Responsibility	14	13	1
HSCB Domestic Abuse:- Understanding Domestic Abuse and its impact Foundation Stage	6	6	0
Hoarding and Self-neglect: Children and Adult Services	12	10	2
Online Platforms and Extremist Content	13	11	2
Safeguarding in Education Termly Seminar	57	49	8
HSCB Advanced Multi Agency-Agency Risk Assessment and Decision Making in Child Protection	29	28	1

HSCB Domestic Abuse:- Responding to Domestic Abuse - Enhanced	8	7	1
Managing Allegations Against Staff and Volunteers (LADO)	10	9	1
HSCB Drug Awareness	7	5	2
HSCB Introduction to Multi-Agency Safeguarding and Child Protection A Shared Responsibility	21	20	1
HSCB Understanding Child Mental Health	9	7	2
HSCB Advanced Multi Agency-Agency Risk Assessment and Decision Making in Child Protection	28	26	2
HSCB Parental Mental Health Workshop	9	9	0
Safeguarding in Education Termly Seminar	85	74	11
Domestic Abuse and Mental Health	10	8	2
HSCB Drug Awareness	7	6	1
Digital Exploitation, Fraud methods (Crypto currency) – CSE/CCE	13	9	4
HSCB Advanced Multi Agency-Agency Risk Assessment and Decision Making in Child Protection	39	37	2
Responding to perpetrators of Domestic Abuse	11	8	3
Safeguarding in Education Termly Seminar	54	41	13
Adult Safeguarding; Modern Slavery & Child Exploitation Awareness	18	17	1
Managing Allegations Against Staff and Volunteers (LADO)	24	20	4
How Adverse Childhood Experiences (ACEs) Fuel Conflict - Parental Conflict Through a Trauma Lens	57	46	11
	541	466	75

Organisations attending the training

Organisations are required to ensure staff are confident and competent in responding and managing safeguarding concerns. In 2022-23 delegates were drawn from a range of roles (Appendix B).

Of the 466 delegates the highest attendance was from education. For the 3 key partners the lowest attendance was police.

- 272 from education (including colleges, schools and nurseries) ,
- 55 from health
- 53 from Harrow social workers (including early help).
- 2 from police (1 delegate for the modern slavery and exploitation session and 1 delegate for adverse childhood experiences session).

Who is delivering training?

Most of the multi-agency training programme is delivered by experienced staff in specialist roles from across partner organisations. These staff have included trainers from;

- Shaftsbury High School
- Norbury School
- RNOH
- WDP/Compass
- Harrow LADO

- Social workers from Harrow Adolescent Safety Development Team (ASDT)
- Social work apprentice from Early support
- An independent safeguarding trainer
- Detective sergeant from NW BCU public protection team
- MPS modern slavery and child exploitation team
- CNWL mental health team.

All have prioritised sharing skills and expertise with the workforce, and this is greatly appreciated by delegates and the safeguarding partnership.

The training pool has lost experienced members through retirement and change of role away from Harrow, including;

- Dr Arlene Baroda Consultant Paediatrician- Designated Doctor for Safeguarding Children, LAC and CDOP - Brent CCG for the perplexing presentations session,
- DS Helen Purcell from NW BCU for the foundation and advanced domestic abuse sessions.

We have been fortunate that Holly Thomas, Domestic Abuse Prevention Coordinator, Central North West London NHS Trust provided Domestic Abuse training which enhanced our domestic abuse training offering which included sessions focusing on the perpetrator.

The Intra Familial Child Sexual Abuse training, hoarding and neglect training and the ACE training have been commissioned from external trainers (funding for the CSA training was through the London Safeguarding Children Partnership, and the ACE training through the Harrow Early Help team).

HSCB collaborate with external agencies and organisations to promote safeguarding training from other providers – including:

- The Amber project - enhancing the response to child abuse linked to faith or belief
- Marie Collins Foundation - when a child is sexually abused online
- YGAM - safeguard young people against gaming and gambling harms.
- NWG - child exploitation (CE) and trafficking within the UK.
- Counter-Extremism Division Regional Prevent Co-Ordinator Department of Education
- London Safeguarding Partnership for Pan London training

Evaluation

Identifying the impact of training on practice and reporting those changes to the Safeguarding Partnership remains a challenge for partner agencies. Impact analysis evaluation implemented in 2021/2022 is heavily dependent upon learning from QA audits and learning from the case review group.

Course participants are offered the opportunity to complete a short course evaluation immediately after attending an event to gain feedback on course satisfaction, relevance to working practice and gauge how the course has improved their knowledge. Then 6-8 weeks after the training event impact evaluations are sent with

more specific questions for participants to review how the learning has impacted on their workplace, their working practice and ultimately the outcomes for children and young people. A course certificate is then issued.

Training Priorities

The training programme will always evolve as there will be provision built in to allow for change and further development such as lessons from local and national reviews, relevant reports, inquiries, legislative policy changes or research. There will be a core offer of safeguarding training:

- Introduction to Multi-Agency Safeguarding and Child Protection A Shared Responsibility
- Advanced Multi Agency-Agency Risk Assessment and Decision Making in Child Protection
- Managing Allegations Against Staff and Volunteers (LADO)

Safeguarding Adults Training

The following safeguarding adults training was provided:

- Basic Awareness, 31/05/2022 – 16 attended.
- Basic Awareness, 11/07/2022 – 20 attended.
- Domestic Abuse Training, 12/09/2022 – 14 attended.
- Basic Awareness, 13/09/2022 – 30 attended.
- Basic Awareness, 22/11/2022 – 71 attended.
- Basic Awareness, 17/01/2023 – 40 attended.
- Basic Awareness, 07/03/2023 – 35 attended.

Voluntary and community sector safeguarding training

The Harrow SCB has commissioned Voluntary Action Harrow (VAH) to provide safeguarding children training and advice to the private, voluntary and faith sectors for several years. VAH has a very successful track record in reaching and supporting these sectors.

In 2021/22, VAH delivered the following:

- 3 Single agency safeguarding training sessions [Level 2]
- 10 multi-agency safeguarding training sessions [Level 2]
- 3 safeguarding sessions for nominated safeguarding leads [Level 3]
- 3 safeguarding support forums
- 6 safeguarding newsletters
- 16, 1:1 support sessions

Total reach:

- 143 Organisations
- 325 Participants

Alongside the training and 1:1 support, VAH also represents the voluntary sector on the quality assurance and learning and development sub-groups providing valuable community input and using the learning to inform their advice.

VAH – priorities

HSSP priority areas

- The safeguarding outreach team will continue to embed learning in the sector linked to the HSP priority areas. This includes learned lesson reviews.

Hard to reach groups

- The safeguarding outreach team will continue to focus on hard to reach groups including faith based groups, sports groups to build relationship and strengthen existing relationships in order to ensure safeguarding is a priority area for all.

