

Appendix A

Barking and Dagenham Safeguarding Children Board

Annual Report 2016/17



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1. Chair's Introduction

I have been the Independent Chair of London Borough Barking and Dagenham LSCB since September 2011. This is a statutory post as set out in the Children Act 2004 section 18.



My job is to hold agencies to account for the effective coordination of the commissioning and provision of services for children to ensure that children are safeguarded and the welfare of children in the area is promoted. I provide independent challenge so each Board agency partner and their representatives are held to account.

My strategic role is to hold partners to account for the safeguarding arrangements for children in Barking and Dagenham, the priorities of which are set out in the LBBDD LSCB business plan. To achieve this, I have quarterly Governance meetings with the Leader of the Council, the Lead member for Children, the Chief Executive of LBBDD and the Strategic Director of People. I also have one to one meetings with the Strategic Lead officers for the statutory partner organisations on a regular basis.

These meetings are effective in influencing the LSCB agendas for successful delivery of the LSCB business plan. Meetings are well attended by partners and the Lead member for Children attends

the LSCB as a participant observer so that she is informed and can provide effective challenge to the Council officers.

My evaluation of the LSCB business plan is that partners have made good progress against the priorities, though there is further work to do on understanding performance data across the partnership and the arrangements to embed the voice of the child into LSCB business and the work of the sub-groups must be more robust to ensure that their voice makes a meaningful difference.

Partners have also made good progress against other significant areas of practice including reducing the numbers of children taken into police protection.

However, there is still too much variation in practice as evidenced through LSCB multiagency audit.

At the same time, the LSCB has been proactive in responding to emerging issues including the CQC inspections at North East London Foundation Trust and Barking, Havering, and Redbridge University Trust. There are also structural and associated operational changes in the Metropolitan Police as they move to a three Basic Command Unit which is being piloted across Barking and Dagenham, Havering, and Redbridge. The LSCB partners are working closely with the police to understand and support changes to ensure children are safeguarded

Partners give vulnerable children and their families the highest priority.

I am also the Independent chair of the Barking and Dagenham Safeguarding Adults Board, a statutory position under the Care Act 2014. I use my knowledge from both Boards to make links and find solutions for children and families including hoarding.

The LSCB is a multiagency partnership and is much more than the sum of its parts. Managers and front-line practitioners across the partnership all work extremely hard under significant resource pressures with some of the most vulnerable children in Barking and Dagenham. LSCB partners have demonstrated they give the highest priority to safeguarding children demonstrated through their commitment and attendance at LSCB meetings, engagement in multiagency audit of practice, serious case reviews and LSCB multiagency training.

However, challenges emerging from case file audit including partners response to Domestic Abuse and Sexual Violence and children experiencing Neglect are priorities for the coming year.

After 6 years it is time for me to step aside and in agreement with partners I will be stepping down from my role in July 2017.

**Sarah Baker | Independent Chair: Barking and Dagenham
Safeguarding Children Board**

2. Executive Summary

Purpose of the Annual Report

The report sets out the effectiveness of the Local Safeguarding Children Board (LSCB) in carrying out its core business under its statutory objectives, the effectiveness of multi-agency practice to safeguard and promote the welfare of children and young people and the progress made against the LSCB priorities of:

1. Board members are assured that arrangements are in place to identify and safeguard groups of children who are vulnerable
2. Board partners will own and share accurate information which informs understanding of safeguarding practice and improvement as a result
3. The Board will see children and young people as valued partners and consult with them so their views are heard and included in the work of the LSCB
4. Arrangements for Early Help will be embedded across agencies in Barking & Dagenham who work with children, young people, and their families
5. Board partners will challenge practice through focused inquiries or reviews based on performance indicators, practitioner

experience and views from children and young people. Collectively we will learn and improve from these reviews.

Achievements

- Delivery of a comprehensive training programme that saw over **1500 participants**.
- The sub-groups drove forward work on progressing LSCB **priorities**
- The arrangements supporting the **Child Death Overview Panel** continue to manage and review all child deaths
- There are good systems in place for the **Serious Case Review** sub-group who are co-ordinating one SCR and one PLR.
- Several new initiatives planned in the next year. These include implementation of the **Pause Practice** for work with women who have had children removed to prevent repeat removals; **Caring Dads** group-work supporting fathers who are a source of safeguarding concerns to focus more on the needs of their children; and **Mockingbird** which is a project aimed at supporting foster carers and improving placement stability for looked after children
- A new electronic records system – **Liquid Logic** – has been commissioned for Children’s Care and Support and the plan is for implementation during the 2017-18 period. This will

provide a significant improvement as a working tool for social workers in their casework and for managers in overseeing this work.

Challenges

- The arrangements to embed the **voice of the child** into LSCB business and the work of the sub-groups must be more robust and ensure that their voice makes a meaningful difference
- The engagement amongst **LSCB members** varies in terms of support in leading or chairing groups
- Whilst there are links with other **key strategic boards** in Barking & Dagenham there is a need for further development to ensure **clarity** regarding key responsibilities, identifying areas of joint work, and linking agendas
- Limited reporting on **performance data** across all partners on key safeguarding areas to the Board or Chairs Group.

Priorities for 2017/2018

Barking & Dagenham LSCB must ensure it provides assurance that safeguarding arrangements are effective. This includes:

- **Reviewing** the current structure to ensure it is fit for purpose and meets the requirements of the Children & Social Work Act.

- **Reviewing** the LSCB budget and **agency contributions** against LSCB requirements
- **Reviewing** protocols with strategic boards to clarify responsibilities and **strengthen** joint working
- Establishing a **performance data set** and dashboard to develop a partnership understanding and provide the LSCB with **assurance** of safeguarding arrangements.
- **Understand** the reason children and young people are **missing** and the risks they face through the Return Interviews.
- **Re-fresh** the multi-agency CSE Operational strategy and action plan and **update** the CSE Problem Profile
- **Develop** an understanding of the relationships between **public health** concerns such as domestic abuse; sexual health; neglect and poverty and the health and wellbeing of children and young people.
- **Recognition** and **response** to **Neglect**: Recognising the signs of neglect, knowing the effects of neglect on vulnerable children and young people and understanding the role that we can play, to prevent neglect and support those experiencing it.
- **Assist** frontline practitioners and CP IRO's **reflect** on the causes and broad categories of **emotional abuse and neglect** - the two main categories used for Child Protection Plans.

3. Key Facts: Barking and Dagenham

Barking & Dagenham is in the East of London and has a projected population for 2017 of 209,149, of which 63,270 are under 18. The borough has a predominantly white British population, with 49% of the residents from a non-white ethnic group. Black Africans are the largest minority ethnic group at 17% of the overall population.

The child population in Barking & Dagenham is estimated to be increasing by around 2-3% each year and at 30% of the population is above the London average of 22%. There has been a 14% increase in the 0-17 population since 2011 compared to the London average (7%).

It is predicted that this will increase by 11% over the next five years compared to the London average (6%). This increase continues to present rising demands for all services across the borough.

The ethnic breakdown of under 18's is projected to be: 27% White British and 9.5% White Other - predominantly Eastern European groups, with 63.4% from Black and Minority Ethnic (BME) backgrounds.

The BME figure can be further broken down to: 23.3% Black African, as 2.2% Black Caribbean, 4% as Black Other, 7.1% as Bangladeshi, 6.6% as Pakistani, 4.5% as Indian, 0.7% Arab, 0.4% as Chinese and 3.6% as Other Asian. A further 9.5% of 0-7 year olds were from a mixed ethnicity while 1.6% were from another ethnic group not shown above.

Barking & Dagenham has 44 primary schools, 10 secondary schools, 2 special schools and 1 pupil referral unit. 5.7% of Barking & Dagenham's 16 to 18-year-old cohort were not in Education, Employment, or Training (NEET), compared to London (3.4%) and England (4.7%) averages.

At least 174 languages are spoken in Barking and Dagenham. Within the school population, 38 of these languages have been identified as being spoken by individual children (source: DfE School Census Spring 2016). The percentage of pupils with an Education Health Care Plan / Statement is **2.3%**. (Source: DfE School Census Spring **2017**).

GLA projections on the gender of the Borough's residents for 2016 indicates that **51.5%** of under 18-year olds are male, whilst **48.5%** are female compared to the general population, where **49%** are male with **51%** being female.

Barking & Dagenham is a borough with high areas of deprivation and poverty and these factors alongside domestic violence impact significantly on social care. Barking & Dagenham has the 6th highest level of child poverty in England and across London is ranked 4th 'worst' for children aged under 16 and 6th 'worst' for children aged under 18.

Domestic violence and abuse continues to be a significant issue in Barking & Dagenham and impacts on all service areas across the borough. It accounts for 46.2% of violence with injury offences in the borough (JSNA, 2016) and was a presenting factor for 15.8% of children's social care contacts in 2016/17.

Property in Barking & Dagenham costs around £310,000 which is over 12 times the average household income of £25,499. This makes home ownership unaffordable for many residents. Most households presenting as homeless will live in private rented accommodation.

Market rents have been rising much faster than household incomes, particularly for those families on benefits. Private rents have increased by 25% over the last two years, outstripping both inflation and Local Housing Allowance rates. This has led to difficulties for low income households accessing or sustaining affordable tenancies in the private rented sector and consequently significantly increased the number of households presenting as homeless.

There is only a 3% turnover in council housing every year, which severely limits the amount of council housing available to re-house homeless households.

The largest single factor for households becoming homeless is loss of private rented sector tenancy. The second largest factor is parental/household 'ejection'. Overcrowding and non-violent relationship breakdown were the most significant causes followed by violent breakdown which is usually associated with domestic violence or anti-social behaviour.

