'Safeguarding Children' Factsheet

Tower Hamlets Joint Strategic Needs Assessment

UPDATED
2015

Executive Summary

This factsheet provides an overview of the mechanisms and processes by which the Tower Hamlets Local Safeguarding Children's Board (LSCB) partners meet their statutory obligations for protecting children from maltreatment in Tower Hamlets as set out in Working Together to Safeguard Children (2015). Separate factsheets cover domestic violence, child and adolescent mental illness, mental health and emotional well-being, children with disabilities, sexual exploitation of children, looked after children and child deaths.

- While levels of identified need in Tower Hamlets are high compared to London and England, comparison with other London statistical neighbours suggests that they are within the expected range given the context of high levels of deprivation in Tower Hamlets;
- Tower Hamlets LSCB partners have robust monitoring and audit processes in place to ensure that their responsibilities toward safeguarding and promoting the welfare of children are met. The most recent Ofsted review (2012) rated the effectiveness of safeguarding services in Tower Hamlets as outstanding
- The LSCB has responded fully to the recommendations of the Munro Review of Child Protection by strengthening the functions of the LSCB; providing high level support for developing social work practice through establishing the post of Principal Social Worker; and enhancing the effectiveness of front line practice across children's social care and health through embedding the Signs of Safety approach to work with families
- The 'Family Well Being Model' has been revised to provide clarity about thresholds between different levels of intervention with families. The model sets out how different levels of need are addressed in Tower Hamlets, and ensures that families and children receive a level of help and support commensurate with their needs.
- The Tower Hamlets Clinical Commissioning Group assumed commissioning responsibility across Health for safeguarding children and have ensured that the major health providers Barts Health NHS Trust, East London NHS Foundation Trust, and General Practice are represented at the LSCB
- Neglect and emotional abuse remain the most frequent reasons for children having a child protection plan in Tower Hamlets. A Neglect Strategy has been developed by the LSCB.
- Child Sexual Exploitation has an increasingly high profile nationally and detailed work is taking place locally to improve identification of and response to vulnerable young people

Recommendations

1. Need to consolidate plans to enhance preventive and early intervention services. Transfer of commissioning responsibility for health visiting from NHS England to LBTH from October 2015 will provide an opportunity to strengthen the role of health visitors in the prevention and early intervention agenda.

2. The partnership will need to continue implementing the local Neglect Strategy and associated training programme, given that 30% of children with a child protection plan was for the primary reason of neglect.

3. The partnership will need to continue the work started on Child Sexual Exploitation through implementation of the local strategy and ensuring that children and young people at risk are identified and that agencies are receptive to concerns raised by vulnerable young people and their parents. Recent national reports in Rotherham and Oxford have highlighted the levels of undetected need and this should remain a priority for further local assessment.

4. The Signs of Safety framework should continue to be implemented and supported across all areas of children's social care and health.

5. The partnership may want to consider focusing multiagency training on emotional abuse which is the most frequent reason for children to have a child protection plan (47.9%).

1. What is safeguarding of children?

Safeguarding children is defined as:

- protecting children from maltreatment;
- preventing impairment of children's health or development;
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care;
- taking action to enable all children to have the best possible outcomes.[1]

See Appendix 1 for definitions of different categories of abuse, as defined in "Working Together" (2015).

The United Nations Convention on the Rights of the Child (1989) sets out the civil, political, economic, social, health and cultural rights of children and requires ratifying states to ensure that legislation safeguards those rights.

The Children Act 1989 places duties on local authorities in relation to children in need (section 17) and children in need of protection (section 47). For children in need the local authority has a duty to provide services directly or request other agencies to provide them; other agencies have a duty to respond to this request. A **child is in need** if:

(a) They are unlikely to achieve or maintain a reasonable standard of health or development without the provision of services by a local authority;
(b) Their health or development is likely to be significantly impaired or further impaired, without the provision for them of services.
(c) They are disabled.