Partnerships & sharing information

- The safeguarding outreach team will be increasing the new shorter training sessions to get more sector organisations to attend training and really get messages across strongly. The safeguarding outreach team will look at growing existing partnerships and creating further partnerships in the borough.

Single agency safeguarding training and development

LNWUH NHS Trust

LNWUH NHS Trust continues to develop and embed a culture that puts the “Voice of the Child” and “Making Safeguarding Personal” at the centre of care delivery. This approach interlinks with all three shared priorities for adults and children - domestic abuse, contextual safeguarding and mental health. LNWUH is fully committed to supporting all three priorities and ensuring they are included in our daily practice. These three priorities also form some of our internal key priorities for 2023 -2024:

- Continue to embed Mental Capacity Act (MCA) and DoLS knowledge and practice through training, supervision, Trust wide PULSE communication, bespoke face to face sessions with Teams, presentation at grand round, forums, etc.
- Update training and policy in line with the Serious Violence Duty 2022 and Domestic Abuse Statutory guidance - this supports our prioritisation of domestic abuse.
- Achieve Trust target of 90% for level 3 safeguarding training which will include elements of contextual safeguarding.
- Continue our work with CAMHs and Social Care to address safe management and timely discharge of patients admitted with mental health conditions. This demonstrates our commitment to improve overall wellbeing of our patients with mental health.
- Rollout of the Oliver McGowan Mandatory Training in Learning Disability and Autism.

In addition, key achievements include:

- CQC Inspection Report: the CQC carried out an unannounced inspection of the Trust in February 2022 and an announced inspection of the trust in March 2022. The report stated, “Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.”
- The Trust Maternity and Emergency Department (ED) were involved in the Harrow Early Help Joint Targeted Area Inspection (JTAI) in March 2023. Initial feedback was, “voice of the child was captured, and appropriate referrals to early help were made by staff. Young children were seen by Youth workers from the NEON project to explore their health, educational, social circumstance, and aspiration. The ED SafetyNet meeting and Maternity Psychosocial meeting is robust in ensuring Early Help, as all children, pregnant women and parents with children who attend ED, Urgent Care Centres and Maternity are screened by the Safeguarding Children Team and rag rated for appropriate referrals to 0-19 services and case discussion at the weekly multi-agency SafetyNet and Psychosocial meetings.”
- The Trust was commended by NHS England for the work done in fast-tracking patients with LD and Autistic People through electronic notification and invited to give a presentation at the National LD Improvement Standards event.
- Electronic Safeguarding Referrals: The Trust rolled out electronic safeguarding adult referrals in 2022. This means staff can make timely safeguarding children and adult referrals electronically to Social Care. The Safeguarding Team are also able to review referrals and provide assurance in a timely manner to ensure effective protection of children, adults and families from abuse.
- Mental Capacity Act (MCA) and Deprivation of Liberty safeguards (DoLS)/Liberty Protection Safeguards (LPS) Steering Group: The Safeguarding Team has continued with bi-monthly MCA, DoLS/LPS Steering Group meetings. As the implementation of the LPS has been delayed beyond the life of the current Parliament, we recognised that we now have the best opportunity to understand and instrument the MCA/DoLS more robustly across the Trust.
- Training Compliance: Safeguarding children and adults training compliance at all levels met the Trust target of 85%. The Trust has now increased the training target to 90% and this compliance is being achieved at levels 1 and 2 safeguarding training. The Team is working with service managers and regular reminders are sent to staff to help in meeting the 90% target for Level 3 training.
- Operational Safeguarding Procedures for Liaison Psychiatry Service (LPS): A new Safeguarding Operational Policy has been implemented to facilitate communication between LPS and Acute hospital staff at LNWH, West London NHS Trust and Central and North-West London NHS Foundation Trust, to ensure that

Local Authorities receive timely contemporaneous information to enable them to process safeguarding children and adult referrals.

- **Safeguarding Champions:** The Safeguarding Team successfully recruited Champions for Safeguarding, Falls, Dementia, Learning Disabilities and Autism. The Champions act as a resource and point of contact for colleagues who require support, guidance and signposting.
- **Timely completion of National Audits:** The Older People and Dementia Team completed the National Audit for Dementia on time with good feedback. The team is implementing actions from this audit.
- The Team also introduced monthly and quarterly Trust wide Falls Audit which has helped in steering the Falls Improvement Plan. The Trust is also involved in the ongoing National Audit for Falls.
- The Learning Disabilities and Autism Team also completed the National LD and Autism Survey on time with good feedback. The team is implementing actions from this survey.

CNWL

Safeguarding Adults

In September 2022, CNWL held a Trust-wide Safeguarding Adults Away Day to strengthen partnership working, highlight organisational structures, promote legal literacy and learning from a Harrow SAR. It also focussed on the complex issues regarding hoarding, self-neglect and mental capacity.

SAR training

In January 2023, CNWL gave a presentation to Harrow adult social care staff, outlining CNWL Safeguarding staffing structure, referral pathways and processes. It also raised awareness of the SAR process and criteria for SARs, explored common themes/learning from SARs, how to resolve professional disagreements and follow the escalation process.

Harrow mental health services remain the highest reporters of safeguarding adults in their division predominantly across community mental health hubs. Mandatory adult safeguarding compliance is 91%.

Disaggregation of Local Authority and CNWL Mental Health Services Section 75 Agreement

- For more than 10 years under section 75 of the Health and Social Care Act, Harrow Community Mental Health Services have been delivered through a partnership agreement between Harrow Council and Central and North West London NHS Foundation Trust (CNWL).
- In July 23 this agreement came to an end and the responsibility for both social care staff management and service delivery was transferred to the Local

Authority Adult Social Care department. These services include support with direct payments and care packages, support with accommodation and daily living – and assessments and support for carers/family members. In effect this means there are now 2 mental health teams in Harrow – a health team provided by CNWL and a social care team provided by the Local Authority. This will allow both services to be much more focussed on their own areas of expertise whilst working together to provide seamless care.

- Much of 2022 was focussed around preparing staff and services for this transition. All staff working under the Section 75 agreement (this included social workers/personal budget staff/admin staff) were transferred over to the local authority. All clients under mental health services were also to be ‘disaggregated’ i.e. screened and assessed as to which service would most appropriately provide treatment/support for them – in many cases this might be both services.
- It was also a period of restructuring CNWL mental health services in order to meet the new service remit and configuration e.g. Harrow Mental health services now comprise one Mental Health Hub (as opposed to 3) and a dedicated Triage and Assessment Team.