Changing market dynamics, the lack of local affordable private rented housing and the progressive erosion of the purchasing power of those on benefits is expected to increase the number of

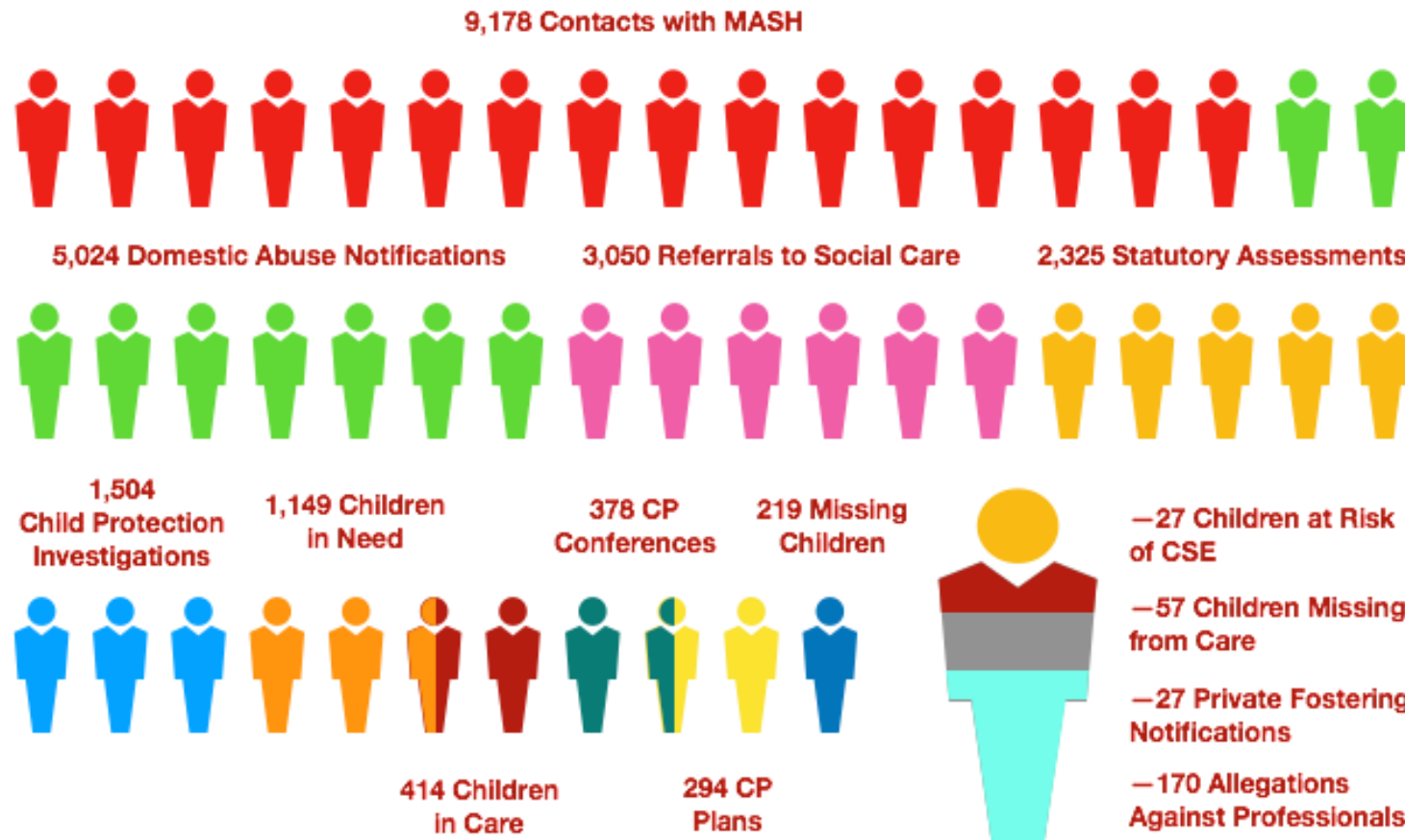
households needing assistance, with the number of households presenting as homeless expected to double by 2020.

Against a background of a projected increase in demand, there is a need to address the underlying causes of homelessness and to find ways to prevent households from becoming homeless in the first place.

There are some actions proposed for the coming year to help to reduce homelessness, these include:

- Early intervention
- Adopting a holistic, multi-agency approach
- Mediation in parental ejection cases
- Employment, debt management and benefits advice
- Working more closely with private landlords

4. Safeguarding 'Snapshot' 2016/17



2,024 Social Care Cases

18% of Children Receive Free School Meals

5. LSCB Core Business

Policies, Procedures, and Guidance

Barking & Dagenham LSCB is part of the London Safeguarding Board and as such follows the Pan London Child Protection Procedures.

Locally, the LSCB has published an Early Help Strategy and revised and re-launched a Threshold document which is available on the website.

In response to a recommendation in the Serious Case Review (SCR) for Child B, the LSCB has re-circulated the “Arrangements for Escalation – Challenge and Resolution”. During the year the referral pathway for Child Sexual Exploitation has also been revised.

Communication & Awareness

The LSCB has a responsibility to undertake communication & awareness raising activity for safeguarding.

The LSCB undertook a range of activity in 2016/17 targeting professionals, the community, children, and young people using a variety of methods to engage the various audiences.

- Practitioner Forum – regular meetings for practitioners across the partnership to raise awareness of the work of the Board, to focus upon various topics of interest and to encourage networking.

- Newsletters are circulated to partner agencies and put on the website

Learning and Improvement Framework (Training)

The LSCB is required under Chapter 4 of Working Together 2015 to have a Learning and Improvement Framework in place that outlines how the board supports and embeds a culture of learning to drive quality and improve outcomes for children and young people.

The LSCB Training Strategy and Training Plan is underpinned by a model of continuous development and seeks to develop the core competencies of the children and family’s workforce.

The training programme is reviewed and developed each year based on:

- evaluation of the previous year’s training
- research and best practice
- learning from case audits
- learning from serious case reviews (national and local)
- consultation and needs analysis across agencies
- LSCB and national priorities and requirements.

During 2016/17, the LSCB ran an extensive multi-agency training programme offering **63** different courses to **1560** people across statutory and voluntary sectors which reached a range of professionals.

The LSCB also has a range of training methods available offering e-learning, face to face training and bespoke packages.

The LSCB pays for 'Gold' membership of the NWG (National Working Group) which provides online information on CSE, membership of the Association of Independent Chairs which provides up to date information via the Business Manager and the council has recently joined Research in Practice.

Evaluation of training demonstrates that the LSCB plan and quality of training is highly regarded and positively impacts on practice.

Overall **1540** people attended courses throughout 16/17 period and **764** responded to an evaluation survey. That works out to a **49.61%** response rate (**50%** if rounded up) overall.

(Stage 1): Ensuring quality

Members of the Performance, Learning & Quality Assurance Committee (PLQ) attend learning events and provide feedback to the committee on the quality of the training delivery and delegate engagement/learning.

(Stage 2): At the end of learning

End of course evaluation is completed on line via Survey Monkey for all courses – each delegate that attends a course receives a link via email no later than the day after the training event inviting them to give their feedback.

The results are collated by Survey Monkey and analysed by the Training Coordinator, results are then shared with trainers.

(Stage 3): Impact Assessment

6-8 weeks after attending a training event, a selection of learners are contacted via survey monkey or telephone to seek further evidence of the impact of learning on practice and outcomes for service users.

Areas of training & development to be included in 2017/18 are:

- Effective early help provision and use of CAF
- Substance misuse and the impact on children
- Domestic abuse
- Violence to women and children including FGM
- Child Sexual Exploitation
- Neglect and the impact on children
- Adult mental health and the impact on children

Single agency safeguarding training by partners has been assessed as part of the Section 11 audit:

BHRUT monitor compliance for Safeguarding Children's Training Level 1, 2 and 3 at the Trust's Safeguarding Children's Operational and Safeguarding Strategic and Assurance Groups. Compliance is reported quarterly to the LSCB. A Safeguarding Children's Training Needs Analysis (TNA) and Strategy for 2016/17 was approved at the Trust's Safeguarding Strategic Assurance Group meeting on 1 June 2016.

Case Auditing

The LSCB has revised and strengthened the case audit process through the Multi-Agency Audit Group (MAAG) to involve more partners enabling them to have a line of sight to frontline practice.

The table below sets out the audit activity for the year that incorporated Thematic audits, including those identified through the Ofsted Inspection in 2014 and those based on LSCB priority areas across neglect, child sexual exploitation, and domestic abuse.

The impact of these audits increased levels of contribution, competence, and confidence by agencies in the case audit process. Case audits have also generated a huge amount of intelligence about effective local practice and areas of development.

April 2016	Police Protection Quality of Strategy Discussions/Meetings
May 2016	Police Protection Quality of MARFs
June 2016	Police Protection Missing children/Return Interviews
July 2016	Police Protection Pre-birth Assessments
August 2016	Police Protection CP Conferences Stepping Down to CIN
September 2016	Police Protection Domestic Abuse
October 2016	Police Protection

	Second time CPP (Q1)
November 2016	Police Protection In-depth audit on second time CPP Q1
December 2016	Police Protection
January 2017	Police Protection Second time CPP (Q2)
February 2017	Police Protection Missing children/Return Interviews
March 2017	Police Protection Parental drug/alcohol misuse & mental health

The findings from completed audits are shared with individual agencies through the Performance, Learning & Quality Assurance Sub-Group members.

Each agency is then required to identify actions and improvements that are relevant to their organisation and ensure these are included in their own safeguarding development plan.

Outcomes are incorporated into training. The learning needs identified through the audit process are also considered by the Performance, Learning & Quality Assurance sub group to ensure that learning is incorporated into the multi-agency training plan.