A child is defined as **in need of protection** if 'there is reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm'**.**

Harm is defined as ill-treatment (including sexual abuse and non-physical forms of ill-treatment) or the

[1] Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children (2015 HM Government)

impairment of health (physical or mental) or development (physical, intellectual, emotional, social or behavioural).

When a child is referred to children's social care, an assessment is carried out to identify if the child is in need of services, which local authorities have an obligation to provide under section 17 of the Children Act 1989. A referral is defined as a request for services to be provided by children's social care and is in respect of a child who is not currently in need. A referral may result in an initial or continuous assessment of the child's need; the provision of information or advice; referral to another agency; or no further action. Local authorities have the flexibility to carry out a single continuous assessment within 45 working days. If the local authority identifies there is reasonable cause to suspect the child is suffering, or is likely to suffer significant harm, it will carry out an assessment under section 47 of the Children Act 1989 to determine if it needs to take steps to safeguard and promote the welfare of the child. If concerns are substantiated and the child is judged to be at continuing risk of harm then an initial child protection conference is convened within 15 working days and a decision will be made as to whether the child needs to become the subject of a child protection plan.

There is compelling evidence of the harmful effects of child maltreatment, affecting all aspects of the child's health, development and well-being and which can last into adulthood. These can include anxiety, depression, substance misuse and self-destructive behaviors. In adulthood, there may be difficulties in forming or sustaining close relationships, in sustaining work, and future parenting capacity can be affected. The high cost of abuse and neglect both to individuals (and to society) underpins the duty on all agencies to be proactive in safeguarding children.[2]

Potentially all children are at risk, risk is increased under circumstances involving domestic abuse, substance abuse, parental mental illness, disabled children, looked after children and children leaving care.

Children with disabilities are three to four times more likely to be victims of violence: 3.7 times more likely for combined measures of violence, 3.6 times for physical violence and 2.9 times for sexual violence. Children with mental or intellectual disabilities were found to be 4.6 times more likely to be victims of sexual violence than peers without disabilities.[3]

Children who are at high risk but have not been identified as such are at highest risk, which is why processes for identification are a key part of a safeguarding system.

[2] National Service Framework for Children, Young People and Maternity Services (DoH 2004)

[3] Jones L, Bellis MA, Wood S, Hughes K et al. (2012) Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies. The Lancet - 8 September 2012 (Vol. 380, Issue 9845, Pages 899-907) DOI: 10.1016/S0140-6736(12)60692-8. http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)60692-8/fulltext?_eventId=login

2. What is the policy context?

The Munro Review of Child Protection (2011)[4] recommended moving away from what was considered a system as "over-bureaucratised and concerned with compliance to one that keeps a focus on children, checking whether they are being effectively helped, and adapting when problems are identified", from a compliance culture to a learning culture that allows social workers to exert professional judgment supported by skilled supervision. Advocated a move to "risk sensible" rather than risk averse services, with more emphasis on effective evidence based interventions rather than just ongoing assessment and monitoring. It suggested that uncertainty cannot be completely resolved and needs to be worked with to reach a position of safe uncertainty.

Subsequently statutory multi-agency guidance has been replaced by Working Together to Safeguard Children (2015).

The Children and Families Act (2014) introduced changes to the law to give greater protection to vulnerable children and includes a new system to help children with special educational needs and disabilities. The Act provides for the introduction of Education Health and Care plans for children with special educational needs.

A cross party manifesto "The 1001 Critical Days" (2014)advocates a holistic approach to supporting families during pregnancy and the baby's first 18 months of life with an emphasis on providing evidence-based services which promote parent-infant interaction from the start. The first 1001 days are seen as critical for a child's social and emotional development and brain development. There are recommendations for improved perinatal psychological care for mothers and babies; better training in infant mental health and attachment , and for children's centres to focus services on the most vulnerable and hard to reach families.