Domestic Abuse

- CNWL continue to grow their Domestic Abuse Ambassador network across all services Trust-wide. This has led to a number of disclosures of DA from colleagues. We have a policy on DA for staff – this means they are supported and managers are clear on which policies have flexibility to support staff in such circumstances.
- We have developed a network of staff with Lived Experience with a dual function of providing support and a safe space to share experiences and also to ensure that those with lived experience have a voice in service planning and development.
- CNWL hosted it’s fifth annual Domestic Abuse conference during the White Ribbon period in December 22. This was a virtual conference attended by over 650 participants. It was themed around the Domestic Abuse Act and whether this had gone far enough – what gaps in policy and strategy still remained. Speakers included Charlotte Proudman, leading barrister and campaigner for women’s rights, Emma Katz internationally renowned expert in Domestic Abuse and coercive control and Jess Phillips, shadow minister for Domestic Abuse.
- CNWL continue to facilitate quarterly round table DA webinars. The aim of these is to take a ‘non expert’ stance and for staff to share different experiences (personal and professional) of the same theme. Webinars over the last year have included – parent to child Domestic Abuse, Intersectionality and sibling abuse. There is always a large attendance – demonstrating the appetite of staff to know more and be involved in discussions around the subject.

- We continue to support the Routine Enquiry of all women entering CNWL services. We have introduced a Routine Enquiry template over the last 18 months in order to be able to record this information systematically.
- Following the introduction of the guidelines to support staff experiencing Domestic Abuse we have been working more closely with Human Resources and Occupational Health in order to improve support systems for staff who disclose.

7. Allegations Against Staff and Volunteers - children's workforce

Each year the HSCB requires the Local Authority Designated Officer (LADO) to report on activity around the management of allegations.

In 2022/23:

- The Local Authority Designated Officer (LADO) role continues to comply with the London Child Protection Procedures and the Working Together to Safeguard Children (2018) Guidance (updated 2020).
- The service has continued to maintain its profile within the children's workforce and maintains awareness raising within the children's community within Harrow by way of training sessions and workshops.
- The case work recording system is fully incorporated in the social care MOSAIC system in a standalone and secure system. The MOSAIC system provides embedded monthly and annual performance reports.

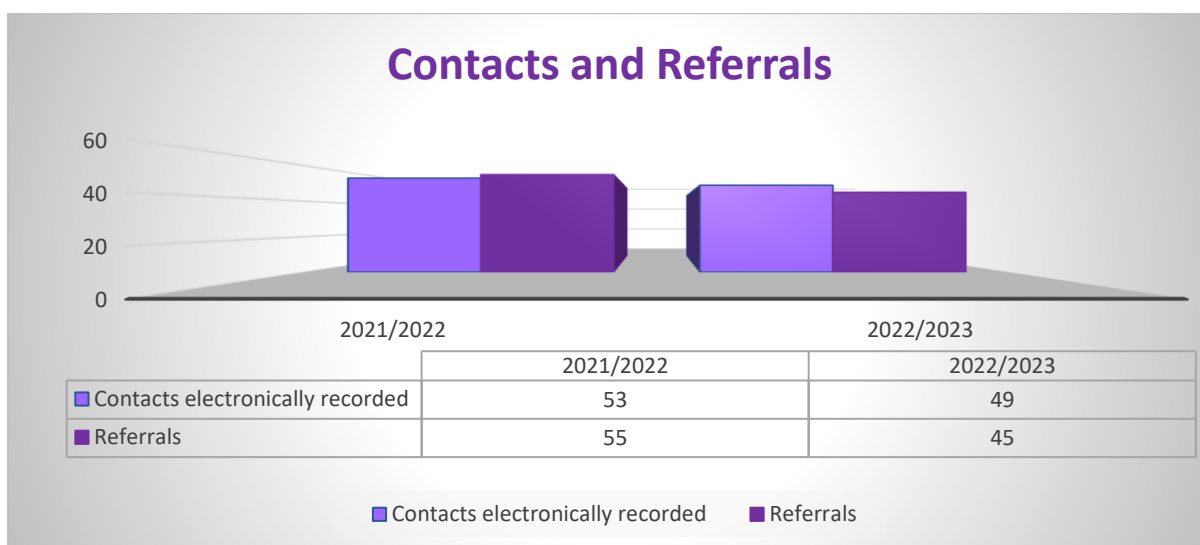
Profile of LADO Referral Activity & Analysis 1st April 2022 - 31st March 2023

Contact and Referrals - Consultations

The numbers of consultations demonstrates the level of advice and guidance the LADO services provides to organisations providing services to children and young people and these include safer recruitment advice, support in managing staff conduct and behaviour where it might lead to safeguarding issues. This level of preventative work is valued and well received by partners, particularly schools and early years settings.

On average there are far more contacts in respect of concerns resulting in LADO oversight of internal management investigations than those cases that met threshold requiring a formal LADO ASV Strategy /Evaluation Meeting. The finding may suggest that that partner agencies within Harrow are unclear about LADO threshold given the level not meeting threshold nor criteria for formal LADO involvement. Alternatively, this may mean partner agencies prefer to discuss low level concerns and allegations; not all low-level concerns specifically those not meeting contact level were electronically recorded by the LADO. The highest number of referrals continues to come from education where children have the most contact with adults who work with children. Generally reporting from schools is higher as a result of the schools' statutory guidance which has existed for some years. Over time this has enabled more staff to be familiar with the managing allegations procedure and the expectations to report any concerns about inappropriate behaviour of colleagues.

Number of contacts/ referrals received - 1st April 2022 to 31 March 2023

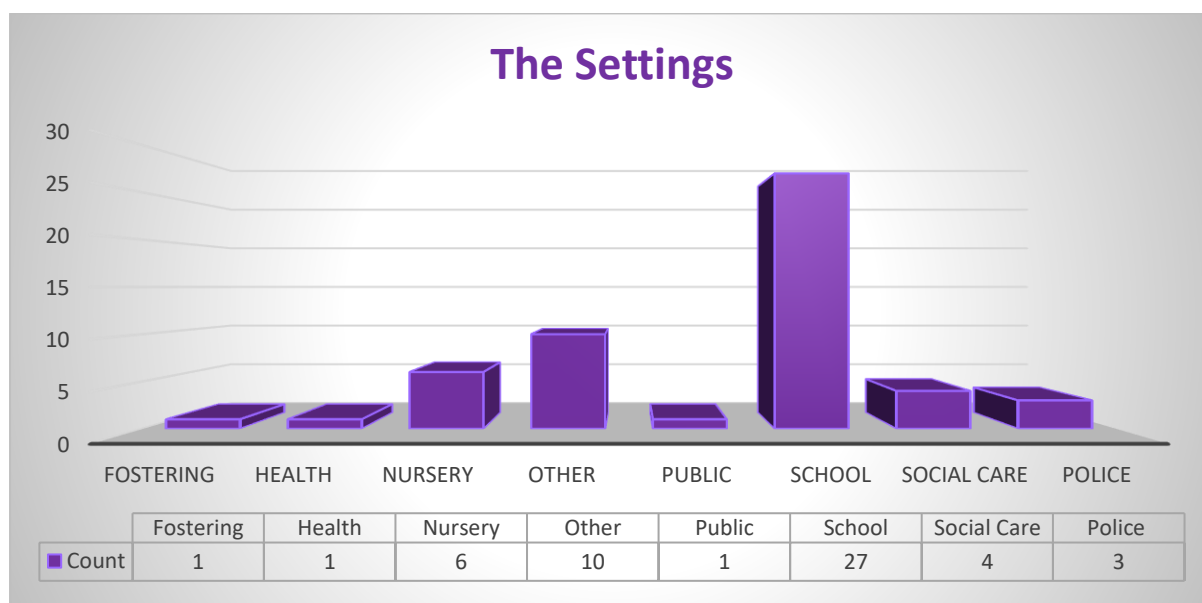


Referrals /contacts on average received via email and telephone requesting consultation. Whereas, in cases where there was a clear allegation identified, or contact in respect of internal management investigation required, the referral method was a LADO referral form submitted via email. Not all telephone contacts regarding low-level concerns which are clearly conduct issues are electronically recorded by the LADO.