Key Learning Points:

Information from case audit has demonstrated that:

- **Police Protection** – All cases of children subject to Police Powers of Protection are audited and discussed with police colleagues to understand the reasons why Police Protection was taken. As a result, the number of children coming into care through police powers of protection during the 2016-17 period was 45 which is 22.1% of all admissions. This compares with 54 (24.5%) in 2015-16 and with 69 (25.3%) children in the 2014-15 period. This indicator was raised in the Ofsted inspection in 2014 as an area requiring improvement.
- **Disguised compliance** - in several cases the word of the parents was accepted
- Lack of **chronologies, genograms** and **ecomaps** evidenced.
- **Reactive** rather than responsive interventions evidenced.
- Lack of evidence of **multi-agency** assessments. Social workers are not consistently using the partnership to complete Core Assessments.
- **Multi-Agency Risk Assessment Conference** (MARAC) minutes not evidenced in social care records.
- **Self-reporting** by parents is accepted as factually accurate.
- **CAF** not considering all children e.g. in other schools no triangulation and a **Think Family** approach.
- Lack of involvement of **absent fathers**.
- Impact of **parental behaviours** on children needs to be considered by all agencies
- Lack of awareness of **Toxic Trio** and use of research and evidence based practice in all partners.
- **Strategy discussions** often taking place over the phone.
- Individual events are being recorded in isolation i.e. no evidence of a use of a **chronology** which would give the “bigger picture”
- Professionals often lack the **confidence / knowledge** to challenge decision making or make use of the LSCB **Escalation** procedure.
- There is no national dataset for **CSE** so difficult to benchmark
- Some cases showed no evidence of the **CSE Risk assessment** tool being used
- Assessments tended to focus on the parent’s relationship rather than the long-term impact on the child where **domestic abuse** was a factor
- History and parenting capacity must be captured in long term **neglect** cases.

Key Strengths:

- ✓ Child sexual exploitation now becoming **recognised** as a causation of sexualized presenting behaviour.
- ✓ Some agencies evidenced good **communication**.
- ✓ Some good evidence of **partnership** working
- ✓ Timely response to referral, good assessment, reference to research, formulation of a **good plan** and review with other agencies.
- ✓ **Strong evidence** of management oversight, decision making and regular supervision.
- ✓ Evidence of **child’s involvement** in the CAF assessment.

- ✓ Good chronology from **school**.
- ✓ Evidence of **good direct work** with child with clear actions.
- ✓ Good **CAF** assessment.
- ✓ Positive agency involvement, partnership working and **information sharing**, prompt actions.
- ✓ **Pro-active** health visiting involvement in following up with SW team and arranging professionals meeting.
- ✓ Good evidence of **escalation** within NELFT using safeguarding Team to support escalation of concerns
- ✓ Clear **communication** between health and school.
- ✓ Good record of discharge planning meeting, good description of intoxicated attendance and impact on parenting, **good social history information**, good use of body map for strategy meeting,
- ✓ Good **information sharing** between professionals.

Section 11 Challenge

The LSCB has a well-established process in place to measure the compliance of agencies with Section 11 of the Children Act 2004 which places duties on a range of agencies to ensure that they have regard to the need to safeguard and promote the welfare of children.

The Section 11 audit in Barking & Dagenham is from 2016 a two-stage process:

1. Self-assessment – where each organisation completes an assessment tool under eight standards, which is further broken down into 50 questions. Each organisation provides an explanation of the services or arrangements in place under the questions and provides evidence to support each requirement. A self-assessed grading is given for each question of red, amber, or green.
2. LSCB ‘challenge session’ is arranged upon submission of the audit where a senior manager from the agency meets a panel to discuss and moderate the completed audit. The agency will then update the audit and grading following the moderation.
3. A new, interactive tool has been introduced for this year’s audit, which has received positive feedback from those who are responsible for completing. As the tool is completed, an action plan is automatically generated by the responses given to each standard.
4. A workshop was held for all the designated officers nominated to complete the Section 11 audit tool to provide support and advice in completing it

What is the impact of the S11 audit?

Overall the outcome of the Section 11 audit has been positive with most of the standards being judged ‘partially met’ or ‘fully met’.

- ✓ There is a good understanding of safeguarding across all agencies

- ✓ A designated individual has overall responsibility for safeguarding and there are established lines of accountability up through the organisation.
- ✓ Most agencies could demonstrate good arrangements in place to assess their contracted service providers under the Section 11 standards
- ✓ There are mechanisms in place that allow the views of children and young people to be taken into consideration
- ✓ Appropriate levels of Safeguarding training are accessed by all members of staff which includes; in-house single agency training and, multi- agency specialist training.
- ✓ All audits evidenced safe recruitment processes, with references taken up and relevant checks made.

Schools Safeguarding Audit

On a bi-annual basis the LSCB implements a school safeguarding audit relating to Section 175 of the Children Act 2004 which measures compliance with statutory guidance 'Keeping Children Safe in Education'. The audit tool is in line with a similar tool issued by the NSPCC and goes above the minimum standard to reflect the constantly changing picture of safeguarding and the responsibility on schools and their staff to safeguard children.

An encouraging picture has emerged from the report that many schools are demonstrating a proactive stance in executing their duties towards the safeguarding of children. Generally, there has

been an improvement in the quality of audits. The next audit will be undertaken in the spring / summer 2018

What is the impact of the Audit?

- ✓ An improvement in the quality of audits
- ✓ 75% of schools returned an audit
- ✓ 63% of schools used the specifically devised training materials for 'whole school' training – the remaining schools use in part or outsource their training.
- ✓ 100% of schools have a clear 'e-safety' policy
- ✓ 81% of schools understood the requirements of CSE with 19% rated 'amber'
- ✓ 100% of schools are fully compliant with the recording and storing of information on child protection concerns
- ✓ A need for more specific training on safeguarding for school governors

Safeguarding in Sport

In November 2016, a former footballer disclosed to the Guardian newspaper that he had been sexually abused as a youth player.

Since then, more people have also come forward with allegations of historical abuse in football including former footballers - including ex-youth players, trainees, and professionals.

The Football Association (FA) have set up an internal review, the Child Protection in Sport Unit, which has assisted the FA with its

safeguarding procedures since 2000, will also carry out an independent audit into the FA's practices and the NSPCC set up a helpline supported by the FA.

In response to these national and historical concerns the Barking & Dagenham LSCB have ensured that:

- all council run leisure/sports facilities must update a S11 audit.
- the principles of S11 must be used in all commissioning and contracting
- a letter is sent to all sports groups in the borough from the LSCB Independent Chair with a link to the NSPCC
- A 'leaflet' with information for parents circulated to all schools and sports facilities in the borough and placed on the LSCB website.

6. Engagement with Children

There are well established consultative and collaborative forums with children and young people to inform, shape and develop multi-agency work and priority safeguarding children areas. The engagement of children and young people in safeguarding is through:

- Barking and Dagenham Youth Forum, including Young Inspectors and Young Mayor
- Children in Care Council (Skittlz), including two annual CiC Consultations
- Young People's Safety Group (sub-group of the BDSCB)

- LGBTQ Youth Group (FlipSide)
- Progress Project (Disabled Children's Parliament)
- Child Protection and Looked After Review processes
- Locally commissioned Advocacy services for CiC.

The Young People's Safety Group met twice over the past year. A session was held in in September 2016, led by the Youth Offending Service and themed on serious youth violence in response to recent incidents in the borough. 56 pupils attended, drawn from five schools in the borough.

A February 2017 session was themed on Child Sexual Exploitation, and was led by Barnardo's. 45 pupils attended from six schools. In both cases, key questions raised by the young people at each session were shared with the Board for appropriate response and to raise awareness of the key issues experienced by young people. In addition to the Young People's Safety Group, young people took over the LSCB in November 2016 as part of national Takeover Day. The session saw BDSCB members interact with members of the BAD Youth Forum, Looked after Children and Young Carers to discuss the key safeguarding issues that affect them in the borough.

The voices of young people are additionally captured through generic and targeted youth provision, such as Vibe, Gascoigne, Sue Bramley and Marks Gate youth clubs. The voices of vulnerable young people are additionally captured through the commissioned services for young carers and AbPhab, a youth club for disabled children. Young people also sit on representative groups, such as

the Children's Services Select Committee and CCG's Patient Engagement Forum.

The Annual Report for the 2016 BAD Youth Forum was presented to Assembly in January. It highlighted several key achievements, including the production of a powerful film raising awareness around mental health entitled 'Breaking the Stigma', which has been shared widely.

Young Inspectors have conducted 62 mystery shopping inspections of pharmacies that deliver the C-Card (condom distribution scheme) this year to date. The borough's C-Card performance is now top in London, with Teenage Pregnancy figures continuing to fall. A future campaign will be Child Sexual Exploitation as a theme and will be developed in conjunction with Barnardo's.

The Children in Care council continues to be very active, with its most recent consultation receiving responses from over 100 LAC. It demonstrated improvements across many annual indicators, including frequency of contact with Social Workers and retention. FlipSide, our LGBT youth group, have also secured 50 places at this year's London Pride parade, and recently conducted a training session for Members.

7. Serious Case Reviews (SCR)

In Chapter 4 of Working Together 2015 it sets out the requirement for LSCBs to undertake reviews of serious cases in specified circumstances stated as:

“undertaking reviews of serious cases and advising the authority and their board partners on lessons to be learned.”

A serious case is one where:

- abuse or neglect of a child is known or suspected and
- either the child has died or the child has been seriously harmed and there is cause for concern as to the way in which the authority, their board partners or other relevant persons have worked together to safeguard the child.

The LSCB has a Serious Case Review (SCR) Sub-committee and all SCR decisions have followed the requirements in Working Together 2015 with the LSCB Independent Chair observing and listening to the conversation and recommendation to be better informed in coming to a decision.

During the year 2016/17 **3** cases were considered by the Serious Case Review panel.

One was progressed to a SCR – Child C which will be published in the summer 2017, one was deemed a multi-agency Practice Learning Review. Early lessons arising from these reviews are:

- disguised compliance by families
- ‘hidden father’ not assessed
- Over optimism of practitioners and acceptance of family’s self-reporting.
- Lack of understanding and knowledge of premature babies

A range of multi-agency learning events are set up to disseminate the messages from the reviews using a variety of methods

8. Child Death Overview Panel (CDOP)

The LSCB is responsible for ensuring that a review of each death of a child living in their area is undertaken by a Child Death Overview Panel (CDOP) as set out in Chapter 5 of Working Together 2015.