Child Sexual Exploitation (CSE)

The Jay Report (2014) into Child Sexual Exploitation in Rotherham made a number of recommendations, many of which are applicable in any local authority area, in particular the need to identify victims of CSE who are not yet in touch with services. CSE is the subject of a separate JSNA factsheet.

Female genital mutilation (FGM)

The practice is illegal under the Female Genital Mutilation Act 2003;
Multi-Agency Practice Guidelines: Female Genital Mutilation (2014)
Duty for all professionals to act to safeguard girls at risk[5]; FGM is child abuse and should be dealt with as such. Under section 47 of the Children Act 1989, anyone who has information that a child is potentially or actually at risk of significant harm is required to inform social care or the police. Professionals must always respond by informing social services or the police.

In order to prevent FGM it is important that LSCBs ensure that they have up to date information in respect of individual agency activity and referral data.

1. Mandatory for health professionals to record the presence of FGM in a patient's healthcare record whenever it is identified through the delivery of NHS healthcare.
2. Mandatory for all Acute Trusts to report the number of patients who have FGM in their active patient caseload to the Department of Health every month.

By October 2015, all GP Practices in England will be required to submit information to the Health and

[4] Munro Review of Child Protection: A Child- Centred System – Final Report (2011)
[5] See section 11 of the Children Act 2004 for details of the bodies with a duty to safeguard girls

Social Care Information Centre when they have identified that a patient has FGM through the standard delivery of care, or if she has disclosed this. This is known as the FGM Enhanced Dataset.

Forced marriage
The Anti-social Behaviour, Crime and Policing Act 2014 make it a criminal offence to force someone to marry.
The Right to Choose: Multi-agency statutory guidance for dealing with forced marriage
Multi-agency practice guidelines: Handling cases of Forced Marriage

Spirit possession
Safeguarding Children from Abuse Linked to a Belief in Spirit Possession

Practitioners should apply basic safeguarding principles, including sharing information across agencies, being child-focused at all times and keeping an open mind when talking to parents and carers. They should follow the guidance set out in Working Together in their work with all children and families, ensure they liaise closely with colleagues, and make connections with key people in the community, especially when working with new immigrant communities, so that they can ascertain the different dimensions of a family's cultural beliefs and how this might impact upon child abuse.

3. What are the effective interventions?

There is a growing evidence base for the importance of preventive approaches and early help for families.

The Marmot Strategic Review of Health Inequalities (2010) presented evidence that disadvantage starts before birth and accumulates throughout life, and recommended that:
"action to reduce health inequalities must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes throughout life be broken. That is our ambition for children born in 2010. For this reason, giving every child the best start in life (Policy Objective A) is our highest priority".

The Review advocated tackling social determinants of health at a local level to reduce the impact of inequalities on health outcomes and advocated a joint approach to commissioning of maternity, infant and early years family support services.

Prevention
Researchers in Australia advocate a public health approach to tackling the underlying causal and contributory factors related to child maltreatment. This links prevalence of safeguarding issues with environmental factors such as housing and income. The impact of poverty on nutrition, education, parental mental health and limited social support networks contributes to developmental and behaviour issues for children. There are strong links between prevalence of child maltreatment and low literacy, crime, substance misuse, teenage pregnancy[6] . The influence of poverty is becoming increasingly relevant as a result of the welfare reforms of family incomes and housing. There are benefits of closer working for housing and employment in addition to those services directly in contact with families such as health, education and social care.

Research into factors which enhance resilience indicates that some families cope better with threats and

[6] Scott,D (2006) Towards a public health model of child protection in Australia. Communities, Families and Children Australia July 2006 Vol 1 Number 1

challenges to their well-being than others in similar circumstances. The notion of resilience defines the ability to adapt positively under adverse circumstances and is linked with promoting better outcomes for children.[7] This approach focuses on prevention through supporting and building family resilience which includes helping to maintain strong emotional connections between family members, providing social support, and supporting with use of effective coping strategies and parenting styles.