Professional Suitability & Personal Life

LADO has seen an increasing number of concerns and allegations related to Transferable Risk, where there are concerns within a staff member or volunteer’s personal life that can impact on their professional suitability to continue working with children. Examples of this may include domestic violence, physical chastisement of one’s children, mental health, or substance misuse issues in their home life. Pressures related to the higher cost of living, housing insecurity and pressures on lone-parent families are some of the pressure points on workers that are impacting on their ability to cope at work and in their home life.

Where referrals came from between 1st April 2022 to 31 March 2023



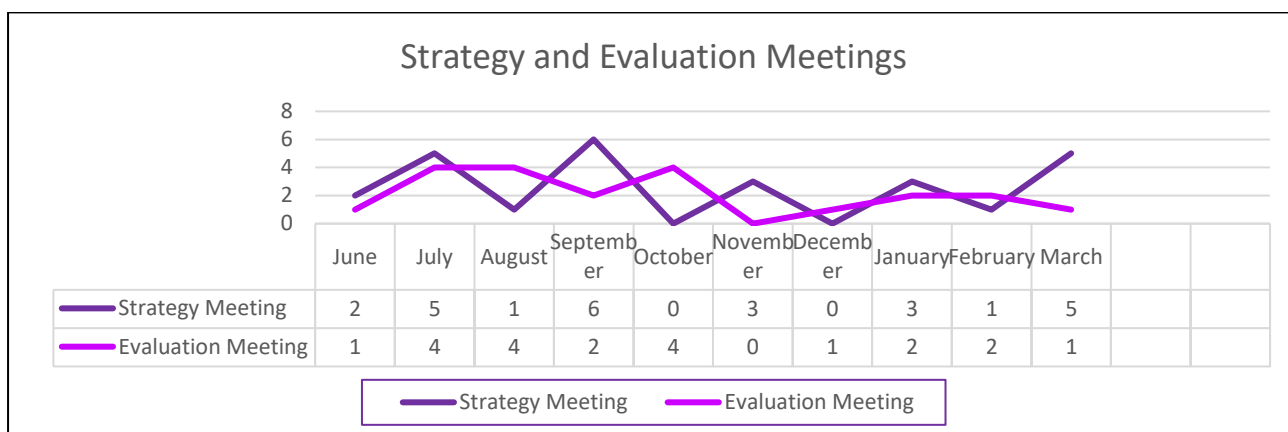
This table shows the type of agency that submitted referrals within the reporting period. Education continues to represent the largest proportion of referrals to the LADO service. Most contacts have come from regulated settings such as mainstream schools and OFSTED-registered nurseries. This finding suggests that regulated settings generally have safeguarding procedures embedded in their organisation culture and are more likely to seek advice when there is a concern or allegation.

Police: The LADO is mindful again there were no referrals in relation to Police Officers in this reporting period. It needs to be noted that the Police Officer would need to be in a position of power and control over children to meet the threshold for LADO involvement. All other Police complaints/allegations are made to the Police complaints committee. However, the LADO remains concerned about the lack of involvement with service, and it would appear they address matters internally rather than refer to LADO or at least consult with the LADO. There were no contacts regarding suitability/position of trust during the reporting year.

Referral Trends

The LADO continues to receive allegations related to unregulated workers and manager-less organisations such as music schools and child-minders. Issues related to these referrals are complex and unique. LADO continues to follow best practice related to allegations related to unregulated workers and manager-less organisations and consults best-practice when responding to these settings.

Strategy and Evaluation Meetings



47 Strategy / Evaluation (ASV) meetings were held following the referrals. 26 of these were strategy meetings. The meetings held covered review meetings held on some individuals due to complexity of the cases.

The evaluation meeting held are when the threshold of significant harm is not clearly met, and further information is required. This may lead to closure, ongoing enquiries, or pass back to the Organisation for an internal management investigation.

LADO Training and Development/ Consultation Sessions

Harrow LADO participates in the national and regional LADO groups and is active within the regional LADO group to ensure that current practice follows best practice related to the statutory guidance.

- ❖ 31 August 2023 - Child Protection Advisors
- ❖ 28 February 2023, Early Years (DSL) LADO Training
- ❖ 19 October 2023, Family Placement Service
- ❖ LADO lunchtime/bitesize sessions for Children's social care are scheduled to take place 17th January 2024 and will continue a quarterly basis.

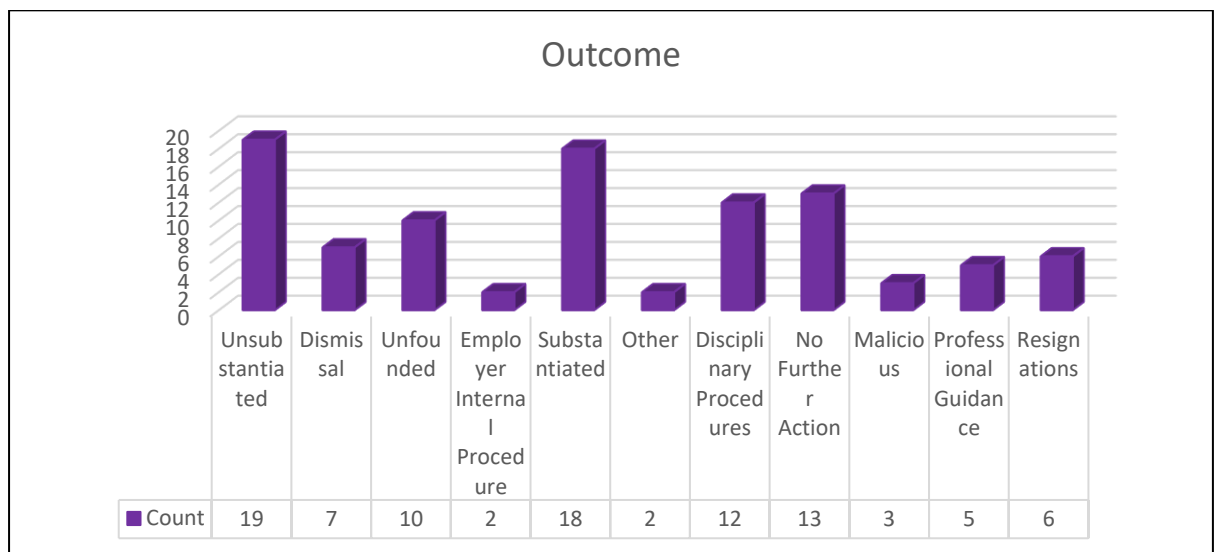
Safer Recruitment

The LADO Service provides training, advice and support to organisations, and in particular schools, working with children in relation to safe recruitment practices. This includes discussions around references, and advice on issues where recruits may have positive DBS checks. This has complimented HR guidance and advice and provided a safeguarding context to recruiting staff.