A CDOP is responsible for collecting and analysing information about each death with a view to identifying:

- any case which may require an SCR
- any matters of concern affecting the safety and welfare of children in the authority
- any wider public health or safety concerns arising from a death or from a pattern of deaths in that area and
- putting in place procedures for ensuring that there is a coordinated response by the authority, their board partners, and other relevant persons to an unexpected death.

The purpose of the CDOP process is to try and reduce the number of preventable child deaths by considering:

- the cause of death
- any modifiable factors that can be identified
- whether the modifiable factors mean the death was preventable
- what recommendations need to be made to agencies, the LSCB, regionally or nationally to prevent future such deaths.

In 2015-16 HM Government, commissioned Alan Wood to undertake a review of Local Safeguarding Children Boards (LSCB)

and Child Death Overview Panels (CDOP). The recommendations for CDOP included:

- Child deaths need to be reviewed over a population size that gives a sufficient number of deaths to be analysed for patterns, themes, and trends of death;
- Responsibility for CDOP should move from Department of Education (DfE) to Department of Health (DH);
- DH should determine how CDOPs can be organised on a regional basis with sub-regional structures to promote learning and dissemination;
- The DH should lead on policy on CDOPs, and consider how they can be supported within the arrangements of the NHS; and
- If the national study recommends the introduction of a national database for CDOPs, the DH should consider expediting its introduction

The Children and Social Work Act has now been finalised and a revised guidance and process is expected to be released during 2017-18. Once changes are ratified and statutory guidance released, CDOP structures will begin to change across all boroughs. Locally, Partners are beginning to have conversations in relation to regional structure changes, however updated legislation is awaited.

During 2016/17 in Barking & Dagenham there were 21 deaths notified and 25 reviewed by the CDOP, some deaths were reviewed more than once. This is an increase of 1 notified death on the previous year.

Expected and Unexpected Deaths

The categorisation of expected child deaths in Barking and Dagenham, continues to follow the same trend as previous years. Unexpected deaths continue to be significantly lower than expected ones, with unexpected deaths being around 50% lower over the last five years.

Financial Year	Expected Deaths	Unexpected Deaths	Percentage difference	Total
2016/2017	14	7	50%	21
2015/2016	16	4	25%	20
2014/2015	15	8	53%	23
2013/2014	17	10	58%	27
2012/2013	15	9	60%	24

Of the 21 new cases notified to CDOP, six (6) Rapid Response meetings were held. All Rapid Response meetings were held within 5 working days of notification, across varying venues. Where possible, meetings were held at the Hospital where the child had

died. This enabled medical staff involved with the care of the child to attend and share information known. The Rapid Response meeting recommended to the Safeguarding Children Board (LSCB) that one case be considered for a Serious Case or Practice Learning Review.

On reviewing the details of this case, the SCR panel agreed that the case did not meet the threshold for a Serious case review or learning review, as detailed within Working Together 2015.

What we know

- The small numbers of child deaths in the Borough make it difficult to identify trends or make comparisons.
- The neonatal age bracket (0-27days) remains the highest proportion of deaths (46%), which mirrors 2015-16 reported figures. Children under the age of 1 year represent 63% of total child deaths reviewed by CDOP over 2016-17.
- Child deaths within the Black African ethnic group continue to be highest cohort recorded. In 2016-17, there were 8 deaths reviewed (33%), four (4) male and four (4) female. This is an increase on 20% recorded in 2015-16, which equated to a total of four (4) cases.
- 75% of children reviewed who were identified as Black African (6), were aged between 0-4 years. 37% (3) cause of deaths were recorded as extreme prematurity as all were delivered between 22-24 weeks.
- Barking and Dagenham CDOP continues to request and record pregnancy and maternity information so factors like late

bookings, birth gestation, birth weight and any high-risk factors can be considered in the review.

What we did

- The LSCB Chair met with the newly appointed Coroner at the start of the financial year, to develop stronger working relationships and further understand the Coroner’s role in relation to child deaths. This meeting enhanced communication and information sharing between CDOP and LSCB and explored enhanced learning which included promotion of learning following Regulation 28’s.
- Whilst undertaking new birth visits, Health Visiting teams were reminded to advise women who exclusively breastfeed, of the importance of Vitamin D supplements. Additional training sessions were held with the Designated Doctor and Nurse, alongside NELFT to disseminate these messages to the workforce.
- Barking and Dagenham CDOP continues to network outside its neighbouring boroughs and links with the National Network CDOPs (NNCDOP), the North-East London CDOP group, and Healthy London Partnership who, in conjunction with NHS England have been charged with reviewing the circumstances and contexts for the death of an infant or child and are contributing to shaping and strengthening services and resources.

Challenges for 2017/18

- The timeliness of notification continues to be monitored. During 2016-17 two notifications were received outside of the 24-hour timeframe. Both were from a Hospital setting, and these were addressed within the Rapid Response meetings held.
- Obtaining timely information from General Practitioners continues to be an issue to the CDOP process. The Panel are working closely with the Named GP to eradicate these issues as information held by GPs are vital to the reviewing process.
- The local Registrar has a responsibility to inform CDOPs of all registered deaths for a person under the age of 18 years at time of death. Whilst these links appear to be robust within other boroughs, this appears to be a weaker link within Barking and Dagenham. The SPOC will continue to liaise with the Registrar to receive timely updates.

9. Allegations Against Professionals

The Local Authority Designated Officer (LADO) is well established, and based within the Safeguarding & Quality Assurance service and provides oversight of allegations against people who work with children as well as advice and guidance to agencies. An annual report is produced and presented to the LSCB.

When an allegation is made against a member of the children's workforce, the safety of the children with whom the professional comes into contact is the priority. Employers, have an additional duty of care towards their staff and therefore the complexities involved in responding to such allegations require balance and careful judgement to ensure risk and support are measured at both levels.

The LADO supports this process through:

- **advice** on thresholds at the stage of notification;
- **mediation** with colleagues in other agencies,
- providing a **proportionate response** to investigations;
- **guidance** on individual risk management including careful consideration of whether suspension of the staff member might be necessary; and
- **support** in the analysis of information and evidence gained as investigations progress, to ensure risks are responded to and appropriately concluded.

Between April 2016 and end March 2017, the LADO recorded **170 allegations** against the children's workforce (including volunteers) in Barking & Dagenham. Whilst this represents a 11% decrease on the previous year (190) the number of contacts for consultation and allegation management support remains high. These contacts mainly relate to staff conduct issues which, on consultation, are designated as below the allegation threshold or unlikely to result in a S47 investigation and are passed back to employers to manage as practice or competence issues. The contacts may also constitute historical matters where staff are no longer working within the children's workforce, or could relate to matters of policy guidance.

The categorisation of a piece of work as a 'consultation' is deceptive and may suggest a lesser input from the LADO. Many consultations require considerable and significant follow-up and analysis by the LADO beyond the initial caller contact.

Working Together 2015 sets out the expectation that 80% of LADO cases should be resolved within one month of referral, 90% within three months, and all but the most exceptional cases, completed within one year.

In Barking & Dagenham 3 cases are outside of these timescales due to the length of police investigations to achieve a timely resolution.

The statistical distribution of allegations in the year indicates that professionals employed in education services including early years, account for 39% of the total LADO referrals (not consultations). Combined, social workers, foster carers, residential workers and youth workers, account for 36%. The remaining 24% are divided by

religious professionals, football coaches and others. It has been noted that there are very low or zero rates of contacts passed to the LADO from or about professionals working in the Health sector. Over the next twelve months work will be conducted to increase awareness within parts of the Health community.

Agency	Number
Education (Schools)	5
Early Years (Nursery)	3
Additional Education Settings	5
Foster Carers	6
Health Professionals	0
Residential Workers	1
Reg. Social Workers	3
Church / Religious Professionals	3
Youth Workers / Organisations	2
Registered Child Minders	0
Football Coaches	3
Others	2
Total	33

Referrals related to concerns regarding persons working or volunteering within additional education facilities, acting as a private tutor or independent sports coach have been identified as a

concern and are not regulated or safely recruited. Nationally, there is no duty on these organisations to adhere to statutory guidance in the safeguarding of children.

There is even less organisational oversight in circumstances where classes are set up in private homes or outbuildings and parents bring in an adult to teach their children.

The lack of statutory guidance in this area creates difficulty holding individuals and organisations to account for the safeguarding and harm of children. There can be no confidence that individuals working or volunteering in this capacity undergo robust safer recruitment checks.

When concerns are raised, there is limited scope for the LADO to exercise powers on behalf of the local authority if there is no independent regulatory body to refer to. The usual referrals to the Disclosure and Barring Service are often ineffective as many of these organisations do not adhere to the requirement for DBS checks before appointment. In the cases referred to the LADO in Barking & Dagenham, it has been reliant on Police to investigate and potentially prosecute to prevent those who are unsuitable to work with children from doing so. This issue will continue to be raised through regional and national forums.

10. Performance Management

The LSCB has a comprehensive performance management framework in place which supports the board in identifying and addressing areas of good performance as well as areas that require attention and challenge. During 2017/18 the LSCB will review and further develop its multi-agency performance management reporting.

The following areas of performance have been key areas of consideration for the LSCB. The provision of performance data from some partners remains a challenge and will be taken forward as a priority action for next year.

Referrals to Children's Social Work Services

The number of referrals received has decreased by 6% during the year (from 3255 to 3050). The rate per 10,000 has fallen from 539 to 505. This is below the statistical neighbour average (700) and the national average (532), but above the London average (491).

The most significant numbers of referrals are received from the Police (816) and from Education (618). 93% of referrals were acknowledged within 24 hours during the year, compared to 80% previously.

The repeat referral rate has reduced from 16.6% to 12.8% during the year.

Statutory Assessments

A total of 2325 assessments were completed during the year, a decrease of 8%. 76.4% of these were completed with required timescales, a slight increase on previous performance but not where we would hope.

Strategy Discussions/Section 47 Investigations

Reflecting significant levels of need and risk in the Borough, the number of Section 47 investigations has continued at a high level. Importantly, this has been looked at more closely as part of two independent reviews - in September 2015 and in October 2016 - and the standard of decision making has been considered as being appropriate.