Attachment is a significant bio-behavioural feedback mechanism that evolves during the first and second years of life in response to early appropriate parenting, and plays a key role in the development of emotional regulation both during the early years and across the life span. Only two-thirds of young children are securely attached to at least one caregiver, and around 80% of children who are abused have a 'disorganised' attachment.[8]

Early intervention

Graham Allen's review Early Intervention: Smart Investment, Massive savings (2011) advocated "the benefits of intervening early in children's lives, before problems develop" using evidence-based approaches. The first three years of a child's life are when they achieve their most rapid development and when early intervention can embed essential social and emotional skills. This is a key age for developing parent child attachment which can help to reduce problems in late life.

The Clare Tickell review The early years: foundation for life, health and learning (2011) recommended that early years practitioners should have the necessary knowledge and expertise to identify children where there are safeguarding concerns and to take appropriate actions as early as possible.

The Munro Review of Child Protection[9] recommended that an "early help offer" is made available to children and families where their needs do not meet the eligibility criteria for children's social care services.

A recent report by the NSPCC[10] highlighted the importance of early detection of perinatal mental health problems by universal services as well as specialist provision. Data shows that perinatal mental illnesses affect at least 10% of women and, if untreated, can have a significant impact on them and their families. Children of mothers who are suffering from mental health problems are likely to experience behavioural, social or learning difficulties and fail to fulfil their potential.

4. What is the local picture?

Children and young people under the age of 20 years make up 24.3% of the population of Tower Hamlets. 89.4% of school children are from a minority ethnic group. The level of child poverty is worse than the England average with 37.9% of children aged under 16 years living in poverty. The rate of family homelessness is worse than the England average. [11] The introduction of national Welfare Reforms (including housing benefit cap) has led to an increase in evictions and homelessness with more families being moved outside the borough and their children continuing to attend schools in Tower Hamlets. There is a wide variation in household income and growing income inequalities within the Borough.

The Department of Education collates information from local authorities on the numbers of children referred to and assessed by children's social services each year. The most recent data is from 2013/14 and the headlines are

[7] Mackay,R. (2003) Family Resilience and good child outcomes: an overview of the research literature. Social Policy Journal of New Zealand Issue 20

[8] Carlson V, Cicchetti D, Barnett D, Braunwald K. Disorganised/disoriented attachment relationships in maltreated infants. Developmental Psychology. 1989; 25:25-31.

[9] Munro Review of Child Protection: A Child- Centred System – Final Report (2011)

[10] NSPCC (2014) Prevention in mind: All Babies Count – Spotlight on Perinatal Mental health

[11] Public Health England (March 2014) Child Health Profile Tower Hamlets

set out in table 1 below.

Table 1: Characteristics of children in need in England, London and Tower Hamlets 2013 to 2014[12]

2013/14	Child in Need rate per 10,000 children throughout 2013-14	Rate of children in need at 31 March 2014 per 10,000 children	Rate/10,000 of becoming subject of child protection plan during 2013-14	Subject to Protection Plans rate at 31/03/2014 per 10,000 children	Looked After Children, number (rate/10,000 under 18) at 31/03/2014
England	680.5/10,000	346.4/10,000	52.1/10,000	42.1/10,000	60/10,000
London	688/10,000	367.8/10,000	43.2/10,000	37.4/10,000	54/10,000
Tower Hamlets	785.8/10,000 (4,640 children)	430.9/10,000 (2,544 children)	52/10,000 (307 children)	55.6/10,000 (328 children)	55/10,000 (325 children)

The number of children identified as being in need in Tower Hamlets (at year end) increased from 2,231 in 2012/13 to 2,544 in 2013/14[13] with the rate increasing from 395.9 per 10,000 children to 430.9/10,000 children.