Outcomes of Allegation

The chart below shows the LADO outcome, using the LADO framework of Unfounded, False, Malicious, Unsubstantiated and Substantiated.

The secondary outcome would be in relation to the organisation involved and show internal management and no further action following an internal enquiry.



Outcomes are defined against two thresholds, where harm or the risk of harm has been caused, and where the standard of care fell below that which could be reasonably expected. In cases where the harm threshold is met, criminal prosecutions are normally considered and referrals to DBS and professional regulatory bodies take place. Over the last twelve months 18 of cases which met the harm threshold were substantiated

The overall outcomes of the cases referred during this reporting period, 18 were substantiated, 19 were unsubstantiated, 10 were unfounded, no malicious outcomes within this reporting year and at the time of writing this report, there were 6 ongoing cases. There were no false outcome recordings.

Consultations Meeting/Not Meeting Threshold

There are a number of consultations with the LADO service which were dealt with and resolved without the need for formal LADO intervention. These are often contacts where staff conduct, or behaviour is of concern or where a complaint has been received relating to safeguarding concerns. Many can be resolved quickly with advice/guidance or referrals to Human Resources. [There is no current facility to record these contacts on the LADO electronic file/Mosaic]

The numbers of consultations demonstrates the level of advice and guidance the LADO services provides to organisations providing services to children and young people and these include safer recruitment advice, support in managing staff conduct and behaviour where it might lead to safeguarding issues. This level of preventative

work is valued and well received by partners, particularly schools and early years settings.

Investigations

Whilst it is no longer an indicator required to be reported on by the Department of Education, where an investigation is initiated, investigations can be stressful for all concerned and clearly the quicker they can be concluded appropriately, the better. Where allegations are investigated by employers oversight by the LADO can ensure that the matter is concluded in a timely manner. As a result, 77% of allegations are completed within a month and 89% within 3 months. However, there remain some cases where investigations take longer, and these are as a result of police investigations where the “beyond reasonable doubt” threshold requires lengthier processes.

Conclusion

The LADO remains confident about the timely level of responses to LADO enquiries regarding allegations and investigations by professionals internally and externally. This year has seen updates to the LADO referral process to ensure clear and concise recording and reporting to ensure more efficient recording and reviewing of LADO cases. The year has seen more frequent contact from a wider range of services with an increased low level enquiries, with a slight increase of substantiated outcomes. The LADO service continues to establish itself within the safeguarding network in Harrow and is seen as a positive and supportive provision. Professionals have feedback the benefits of learning and knowledge acquired as a result of working with LADO. *[An electronic LADO feedback form was introduced summer 2023 please go to <https://forms.office.com/e/k9k5X6arQR>]*

8. Appendices

HSSP Budget & Expenditure 2022-23

Harrow Safeguarding Partnership 2022/23	
	Outturn
NHS NWL Integrated Care Board	40,000
Training Income	10,580
Mayor's Office for Policing & Crime	10,000
North West London NHS Trust	5,000
Royal National Orthopaedic Hospital	5,000
Probation Service Harrow and Barnet PDU	1,000
Total Income	71,580
Partnership Manager	68,381
Business Support	32,724
Learning & Development Manager (0.8 FTE)	30,315
Learning & Development Co-ordinator (0.5 FTE)	21,574
HSCB Chair	20,800
HSAB Chair	10,049
Voluntary Action Harrow	14,000
Independent Reviews	0
Total Staffing & consultancy expenditure	197,843
Council charges	29,879
Realise	2,678
TASP	1,750
Phew	1,097
Formsite	801
Legal fees	358
Mobile Phones	283
Adobe	269
Total Delivery Costs	37,115
Total Expenditure	234,958
Net Expenditure funded by LB Harrow	163,378

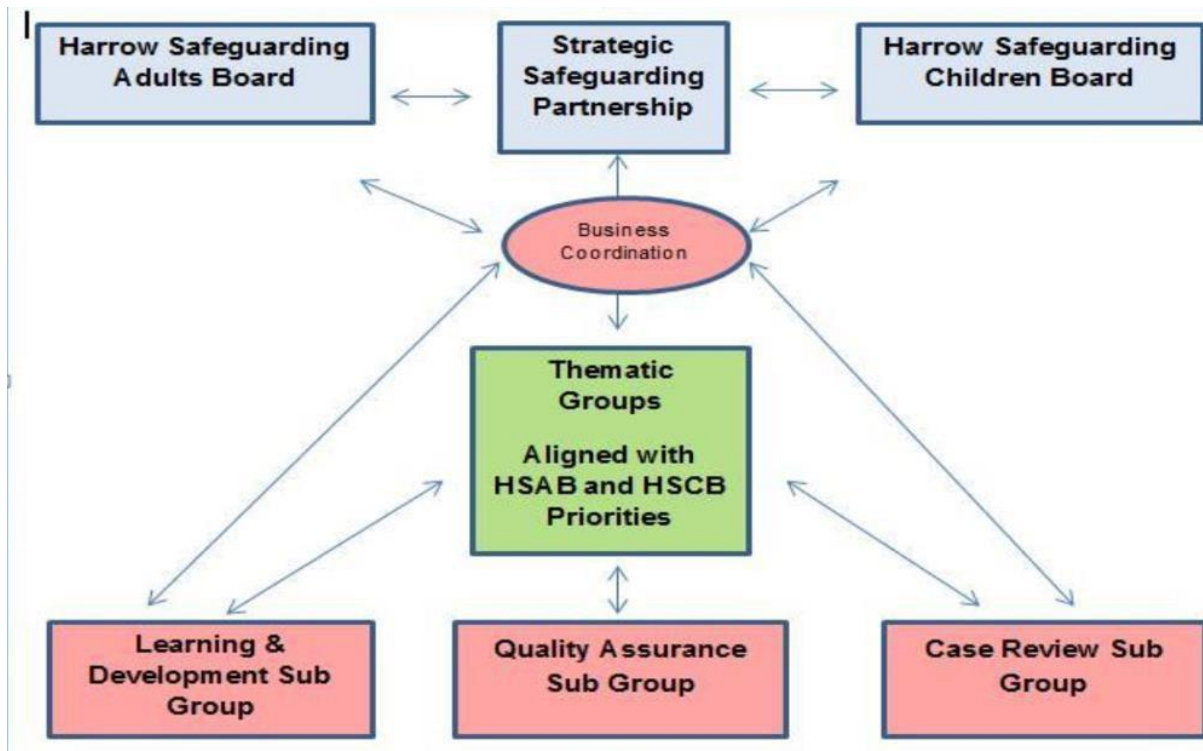
Meeting attendance

Harrow Strategic Safeguarding Partnership	Oct-23	Feb-23	Total
Independent Chair	0	1	1/2
Elected Member	0	0	0/2
CCG	0	1	1 /2
Metropolitan Police Service	1	1	2/2
Local Authority	1	1	2/2
Schools - Primary	1	1	2/2
Schools - Secondary	0	1	1/ 2
Designated Nurse - Children	1	1	2/2
Designated Nurse - Adults	0	1	1/ 2
London Fire Brigade	1	0	1/2