The number of cases in 2016-17 which were progressed to Section 47 investigations was 1175 out of 1504 strategy discussions, a conversion of 78%. For the previous year this figure was 86%.

The number of Section 47 Investigations being completed remains comparatively high when considered against national and London averages, however this is reducing.

The number of strategy discussions taking place with involvement of other agencies has increased from 121 (8%) to 618 (41%). This area of practice had been shown as needing improvement as strategy discussions are often needed within short timescales. This has been achieved using technology and introduction of telephone conference facilities during the year.

Core Groups

The number of core group meetings held in timescale for children subject to child protection plans has increased to 88% as of the end of 2016-17 compared to 84% a year earlier. This remains a positive story with a sustained improvement when compared to the performance of 2013-14 which was 34%.

Children Subject to a Child Protection Plan

378 cases were considered at initial child protection case conferences during the year at a rate per 10,000 of 63, a higher number than in the previous year. The current rate per 10,000 of 63 compares with rates in 2015-16 period of 74 for statistical neighbours, 54 for London and 63 for the national rate.

At the end of the year 294 children and young people were subject to Child Protection Plans, an increase of 16% from the same point last year. This is notably higher than national and local trends.

The number of children becoming subject to a child protection plan for the second time in 2016-17 was 56 (16.8%). This compares with 24 children (7.7%) in 2015-16.

Although performance has increased over the last year, we remain below the national and statistical neighbour averages which were 17.9% and 17.1% respectively at the year-end of 2015-16.

This year has seen an increase in the percentage of children who were on a child protection plan for two years or more although the total number of children involved – a total of 19 - is relatively low. This equates to 6.5% and compares with 12 children in the 2015-16 period which was 2.9%.

This area of performance is above the target of 5% and higher than the national and statistical neighbour averages for the 2015-16 period which were 3.8% and 4.1% respectively

Child Protection Conferences

There has been good performance in the work to achieve 97% of initial child protection case conferences within the 15-day timescale. This is significantly higher than all comparators (between 75% and 77%).

Child Protection Review Conferences being held in time has remained as a strength at 100%.

Child Protection Visits

This year has seen an increase in the percentage of children who were on a child protection plan for two years or more although the total number of children involved – a total of 19 - is relatively low. This equates to 6.5% and compares with 12 children in the 2015-16 period which was 2.9%. This area of performance is above the target of 5% and higher than the national and statistical neighbour averages for the 2015-16 period which were 3.8% and 4.1% respectively.

86% of children subject to child protection plans were visited and seen within 4 weeks in the period of 2016-17, no change on the 2015/16 performance.

Missing Children

219 children with 584 reports/incidences

A total of 243 return interviews took place. Of these, 92 (37.8%) were held within the recommended 72-hour period following the child's return. 20 interviews were either declined by the child or could not take place because the young person was immediately taken into custody.

Risk of CSE

Police investigate all cases where there is a suspicion or evidence of CSE. Those children and young people identified as at risk of or vulnerable to CSE are supported through several pathways ranging from early help to children's social care. The CSE Police in Borough are responsible for cases at Level 1 (suspicion of) and Level 2 cases including those involving on-line sexual exploitation.

Level 2 cases, where there is evidence of CSE are investigated by the Police Sexual Exploitation Team (SET).

At 31st March 2017, there were 27 children and young people from Barking & Dagenham subject to investigations by Police; 23 were open investigations to the local CSE Team and 4 were actively being investigated by the Police SET.

Police Powers of Protections

At the end of March 2014 136 children had been removed via Police Powers of Protection which accounted for 43% of admissions to care. Work between Children's Social Care and the Police has reduced this figure to 45 children which is 22% for the 2016-17 period.

This reduction is hugely important for reducing the impact of trauma on individual children and continues to receive close attention through regular meetings with Senior Police Officers to review performance and consider individual cases highlighted in the audit of the cases.

Private Fostering

During the period 2016/17, the Fostering Team received **27** private fostering notifications compared to **45** in 2015/16. Of the 27 new notifications, 6 met the criteria for Private Fostering. Of those 6 cases, 5 were closed during the financial year – 3x return to birth family, 1x turned 16 years, and 1x moved out of Borough. One remained open.

11 cases were carried over from 2015/2016 to 2016/2017, of the 11 cases, 8 were closed as 3 young people turned 16 and were no longer within the Private Fostering arrangement; 1 moved out of borough and 1 returned to mother; 2 returned to birth family, and 1 was referred to the Assessment Team due to safeguarding concerns. As at 31/3/17, the Fostering Team held in total 4 active private fostering cases

11. Priorities for 2016/17: Revisited

Priority One: Board members are assured that arrangements are in place to identify and safeguard groups of children who are particularly vulnerable

Reduce the harm from child sexual exploitation

What have we done?

Child sexual exploitation (CSE) is an issue of ever growing significance and is a fast-moving area with new reports, requirements and guidance being published on a regular basis. The LSCB partnership has been working hard to ensure that that our practice, policy, and procedures are updated in line with these.

Reducing the harm from CSE has continued to be a priority area of focus for the LSCB. A CSE Strategic Group has been in place, although the Board has now agreed that there will be direct reporting from the MASE and the Missing groups through to the Performance, Learning & QA group.

There are shared strategic priorities across partnership groups such as the Community Safety Partnership and Health & Wellbeing Board. A report on CSE was submitted for discussion in March to the Councils Children's Select Committee

The CSE Strategy and action plan currently being refreshed for 2017/18, outlines the accountability framework for tackling CSE within Barking & Dagenham.

A CSE Champions Forum take place termly and provides opportunities for training, presentations, and networking. Champions have been identified from partner agencies and from schools in the borough.

Our CSE Champions have developed and confirmed their Mission Statement setting out what they aim to do as individuals and as a collective and this will be published on the BDSCB website

Champions have also developed an Action Plan outlining what they need to achieve their goals. Work on this is ongoing and will be reviewed at Forums throughout the coming year.

We have revised our Pre-MASE Membership and updated the Terms of Reference and Agenda for this meeting to ensure that it appropriately supports the function of the MASE.

Work is underway to revise the Terms of Reference and Agenda for this meeting in line with the recently refreshed London CSE Operating Protocol – due to be published in June 2017. The revised documents will provide a focus on increasing the strategic oversight and value of this meeting.

We have strengthened the strategic and operational links between missing children and children in gangs in recognition of the cross-over of issues and increased vulnerabilities for this cohort of young people.

Following an HMIC inspection of the Metropolitan Police, our borough Police CSE team have been restructured and now form part of a 3 Borough East Basic Command Unit that works across Havering, Redbridge and Barking and Dagenham. The CSE element of this Unit remains located in the borough.

Police investigate all cases where there is a suspicion or evidence of CSE. Those children and young people identified as at risk of or vulnerable to CSE are supported through several pathways ranging from early help to children's social care.

A CSE toolkit was implemented by NELFT to support the identification of CSE and enable an appropriate response by staff. The CSE Services Self-Assessment Framework developed by NELFT was acknowledged by NHSE as a valuable resource to enable services to temperature check that they are ready to respond effectively to CSE.

Missing and CSE

Not all children who go missing are at risk of CSE. Not all children at risk of CSE go missing. But the link between missing and CSE is very clear. 39 of the children reported missing were identified as being at risk of CSE. At the time, all of them had an allocated social worker. Every case was discussed at Pre-MASE and/or MASE meetings.

Going missing is a dangerous activity. There are concerns about the links between children running away and the risks of sexual exploitation, gangs, and radicalisation. A child/young person who

goes missing just once faces the same immediate risks as those faced by a child/young person who regularly goes missing. The LSCB has a Missing Children Strategic Group (MCSG). It is a multi-agency meeting comprising of representatives from the police, Social Care, Education, and Health and meets every eight weeks to review missing children procedures and data.

The CSE Coordinator is a member of the MCSG so that links between children missing and CSE can be explored.

Each quarter, data is provided to the Performance and Quality Assurance Committee on children reported missing within this borough.

Return interviews

When a child returns from being missing, or is found, the police undertake a 'safe and well' check (a type of return interview). The purpose of this is to clarify if the child has been the victim, or perpetrator, of a crime.

The police will try to get the child to explain why they went missing but it is the Local Authority Return Interviews that is the key tool in understanding why a child went missing; what happened to them whilst they were gone and what can be done to stop them going missing again.

A total of 243 return interviews took place. Of these, 92 (37.8%) were held within the recommended 72-hour period following the child's return. 20 interviews were either declined by the child or

could not take place because the young person was immediately taken into custody.

There is no reliable data to compare to previous years. Ensuring that return interviews take place within 72 hours is a performance indicator and the focus is on trying to improve the percentage of interviews taking place within this time.

What difference has it made?

- ✓ The risk management processes in place in relation to CSE are robust. The links between children who go missing and CSE are well understood and acted upon.
- ✓ The Missing Children Group considers data and themes from independent return interviews (IRI). This IRI information is fed back to lead professionals and the police to inform interventions.
- ✓ There are up to date policies and procedures in place for CSE and missing children tested out through case audit.
- ✓ Police continue to take the lead in training for CSE, both to Police personnel and other partners via a series of workshops. We have also commissioned “Advanced” CSE training through the NSPCC as well as training on Harmful Sexual Behaviour (HSB) through Safer London. This training will take place toward the end of 2017.
- ✓ The BDSCB continues to work with Police colleagues to promote “Operation Makesafe” across the partnership and earlier in the year hosted an extremely successful breakfast for local hoteliers and taxi drivers.

- ✓ The police have issued several child abduction notices during the year to suspected perpetrators and have submitted applications for Sexual Harm Prevention Orders against specific offenders

What will we do next?

The local profile will be updated to inform the local picture of the prevalence of CSE to enable resources to be targeted.

There will be a continued clear focus on preventing the risks and causes of CSE through education and prevention both with individuals and communities and through universal provision, early help, and targeted interventions. There continues to be a need to continue to raise awareness of CSE with children and young people so that they are educated and empowered to recognise this form of abuse including within their online world.