Comparing the number of children in need to the population helps to determine if the change is caused by an increase in the population; the rise in rate here reflects this is not a population driven increase.

Over the same period rates fell across London (from 368.4/10,000 to 367.8/10,000) and rose across England from 332.2 per 10,000 to 346.4 per 10,000.

The rate per 10,000 of children subject to a protection plan fell between 2012/13 and 2013/14 in Tower Hamlets (from 58.2 to 55.6/10,000), although absolute numbers remained the same over that period. Rates in London similarly fell, against a national increase in England as a whole from 35.5 to 42.1/10,000 children.

Data on age and ethnicity are not provided at the local authority level for children in need in the annual Department of Education statistical releases.

The largest category of need for children in need in Tower Hamlets as of 31st March 2014 was abuse/neglect (41%) followed by family dysfunction (8.6%) with 28% 'not stated' cp. 7.3% for London. A similar breakdown applied to London.

The categories of abuse for children who were the subject of a child protection plan in 2014 were emotional abuse (47.9%) followed by neglect (30.6%), physical abuse (16%), sexual abuse (2.9%) and multiple forms of abuse (2.6%). Across London the categories were neglect (38.7%), emotional abuse (38%), physical abuse (11.8%), sexual abuse 3.3%) and multiple (8.1%).

See Appendix 2 for the full data set supporting this section.

Local information on referrals using the Common Assessment Framework (CAF) (Appendix 3) shows a 22% increase in CAF referrals in the 3 year period from 2011 to 2014. CAFs from education related services accounted for 66% of CAF referrals in 13/14; and CAFs from children's centres and early years accounted for 22%. Only 4.28% came from community health services. It may be useful to explore whether this indicates a problem in health with using the CAF system or whether referrals are still being made but by using a different mechanism.

[12] https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2013-to-2014
[13] https://www.gov.uk/government/statistics/characteristics-of-children-in-need-in-england-2012-to-2013

The experimental Female Genital Mutilation Prevalence Dataset is an aggregated return of data from acute hospital providers of the incidence of FGM including women who have been previously identified and are currently being treated (for FGM related or non FGM related conditions) and newly identified women within the reporting period. This has been collected from 1 September 2014 to March 2015.

Barts Health NHS Trust identified 29 newly identified cases of FGM over this period and an active caseload of 284 patients who had undergone FGM.

5. What is being done locally to address this issue?

Tower Hamlets Children's Social Care participated in an **Ofsted Thematic Inspection of child neglect** across a number of authorities which reported in 2014.[14] The report found that at the national level children were often left in situations of neglect for too long; parents were failing to engage; assessments were inadequate; there was poor planning; lack of professional challenge; and a limited appreciation among professionals of the cumulative impact of neglect on a child's well-being and development. The report recommended a strategic approach to neglect.

A three- year (2014-2017) **Tower Hamlets Improvement Plan** has been developed which aims to increase awareness and understanding of neglect, improve recognition of neglect, improve the quality of planning and assessment and timeliness of intervention and increase the resilience and engagement of families thereby improving outcomes for children.

A **Neglect Strategy** has been developed by the Tower Hamlets LSCB (Local Safeguarding Children Board).[15]

Tower Hamlets has introduced a **single assessment framework** for recording social work assessment of children and their families, in line with recommendations from Working Together 2015. This replaced the previous initial and core assessments.

The **Tower Hamlets Family Wellbeing Model** has been revised (in line with recommendations for Working Together 2013) to clarify thresholds for intervention and provide information about early help services, and promote the use of "Signs of Safety" as a practice tool across social care and community health staff.

The **Signs of Safety approach** continues to be implemented jointly across children's social services and health since it was introduced in 2012. Signs of Safety is a strengths-based and safety-focused approach to child protection developed in the 1990s in Western Australia. It incorporates the views of parents and children as well as professionals to identify together the dangers and strengths within a family environment and how to ensure safety for the child. It helps professionals to be clear about the interventions that would be helpful for a family in order to protect the child.