HSAB	Jul-22	Jan-23	Total
CCG	1	0	½
CLCH	1	0	½
Elected Councillor	1	0	½
RNOH	1	0	½
Lay Member	0	0	0/2
LNWHT	1	1	2/2
Business Intelligence	1	0	½
WDP	1	1	2/2
MPS	1	1	2/2
Probation	0	0	0/2
Chair of HSAB	1	1	2/2
Commissioning	0	0	0/2
London Fire Service	1	1	2/2
CNWL	1	0	1/2
Healthwatch Harrow	0	0	0/2
Community Connex	1	0	1/2
Mind in Harrow	0	0	0/2
DBS	0	0	0/2
Harrow Association of Disabled People	1	1	2/2
Housing	1	1	2/2
Harrow Council - Children Services	1	0	1/2

HSCB	July-22	Dec-22	Mar-23	Total
Independent Chair	1	1	1	3/3
Vice Chair/Lay Member	1	1	0	2/3
Elected Member	1	1	1	3/3
CCG	0	0	1	1/3
Met Police	1	1	1	3/3
Local Authority	1	1	1	3/3
Designated Nurse	1	1	1	3/3
CNWL	1	0	1	2/3
LNWUHT	1	1	1	3/3
RNOH	1	1	1	3/3
Secondary Schools	1	0	0	1/3
Special Schools	1	1	1	3/3
Independent School	1	0	0	1/3
Colleges	0	0	0	0/3
WDP	0	0	0	0/3
Voluntary Sector Rep	1	1	1	3/3
Public Health	1	1	0	2/3
Housing	0	1	1	2/3
Probation	0	0	0	0/3
London Ambulance Service	0	0	0	0/3
London Fire Brigade	1	0	1	2/3
CAFCASS	0	0	0	0/3

Harrow Safeguarding Partnership Structure

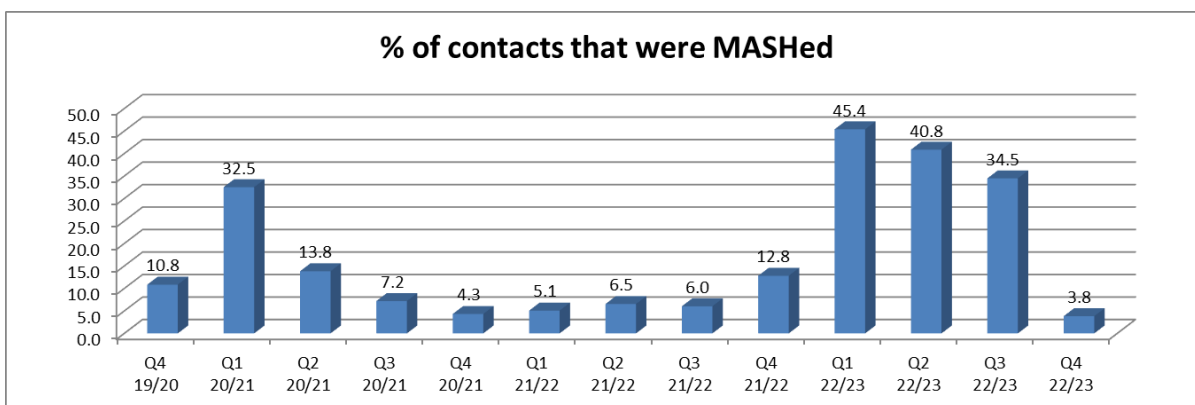


Children's social care - safeguarding data

Contacts

Number of contacts processed each quarter

	Q4 20- 21	Q1 21- 22	Q2 21- 22	Q3 21- 22	Q4 21- 22	Q1 22-23	Q2 22-23	Q3 22-23	Q4 22- 23
Number of contacts	2710	2881	2755	3051	2810	2832	3087	2910	3002
Number of contacts that were MASHed	117	146	180	184	360	1285	1261	1003	115



Sources of contacts

Year to date, the most frequent source of contact was Police accounting for 26.5% of the total, this was followed by totalled Education Services and Health Services accounting for 22.5% and 18.2% respectively.

Contacts YTD - Contact Source	Count	%
Police	3143	26.5%
Education Services - Schools, school nursery	2670	22.5%
Legal Agency -eg courts, probation, immigration, CAFCA	979	8.2%
Health Services - A&E and Ambulance Service	902	7.6%
Health Services - Other (eg Hospital, CAMHS, hospice)	785	6.6%
Other - eg children's centres, independent or voluntary org	748	6.3%
LA Services - Non - Harrow Local Authority departments	610	5.1%
Individual - Family member / relative / carer	372	3.1%
Health Services - GP, walk in centre, 111	353	3.0%
Education Services - Other (admissions, SENCO, nursery)	311	2.6%
LA Services - Internal Social Care Dept. eg Adults, EDT,	274	2.3%
LA Services - Early Support	159	1.3%
Individual - Self	129	1.1%
LA Services - Internal other e.g. Youth Offending	129	1.1%
Health Services - Health Visitor	102	0.9%
LA Housing dept or housing association	98	0.8%
Individual - Acquaintance eg. neighbours / child minders	42	0.4%
Individual - Other (Including strangers, MPs, Councillor)	23	0.2%
Anonymous or name not to be shared	18	0.2%
Health Services - School Nurse	17	0.1%
Unknown	8	0.1%
Health Services - Primary (e.g. Dentist, Optician)	2	0.0%
Total	11874	

Top 10 presenting issues

The most common presenting issue for contacts year to date is Parenting Support accounting for 34.9% of the total. This was followed by Request for Information and totalled abuse & neglect accounting for 11.5% and 8.6% respectively.

Rank	Presenting Issues YTD	No.	%
1	Parenting Support	5676	34.9%
2	Request for information	1868	11.5%
3	Totalled Abuse and Neglect*	1072	8.6%
4	Domestic Abuse	1202	7.4%
5	Missing from education	984	6.0%
6	Mental Health Concerns (Parental)	543	3.3%
7	Illness or Disability - Child	389	2.4%
8	Socially Unacceptable Behaviour (Victim)	334	2.1%
9	Mental Health Concerns (Child/Young Person)	312	1.9%
10	Housing - other issues	260	1.6%

*Totalled Abuse and Neglect	No.	%
Abuse - Physical	709	4.4%
Abuse - Neglect	369	2.3%
Abuse - Emotional	183	1.1%
Abuse - Sexual	139	0.9%
Total	1400	

Contact outcomes

The main outcome from contacts completed in the quarter was NFA - Contact (52%), this was followed by Social Work Assessment accounting for 23%.