CSE is still an area that the LSCB will to focus on to ensure that risk locally continues to be managed effectively. CSE will remain a priority for 2017/18.

Reduce the harm from neglect

What have we done?

Reducing the harm from neglect continues to be a significant safeguarding priority nationally.

The proportion of children and young people the subject of a child protection plan because of neglect and because of emotional harm is increasing.

Neglect and Emotional harm have remained the most prevalent reasons for child protection plans locally over several years and remains the most prevalent form of child maltreatment nationally.

A multi-agency audit of cases to assess the quality of work across the partnership where neglect is a factor was carried out in December 2016. Further audits of children subject to a child protection plan for neglect have also been undertaken and reported to the Performance, Learning & QA group and to the Board.

A 'Home Conditions' tool is used by Early Help staff to assess neglect.

Training has been enhanced for social workers on attachment based approaches to support children and families.

Supporting parenting capacity is critical in reducing the harm from neglect and abuse, promoting healthy attachments between parents and children and providing help for parents who have particular needs of their own which impact on their parenting capacity. These include substance misuse, mental health issues and domestic abuse. Outcomes from these audits also span across to neglect of children so recommendations are also considered as factors to ascertain neglect.

What difference has it made?

- ✓ Learning from case audits has been disseminated through the LSCB, Multi-Agency Audit group and the PLQA group
- ✓ Revised and updated neglect training is part of LSCB training programme for 2016/17 and for 2017/18
- ✓ Training on attachment based approaches to supporting children and families is part of the Children's Care & Support training programme.
- ✓ Early help is proactive in supporting families through a range of approaches.
- ✓ Families whose children are made subject of a child protection plan for neglect make positive progress. Data demonstrates that; there are low numbers of children subject of a child protection plan for 2 years or more, and, there are few children with second/subsequent child protection plans.

What will we do next?

In Barking & Dagenham, neglect and emotional harm have remained the most prevalent reasons for child protection plans. So, understanding its consequences and the potential for prevention and early intervention is important. Evidence from our audits indicates connections to other forms of harm and vulnerability to CSE in children and young people.

There has been limited attention given to the social determinants (such as poverty, inequality, and availability of community based support) that contribute to neglect.

In Barking & Dagenham, a high proportion of the children and young people becoming subject of child protection plans for emotional harm and neglect had domestic abuse in their family background. Further exploration should be undertaken to ascertain links to neglect and identification at an earlier stage.

The Neglect Strategy and Action Plan is being reviewed and updated.

A multi-agency neglect tool and guidance is being reviewed and updated.

Reduce the harm from Domestic Abuse

What have we done?

The Barking and Dagenham Community Safety Partnership (CSP) oversees domestic and sexual violence which is a priority for the CSP and the LSCB.

Domestic and Sexual violence impacts on all service areas across Barking and Dagenham. It accounts for 46.2% of violence with injury offences in the borough (JSNA, 2016) and was a presenting factor for 15.8% of children's social care contacts in 2016/17.

Domestic and sexual violence are significant issues for Barking and Dagenham. The borough has the highest number of reported incidents of domestic violence per 1000 population in London. The available data does not include those victims who do not report to the police and therefore, is only an indicator of the true scale of the problem.

During 2016-17, the Independent Domestic and Sexual Violence Advocates (IDSVA) worked with 697 victims. Of these, the majority were referred via the Police. This trend reflects the profile of MARAC referral data with a high level of Police referrals and low levels of referrals from other key statutory and voluntary agencies. Consequently, in Barking and Dagenham most victims are identified if their case has come to the attention of the criminal justice system and not at an earlier stage of victimisation.

The Multi Agency Risk Assessment Conference (MARAC) meets monthly to conference the highest risk cases in the borough by developing robust multi-agency support plans. During 2016/17, the total number of cases discussed was **348**, which represented a **3.3%** increase compared to **337** cases the previous year. Of these, **28%** were repeat cases which is on par with the 'Safelives' national recommendation of **28-40%** repeats to MARAC.

A significant number of children (**419**) were attached to these cases, which represents a **10%** increase compared to **381** in 2015/16.

57.8% of referrals to MARAC were from police and **25%** from the IDSVA service. Children's Social Care accounted for **2%** with just **7** referrals over 2016/17 to MARAC. Referrals from other statutory and voluntary agencies remain low.

3.9% of cases referred in 2016/17 were for a victim who was 16 or 17 years old. This represents a **35%** increase compared to the previous year. The number of people harming others who are 17 years or younger has increased by **175%** compared to 2015/16

although the numbers in comparison to total cases heard **(3.2%)** are rationally low for a borough with a large population of children and young people.

The number of victims from black or minority ethnic (B&ME) backgrounds reflects the percentage of referrals of victims who are non-white British. We would expect referrals to the MARAC to be representative of the local B&ME population.

SafeLives recommendation for cases with LGBT victims is 5-7% of total cases. In line with the national average, Barking & Dagenham is lower than expected, sitting at 1.1% in 2016-17.

Both the local and national average for cases where the victim has a disability is lower than the expected 16% (or above) which is partly due to barriers in reporting, 3.7% of Barking and Dagenham MARAC cases had a victim who had a disability.

Compared to 2015/16 the total number of MARAC cases heard where the victim was male has not changed. Expected national average for male victims at MARAC is between 5 and 10% based on the current understanding of the different experiences of domestic abuse by gender. Less than 3% of Barking and Dagenham MARAC cases discussed in 2016/17 were male victims.

What difference has it made?

- ✓ The jointly commissioned IDSVA (Independent Domestic and Sexual Violence Advocate) service includes a young person's IDVA and two Child Domestic Abuse Caseworkers. There are

also IDSVA's and caseworkers available who will work with adult victims experiencing differing levels of risk. The IDSVA service has experienced some difficulties in 2016/17 with high turnover of staff and lack of a dedicated resource in the police community safety unit. The formation of a Police tri-borough Basic Command Unit with Havering & Redbridge has also led to fewer referrals. This has been raised through formal channels and is anticipated to be part of the bedding in of new structures and processes. The children's specialist posts have seen low referral rates and would benefit from internal promotion going forwards.

- ✓ The Domestic Violence Treatment Programme, commissioned by children's services, is a 12-week programme for children between 4 and 19 years of age. The programme offers support and help to children to understand their experiences and develops their emotional resilience. The mothers can access a concurrent programme which explores reducing self-blame, helping them understand the impact of domestic abuse upon their children, increasing their own awareness of domestic abuse, a guide to healthy relationships, rebuilding their self-confidence and relationships with their children. Throughout 2016/17 this service included access to psychotherapy and play therapy sessions.
- ✓ The Council commissions a refuge service for women who need to leave their homes because of the violence and abuse they experience. Service users may be referred from Barking and Dagenham but also from across the country.

- ✓ Additionally, there are regionally commissioned services providing support to Barking and Dagenham funded by various commissioners including London Councils. This includes the Ascent consortium – 22 specialist organisation’s accessible from one central hub and able to provide specialist services for victims facing multiple disadvantages such as no recourse to public funds.
- ✓ The IDSVA service has provided training to different agencies and continues to do so. A conference was held in November 2016, targeted at social workers, and sought to raise awareness of Domestic and Sexual Violence and VAWG issues, and increase confidence in responding to disclosures.
- ✓ There is increased visibility by the Independent Domestic Violence Advocate based at Queen’s Hospital who also provides support at King George Hospital.
- ✓ There has been a significant increase in referrals made by NELFT practitioners to MARAC across the 3 boroughs during the year. This evidences the impact of training and the application of the Safe Lives risk assessment tool.

What will we do next?

Areas for development in 2017/18 include the formation of a VAWG sub-group reporting to the Community Safety Partnership. This group will provide strategic oversight of the borough response to Domestic and Sexual Violence and VAWG and will support and steer the MARAC and Domestic Violence Forum.

A MARAC self-assessment is recommended which will inform a MARAC improvement plan.

A mapping exercise of support available, a comprehensive communications plan including the development of a multi-agency training offer are also areas of development.

Priority Two: Board partners will own and share accurate information which informs understanding of safeguarding practice and improvement as a result

What have we done?

Through the S11 audit we have checked that agencies fulfil the requirement to have effective systems, processes, and policies

We have challenged agencies to provide evidence of the work that they are undertaking to improve outcomes overall and in relation to specific areas of business

We have undertaken audits to understand how effectively the whole system is working and to make sure that the child's journey is always the focus.

We have made sure there are strong governance arrangements in place with Children's Trust, Health & Wellbeing Board, and Community Safety Partnership; and that there is evidence of two-way communication and challenge.

The CDOP Annual Report shares learning & performance data, and escalates concerns to the Board

Performance, Learning & Quality Assurance subgroup scrutinise performance data on behalf of the Board

Increased visibility of the LSCB through regular newsletters, updates on the website and use of social media – Facebook & Twitter

In 2016, The Named GP and Designated Nurse started a GP Forum, meeting quarterly, to enable GP leads in Safeguarding to meet, discuss, and work together for the benefit of the whole B&D Primary Care / General Practice community. Work has started looking at ways of improving time limited information sharing between Primary Care and Children's Social Care.

The Named GP has produced supportive documentation / policy templates for all GP practices to help them prepare for their personal CQC inspections. This will assist practices in having all necessary Safeguarding processes and pathways and assuring CQC of robust safeguarding practices.

What difference has it made?

- ✓ A new, interactive tool has been introduced for this year's S11 audit, which has received positive feedback from those who are responsible for completing. There is a good understanding of safeguarding across all agencies
- ✓ In 2016/17, the LSCB continued to have consistent leadership through its Independent Chair and Director of Children's Services. Local political leaders have a clear line of sight of the safeguarding agenda in Barking & Dagenham and the work of the LSCB.

- ✓ The board has clarity about its role and function, which is described in the memorandum of understanding, signed up to by all board members.
- ✓ Partnership working is established at all levels
- ✓ Partners are engaged in the safeguarding agenda and share a clear vision and commitment for safeguarding children
- ✓ Partners demonstrate mature relationships with respectful challenge.
- ✓ The LSCB has strong links with other strategic groups and this ensures that priorities for children are shared and embedded across the strategic partnerships
- ✓ The LSCB has responded quickly and proactively to national changes in safeguarding children in 2016/17. The 'Wood Report: Review of the role and functions of LSCBs' and the response from the government were published in 2016 with the Children & Social Work Act 2017 receiving Royal Assent in 2017. The reports set out changes about the strategic and statutory arrangements for the organisation and delivery of multi-agency arrangements to protect and safeguard children. The new arrangements include greater flexibility regarding local arrangements and that the three key agencies being the local authority, health and the police should determine the multi-agency arrangements for protecting and safeguarding children in their area. The LSCB in Barking & Dagenham have proposed a different structure beginning in the Autumn of 2017 that brings together the Chief Officers and Chairs from all the strategic partnership groups to act as a single 'umbrella'

group by which to lead safeguarding across the borough. It is envisaged that this will reduce crossover and duplication whilst incorporating safeguarding priorities across the partnership. The LSCB structure will be further reviewed in response to the revision of Working Together 2015.

What will we do next?

The LSCB will further strengthen the case audit process to involve all board members

Case audits generate a huge amount of intelligence about effective local practice and areas of development. During 2017/18 we will communicate with practitioners and use these areas of learning to change practice.

Priority Three: The Board will see children and young people as valued partners and consult with them so their views are heard and included in the work of the LSCB

What have we done?

Learning from National Serious Case Reviews indicates that in too many cases the child was not seen enough by professionals involved, or was not asked about their views and feelings; that agencies did not listen to adults who tried to speak on behalf of the child; that parents and carers prevented professionals from seeing and listening to the child and that practitioners often focused on the needs of the parents, overlooking implications for the child.

The LSCB has a Young People's Safety Group as part of its structure. The Young People's Safety Group continues to be a popular forum through which the borough's schools can engage collectively around issues of safeguarding. The existence of the Group allows the LSCB to respond quickly to specific issues, such as theming the September 2016 meeting around Serious Youth Violence.

The dissemination of key messages by schools following each meeting, ensures that the learning goes beyond just those young people that attend the sessions. In addition, the identification of two key questions for the Board following each meeting retains a strong and progressive two-way link between the YPSG and LSCB.

A survey regarding the Young People's Safety Group has recently been conducted with schools. Results indicate that schools largely value the sessions, but would like additional resources to use back in school linked to successive YPSG themes. Most schools share learning back in school (usually through pupil assemblies), which indicates that the issues and learning from the YPSG is having a wider reach than the meetings themselves.

We have listened to the views of children and young people and used these to inform best practice. For the second year, the Young People's Safety Group organised and 'took over' the November Board meeting as part of Young People's Takeover Day. Young People from the BAD Youth Forum, Young Carers and Arc Theatre, used presentations and 'round table' discussions for items they wanted the Board to take forward. This not only provided LSCB members with an insight into current safeguarding issues as experienced by the young people of the borough, but also provided an opportunity to ask questions, discuss these issues directly and plan actions to address the issues raised.

What difference has it made?

The YPSG continues to triangulate LSCB priorities with the needs and wishes of young people and local triggers, such as Serious Youth Violence. The delivery of a Young People's Takeover Day session in November 2016 helped provide some new priorities for the Group, particularly around substance misuse, which is a theme that has not been explored by the YPSG for some time.

Link the work of BDSCB members to the YPSG and provide them with opportunities to consult with young people.

Ensures participation from all schools in the YPSG. Meeting dates and themes for YPSG are planned for the academic year and align with BDSCB priorities

What will we do next?

More detailed analysis is needed of YPSG participants to accurately monitor participation from vulnerable groups and act in response.

Discussions have been held with the Barking College regarding their participation in the YPSG. The College have launched a student forum, which is looking to link with the work of the YPSG and BAD Youth Forum. The College are seeking to send representatives to future YPSG meetings and to potentially host future meetings. YPSG themes may also be explored through their own student voice forum.

Priority Four: Arrangements for Early Help will be embedded across agencies in Barking & Dagenham who work with children, young people, and their families.

The Early Intervention Foundation states that “early intervention involves identifying children and families who may be at risk of running into difficulties and providing timely and effective support”. The terms ‘early intervention’ and ‘early help’ are used interchangeably, and describe a range of services, programmes or interventions to help children and families resolve problems before they become more difficult to reverse or require more interventionist support.

Early Help services in Barking & Dagenham are changing to include the triage of early help through the Multi-Agency Safeguarding Hub (MASH) or Single Points of Entry and multi-agency support. Known as Community Solutions, the changes have been part of deliberate change to provide more efficient and targeted support, transforming the role of services from a ‘fixer of problems’ to a stimulator of family owned change.

The Integrated Working Team currently covers the CAF support across the borough, by supporting practitioners to identify children with additional needs, complete an assessment to identify the areas that would benefit from support and help in deciding what

services to put in place to support the child, young person, or their family.

The team oversees three Multi Agency Panels (MAPs) that receive all the Police MERLINS that have been rated as ‘Green’, referrals that do not meet the threshold for social care, step down assessments from the assessment team and case presentations from staff either in or out of borough with a concern for a child, young person, or family where they would benefit from a targeted intervention. Of the Total Number of referrals to MAP’s – 4404 - 3206 (72.7%) were made up of MERLINS rated ‘Green’. Of these: Number escalated to Social Care: 172 / 5.3%

Number referred to YOT: 106 / 3.3%

Number allocated to a Targeted Service: 963 / 30%

Number allocated to a Universal Service: 830 / 25.8%

Number closed as No Targeted Intervention Required: 1134 / 35.3% (Cases can be closed to MAP as no targeted intervention required either once the MAP chair has undertaken the screening, or after the case has been discussed at a MAP meeting and a task has been undertaken, for example a home visit to clarify the concerns in the referral received or when families decline services).

The team provides multi-agency training on CAF throughout the year through a 1-day course named Integrated Working Through Information Sharing and Assessment (IWISA) and CAF briefings that

are half a day. The Integrated Working Team is represented on the LSCB Multi Agency Audit Group as well as completing single agency audits.

What have we done?

- ✓ Work has been undertaken to clarify thresholds with partners to ensure a more consistent application and to reduce a 'risk averse' practice by some partners reluctant to apply the threshold.
- ✓ The team has moved into the second year of traded services to schools for CAF support. Over forty schools have bought into the traded services for 2016-17, which was the second year of being a Traded Service. The team has continued to support schools in the CAF process, supporting the settings with their processes for recording, identifying children with additional needs and with data for Governors reports and Ofsted visits. The team has undertaken briefings at the schools to ensure they are aware of the process of CAF and highlighting any concerns and areas of good practice. The team also supports schools with their threshold application for referrals to social care and other services.
- ✓ The Multi-Agency Panels worked with the Police and Social Care to agree a Pathway for the 'Green MERLIN's to be passed straight to the Multi-Agency Panels rather than going to MASH, which has greatly reduced the number of contacts needing to be screened at the 'front door'. The process for Green MERLINS to be passed through began in January 2016 and has continued to date. During 2016-17, the team worked closely with Social Care and Police colleagues to ensure the threshold applied was consistent, met with Police staff to advise them of the Multi-Agency Panel processes to ensure they are aware of the Early Help response and continued to escalate MERLINS to social care where a safeguarding concern has been identified.
- ✓ A team member now attends the MARAC and MASE meetings to provide information from a CAF and MAP perspective to assist the multi-agency discussion for families.
- ✓ The Barking and Dagenham Early Intervention Worker works in partnership with BHRUT Safeguarding Team and supports front line staff across the organisation in accessing services for children and families. There is demonstrative evidence that this post holder has worked alongside staff and families as the number of referrals increased during this reporting period.
- ✓ The CAF is now in use within the Midwifery Department, Neonatal Unit, Paediatric Wards, Children Home Care Team, Emergency Department, and Sexual Health in Queens Hospital.
- ✓ Trust Staff are provided with CAF training as part of level 2 and 3 Safeguarding Children training and BHRUT continues to be supported by an Early Intervention Worker.
- ✓ During the reporting period 283 Pre CAFs were completed by front line staff.
- ✓ A Liaison Social Worker and an Early Intervention Worker (EIW) are based within the Safeguarding Children Team at Queen's Hospital, providing advice and support for the

Emergency Departments, Maternity and Paediatric inpatient areas. The EIW supports the completion of Pre CAFs in the clinical areas and in the community, and helps with the facilitation of Pre-CAF training at mandatory update meetings for staff. The Social Worker attends all Psychosocial and Maternity Partnership meetings across sites.

What difference has it made?

The continued support to schools is valued and has ensured that the working relationships between the team and the settings has been maintained.

The team have enabled long term relationships which has been a factor in the success of the Traded Services.

It has allowed a varied focus including new ways of working with schools, for example, concentrating on specific groups of vulnerable children, supporting the schools to design new recording systems and identify training gaps for staff.

The receiving of the Green MERLINS has ensured that the number of contacts to social care has reduced. It has also meant that families that require targeted support are receiving it sooner than they would have previously, as a level of screening has been removed by taking the social care element out of the process.

30% of the MERLINS now result in a targeted service being allocated to the families, whereas previously, it could have been dealt with by a MASH social worker and closed with no onward work undertaken. The team discuss cases where the threshold

needs some discussion through a MASH manager and have an agreed process for escalating cases to MASH.

The team's attendance at MASH and MARAC has provided more Tier 2 information being shared to assist decision making. It has also assisted workers from a Tier 2 perspective being aware of a family being discussed at a MASE or MARAC meeting.

It has also assisted the team's knowledge with screening of MAP cases, as the team now consider referrals to the MARAC meeting or is able to seek advice from a member of staff in that area.

What will we do next?

The schools will continue to be supported through the Traded Services offer and will have the opportunity to personalize the support that is on offer through the service level agreement.

The Green MERLINS will continue to be screened by the team and targeted and universal services will continue to be recommended. Cases will be escalated to MASH as and when required.