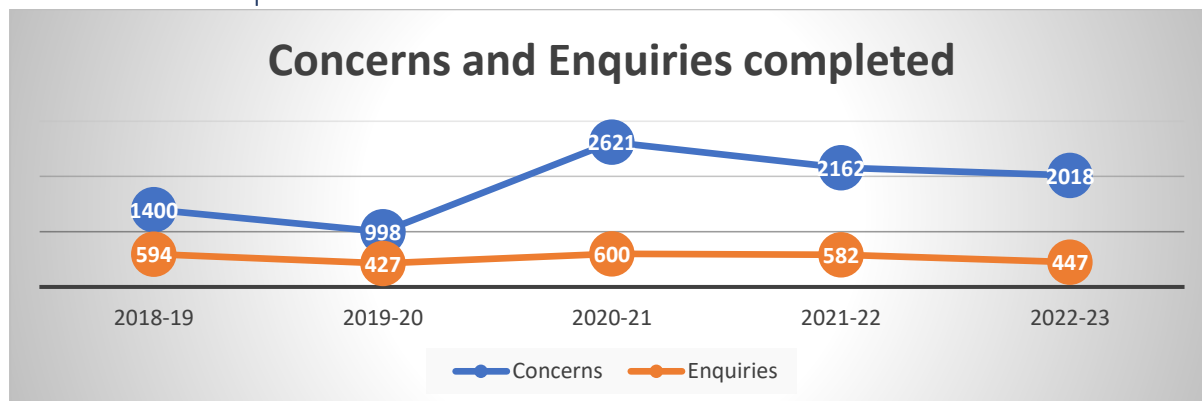
Completed Contacts Outcomes YTD*	Count	%
NFA	6121	51.5%
Social Work Assessment	2784	23.4%
Early Support	1798	15.1%
Referral to Education	848	7.1%
Core Offer Short Breaks	144	1.2%
Strategy Discussion	88	0.7%
Occupational Therapy	32	0.3%
Prevent CISR	25	0.2%
CP Transfer In Conference	14	0.1%
Adoption Support Request	5	0.0%
Special Need Housing Assessment	3	0.0%
Enablement Referral	1	0.0%
LADO Allegation Referral	1	0.0%
Private Fostering Assessment	1	0.0%
Total	11874	

Adult Social Care - Safeguarding Adults Data

Key facts

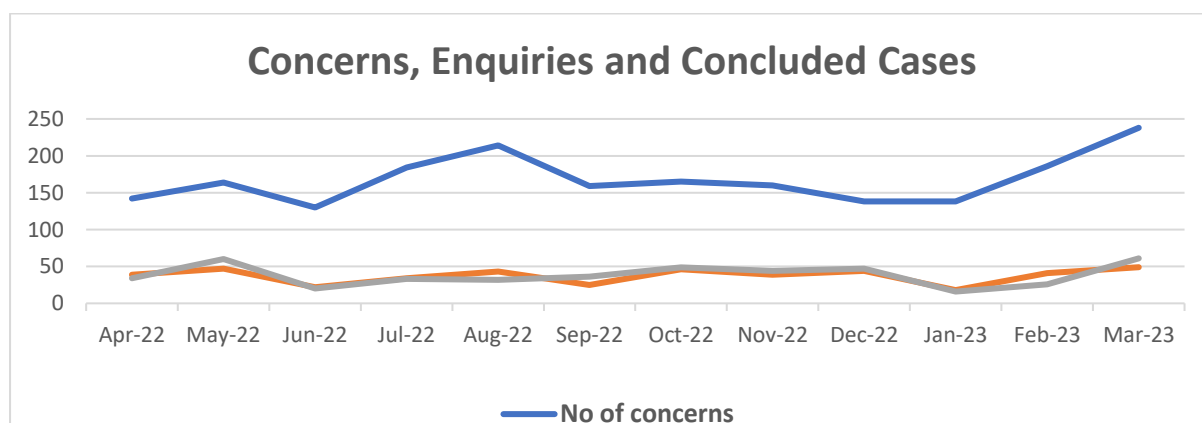
- Data collected for the financial year 2022-23 for all over 18s with a safeguarding concern (which may lead to enquiry and further work)
 - concerns
 - enquiries
 - completed work
 - Making Safeguarding Personal
 - Reduction of Risk

Concerns and Enquiries



In Harrow the number of concerns and enquiries have reduced 7% and 23% respectively compared with the previous year. Conversion rate: 22% in 2022-23; 27% in 2021-22

Demand – Concerns, Enquiries and Concluded cases



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Grand Total	Average
Concerns	142	164	130	184	214	159	165	160	138	138	186	238	2018	168
Enquiries	39	47	22	34	43	25	46	39	44	18	41	49	447	37
Concluded Cases	34	60	20	33	32	36	49	44	47	16	26	61	458	38
Conversion rate	27%	29%	17%	18%	20%	16%	28%	24%	32%	13%	22%	21%	22%	22%