The multi-agency involvement and impact will be assessed and reported to the LSCB as the early help work moves into the new service of Community Solutions.

Priority Five: Board partners will challenge practice through focused inquiries or reviews based on performance indicators, practitioner experience and views from children and young people. Collectively we will learn and improve from these reviews.

What have we done?

The LSCB has a Serious Case Review (SCR) Subcommittee and there is a robust scheme of delegation from the LSCB Independent Chair. All SCR decisions have followed the requirements in Working Together 2015.

The SCR committee has considered three referrals during the year:

- 1 did not meet the criteria for a Review
- 1 is being considered as a multi-agency Practice Learning Review
- 1 met the criteria for a Serious Case Review and will be published during the summer 2017

Following the last Serious Case Review – Child B published in 2015, there has been a substantial programme of awareness raising and publication of the lessons learnt to include, staff briefing sessions, presentations at strategic partnerships, staff information included in the LSCB newsletter and incorporated into training.

A multi-agency audit has been undertaken and jointly co-ordinated by a Quality Assurance and Audit officer on behalf of the LSCB and the Named Nurse – Safeguarding Children NELFT. The case was raised using the LSCB Escalation process. All practitioners with involvement in the case met with the two auditors to describe their involvement in the case and the outcomes and learning from the subsequent report was agreed and signed off by the agencies represented at the Performance, Learning & Quality Assurance sub group and disseminated to practitioners through a learning day. Learning points were also included in the LSCB Training plan.

A multi-agency audit on Neglect using the Ofsted JTAI Framework has been carried out and outcomes reported to the BDSCB.

Work on the Ofsted improvement action plan put in place in 2014 has continued to be reviewed to ensure that recommendations and actions completed.

The key elements of practice that remain a focus, include the quality of referrals, assessment work and planning, capturing and being influenced by the voice of the child and ensuring good supervision and management oversight.

The CQC carried out an unannounced inspection in the Barking, Havering, Redbridge University Trust (BHRUT) in September and October 2016, to review progress of the improvements that had been implemented, to apply ratings, and to make recommendations on the status of special measures.

The resultant report identified that the Safeguarding Team had made significant progress in ensuring that it effectively executes its duties and responsibilities by maintaining a focus on the welfare of all children and young people, adults, and services users. The result of this progress meant the Trust has been removed from 'special measures'.

The National Probation Service National Safeguarding Reference Group has produced an Action Plan with many key themes; learning from DHRs, SCRs, audits, inspections, etc. It was instrumental in the Safeguarding Children launch in the last financial year within NPS and it has also promoted an Audit Tool for Assurance Processes.

What difference has it made?

- ✓ Better understanding of the use of all multi-agency meetings and attendance thereby improving communication
- ✓ Highlighted the lack of local knowledge about what is available for families experiencing domestic abuse.
- ✓ Arrangements to distribute invitations, minutes, and update about child protection plans, particularly with Health agencies is better understood
- ✓ Review of communication re safeguarding processes in paediatrics
- ✓ Poor use of CSE risk assessment tool across agencies
- ✓ Multi-agency neglect 'task -to-finish' group set up to consider the requirements of the JTAI across the partnership

What will we do next?

A Meeting Matrix has been compiled setting out what each multi-agency meeting is for and circulated across the partnership, placed on the LSCB website and in procedures

Update of directory listing DV services locally & nationally. Two MARAC workshops held. Review of DV training for frontline staff.

Generic e mail accounts have been set up across the health agencies and a revised document for the setting up of CP Conferences for social work staff

Review and revision of pathway, including documentation and nursing input on ward rounds

CP IRO's will ensure CSE and the risk is included in plans for children and young people. CSE Champions training to include the use of the CSE tool.

The JTAI group will progress actions arising from the Neglect audit and initiate work across adult services, including the SAB to review understanding of staff working with adult substance and alcohol misuse where they are parents to reduce neglect.

The findings from the serious case review for Child B have been disseminated to staff across the service during 2015-16 but this also carried over in to 2016-17 to complete implementation of the actions, which included:

- guidance about practice for pre-birth assessments;
- training on working with fathers; and

- further communication about resources for working with domestic abuse and substance misuse.

12. Direction of Travel

This Annual Report provides evidence of changes in activity, characteristics of the Borough and the needs of children and young people. Collectively, it presents a busy terrain of interlocking factors, challenges, and enablers. Being able to focus on what has, or could have the biggest impact and identifying those which offer both challenge and support improvement is critical for the coming year.

The year 2017-18 will see significant organisational changes which will include:

- supporting the safe transition of management of the Multi-Agency Safeguarding Hub (MASH) across to the new Community Solutions service.
- The Youth Offending Service (YOS) will be managed within Children's Care & Support.
- The Disabled Children's Team will join the Disability Service for all ages.

Another key development to note for 2017/18 is that the Children's Assessment and Care Management services will be aligned to the new locality model for health and social care.

This will enable closer working relationships to develop between, for example, schools, health services and children's services. There will be closer links with the Multi-Agency Partnership (MAP)

arrangements for the localities and this will bring benefits through strengthening working relationships for early help.

Two new initiatives are planned for 2017/18.

Implementation of the '**Pause Practice**' for work with women who have had children removed and to prevent repeat removals into care.

Caring Dads groupwork which aims to support fathers who are a source of safeguarding concerns to focus more on the needs of their children. These initiatives will be reported on in the next Annual Report.

Challenges

- To develop the right culture that is less 'risk averse'
- Improvement in the collation and reporting of data and performance management across all agencies
- Workforce – the recruitment and retention of staff across all agencies is a challenge. Attracting staff with experience and reducing 'churn' as staff move around London due to greater incentives has been a difficulty.
- The level of risk and vulnerability of children is likely to increase because of the social and economic pressures on families.
- Children's needs are becoming increasingly complex
- Improvement in the Metropolitan Police after the HMIC inspection in 2016 and the regional changes to work across a tri-borough in east London.

13. Priorities for 2017-18

1. Board members are assured that arrangements are in place to identify and safeguard groups of children who are particularly vulnerable

- Learn from the feedback from Missing children and Return Interviews.
- The local Problem Profile will be updated to inform the local picture of the prevalence of CSE to enable resources to be targeted.
- The Neglect Strategy and Action Plan and multi-agency tool will be reviewed and updated.
- Review the current structure to ensure it is fit for purpose and meets the requirements of the Children & Social Work Act 2017.
- Whilst there are links with other key strategic boards in Barking & Dagenham there is a need for further development to ensure clarity regarding key responsibilities, identifying areas of joint work, and linking agendas
- Review the LSCB budget and agency contributions against LSCB requirements

- Challenge greater engagement amongst LSCB members in terms of support in leading or chairing groups
- ### 2. Board partners will own and share accurate information which informs understanding of safeguarding practice and improvement as a result
- The performance information for 2016-17 shows some change in the volume of traffic at the front door through reductions in the number of referrals being received and the number of open cases.
 - It is important for the safeguarding partnership to understand the complexity of cases and the increase over the year in the numbers of children subject to child protection plans and becoming looked after. This complexity leads to pressure on caseloads across all agencies.
 - There is limited data available from some partners, so we must review and establish a performance data set and dashboard to develop a partnership understanding of the story behind the data and provide the LSCB with assurance about safeguarding arrangements
 - The LSCB will further strengthen the case audit process to involve all board members and ensure that practice is improved as a result.

3. The Board will see children and young people as valued partners and consult with them so their views are heard and included in the work of the LSCB

- The arrangements to embed the voice of the child into LSCB business and the work of the sub-groups must be more robust and ensure that their voice makes a meaningful difference
- More detailed analysis is needed of YPSG participants to accurately monitor participation from vulnerable groups and act in response.

4. Arrangements for Early Help will be embedded across agencies in Barking & Dagenham who work with children, young people, and their families

- The current trends highlighted in the analysis of data demonstrate the need for continued analysis, understanding and discussion about demand for services in the Borough and how this is managed. Most particularly what further can be done about prevention and early help at a challenging time of demographic change and of reduced resources, including the impact of Community Solutions.
- The multi-agency involvement and impact will be assessed and reported to the LSCB as the early help work moves into the new service of Community Solutions.

5. Board partners will challenge practice through focused reviews or audit based on performance indicators, practitioner experience and views from children and young people. Collectively we will learn and improve from these reviews.

- Re-refresh the multi-agency CSE Operational strategy and action plan and update the CSE Problem Profile
- Put children's needs onto the public health agenda. Develop an understanding of the relationships between public health concerns such as domestic abuse; sexual health; neglect and poverty and the health and wellbeing of children and young people. Identify triggers to support joined-up commissioning and service delivery.
- Assist frontline practitioners and CP IRO's reflect on the causes and broad categories of emotional abuse and neglect - the two main categories used for Child Protection Plans.
- The JTAI group will progress actions arising from the Neglect audit and initiate work across adult services, including the SAB to review understanding of staff working with adult substance and alcohol misuse where they are parents to reduce neglect.

Appendix 1: Finance

Income

Partner Contributions	£
LBBB Children's Care and Support	92,240
LBBB Housing	10,221
Barking, Havering, Redbridge Hospital Trust (BHRUT)	3,716
North East London Foundation Trust (NELFT)	3,716
Barking and Dagenham Clinical Commissioning Group	37,034
Police	5,000
Children & Family Court Advisory and Support	550
National Probation Service (NPS)	1,050
Community Rehabilitation Company (CRC)	1,000
<i>Total Partnership Income</i>	<i>154,527</i>
Schools Forum	50,000
Fire Service	500
Training Income	12,252
<i>Additional Income</i>	<i>62,752</i>
<i>Carried Forward 2015-16</i>	<i>98,048</i>
Total BDSCB Income	315,327

Expenditure

Expenditure	£
BDSCB Chair	21,819
BDSCB Training	11,811
Staffing costs (including on costs)	59,338
Staff expenses	735
Serious Case Review	8,495
Other	2,856
Total BDSCB Expenditure	105,054

Balance

Total Income	315,327
Total Expenditure	105,054
Carry forward 2017-18	210,273