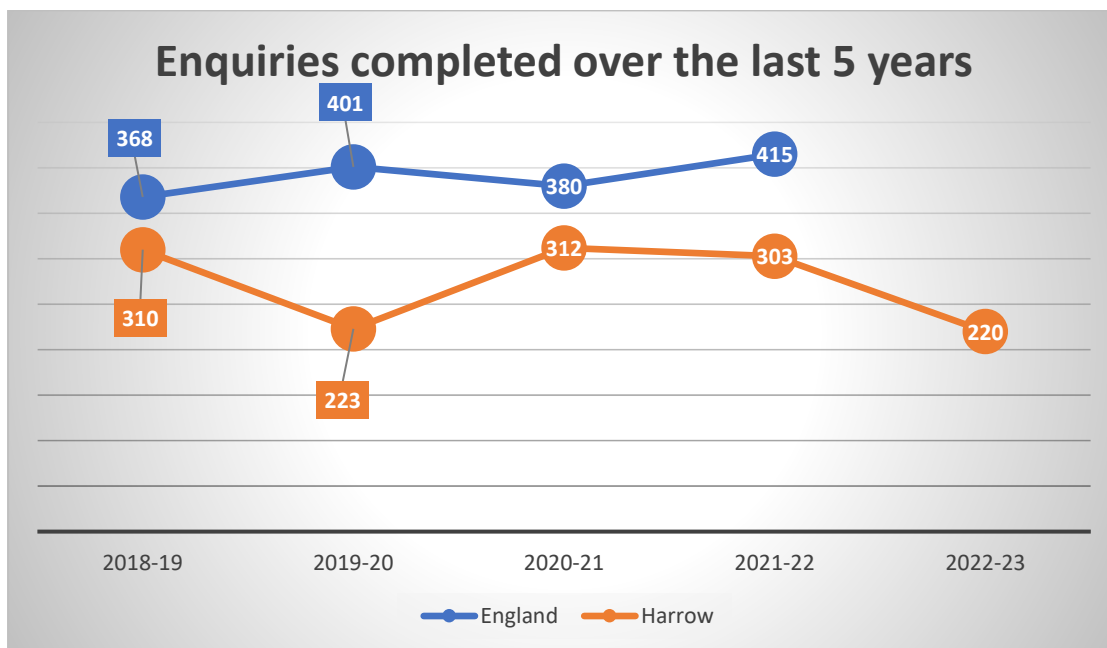
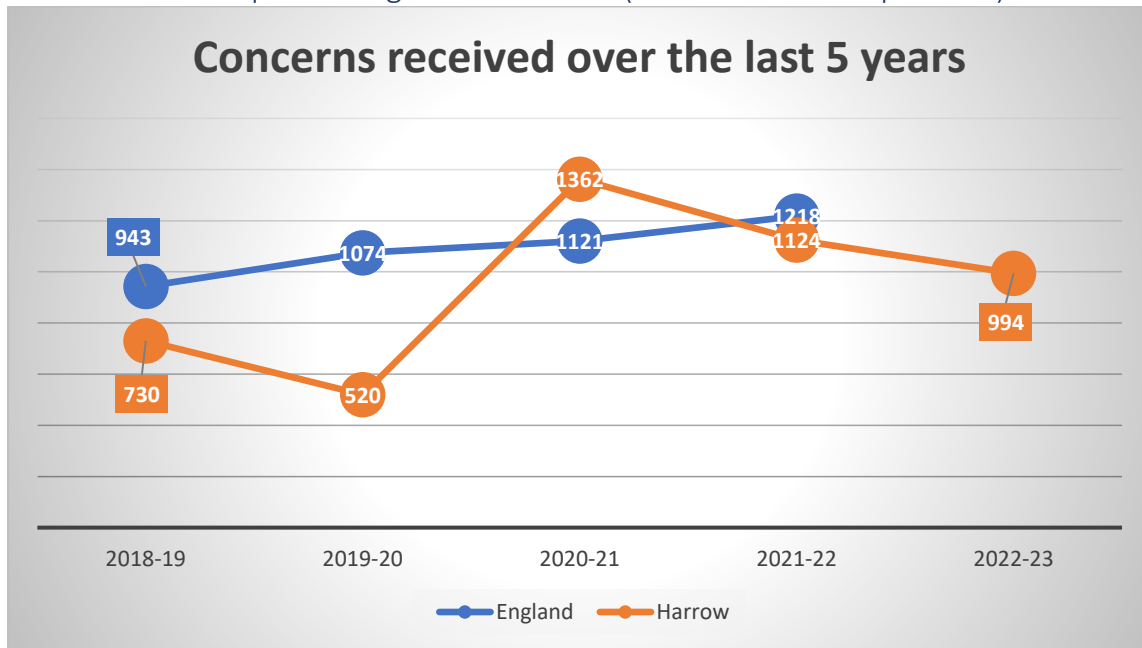
Concerns – volume and change in types of abuse

Type of Abuse	2021-22	2022-23	Change
Psychological Abuse	633	530	-16%
Neglect and Acts of Omission	608	497	-18%
Self-Neglect	533	490	-8%
Physical Abuse	472	328	-31%
Financial or Material Abuse	325	278	-14%
Domestic Abuse	224	268	20%
Sexual Abuse	86	73	-15%
Sexual Exploitation	23	27	17%
Discriminatory Abuse	9	11	22%
Organisational Abuse	9	6	-33%
Modern Slavery	8	5	-38%
Grand Total	2930	2513	-14%

Overall a 14% reduction in the types of abuse reported in 2022-23 compared with 2021-22. Although we can see a reduction in most types of abuse reported, domestic abuse has increased along with sexual exploitation and discriminatory abuse.

Note: in Q1 of 2021-22 Harrow was still recording all Merlins (from the Police) as concern as we did in 2020-21. This practice ended towards the end of Q1.

Concerns and Enquiries: England Vs Harrow (Per 100K adult Population)



When comparing the previous year per 100K adult population we can see a slightly bigger reduction in the number of concerns (12%) and enquiries (27%) compared with the previous year. This is due to the increase in the mid year estimates for 2021 which as increase by almost 11k residents.

Note: England figures includes section 42 and other enquiries while Harrow only submits Section 42 enquiries.

Concerns - Age groups and the types of abuse that affect them

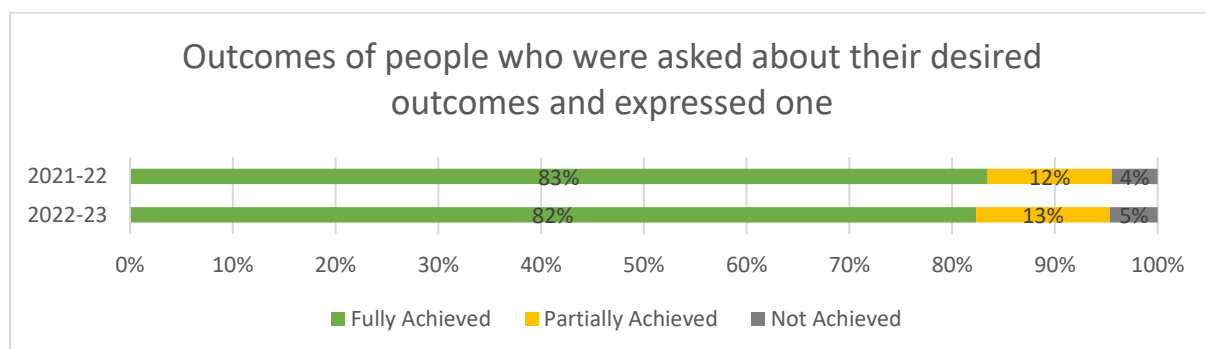
Older age group still mainly affected by Neglect, while younger adults mainly affected by Psychological abuse and Self-Neglect

2022-23				
	18-64	65+	85+	Nos.
Neglect and Acts of Omission	12%	33%	47%	416
Self-Neglect	20%	17%	10%	382
Psychological Abuse	25%	14%	9%	409
Physical Abuse	13%	14%	14%	276
Financial or Material Abuse	11%	13%	17%	234
Domestic Abuse	13%	7%	2%	206
Sexual Abuse	4%	1%	1%	58

Concluded Cases – Making Safeguarding Personal

In 81% of cases in 2022-23 people were asked for their desired outcomes compared with 84% in 2021-22.

The proportion of outcomes that were fully and partially met are similar to the previous year.



Concluded Cases – Risks Identified

In 72% of cases Risk was identified in 2022-23 compared with 71% of cases in 2021-22. The proportion of reduced and removed are similar.