A local **Child Sexual Exploitation (CSE) operational practitioner group** has been established which has developed a draft Tower Hamlets CSE Strategy. A Multi Agency Sexual Exploitation (MASE) Group was established in February 2014.

The **Multi-Agency Safeguarding Hub (MASH)** was established in 2013 developed from the integrated pathways and support team. This co-locates representatives from police public protection, probation, children's social care youth offending, health visiting, and the domestic violence team to provide more effective and informed decision making at the first point of contact with a family.

[14] Ofsted (March 2014) "In the Child's Time: Professional Responses to Neglect"
[15] Tower Hamlets Safeguarding Children Board (August 2014) Annual Report 2013-2014

Tower Hamlets Local Authority and Royal London Hospital urgent care settings have become early implementers of a new **Child Protection Information Sharing System** – a Department of Health/NHS England led project developed to enable details of children who are subject to a Child Protection plan or in care to be shared by local authorities with health organisations via the NHS spine.

A number of specific programmes are operating in Tower Hamlets which focus on prevention and early intervention.

Early Intervention

The **Troubled Families Programme**, established nationally following the London riots in 2010, and focused on increasing school attendance, reducing youth crime and increasing employment, is entering Phase 2 and will focus more on early intervention.

The **Family Nurse Partnership** is a public health programme targeted at vulnerable young first-time mothers and their babies. It offers intensive and structured home visiting, delivered by specially trained nurses, from early pregnancy until age two. The programme aims to improve pregnancy outcomes; improve child health, development and future school readiness and achievement and improve parents' economic self-sufficiency. The programme is underpinned by a robust evidence base and has the potential to change the life chances of some of the most vulnerable parents and babies, with long-term positive impacts on health, social and educational outcomes. Evidence shows that this programme is effective in preventing child maltreatment, child physical abuse and neglect . The programme in the UK is currently being evaluated. NHS Tower Hamlets in partnership with LBTH was one of the first 10 sites in England to take part in the randomized control trial to test this new way of working.

A **perinatal mental health service** is provided by the East London NHS Foundation Trust. This team works closely with the local Gateway team of midwives to support vulnerable women with identified mental health needs during pregnancy and for a year afterwards. They provide support with parent-child attachment, parenting as well as managing the mental health condition.

Prevention

Commissioning responsibility for early years public health services will be transferring to the Council from NHS England on the 1st October 2015. The transfer of public health commissioning responsibilities for 0-5 year olds (**Health Visiting and Family Nurse Partnership services**) marks the final part of the overall transfer of public health responsibilities to the Council and will allow for the alignment of early years public health services with children and young people services (0-19) including the **School Health services**, commissioning responsibility for which passed to the Council in 2013. There has been significant national investment in increasing the number of health visitor posts through the national "Call to Action" strategy[16]. In Tower Hamlets this will mean an increase in the number of funded posts. In addition, the Family Nurse Partnership programme has been expanded with funding of two additional family nurses.

Health visiting and school health services play an important role in providing a clear understanding of the needs and views of children and taking a child-centred approach to providing early help from the foundation years to the teenage years.

A **locality parent and infant well-being pilot programme** has recently been initiated by Public Health. This aims to support mothers' emotional wellbeing during the perinatal period and helping to establish secure emotional attachment/attunement with the baby and provide sensitive early caregiving.

[16] Department of Health (2011) Health Visiting Implementation Plan 2011-15. A Call to Action

Tower Hamlets is one of 19 sites in England currently piloting the **NSPCC Coping with Crying Programme** to help parents cope with crying babies and reduce the incidence of non-accidental head injuries in babies under one year age. Persistent infant crying is associated with parental stress and depression. National evaluation to be concluded by the NSPCC later in 2015.

6. What evidence is there that we are making a difference?

The most recent Ofsted Inspection (2012)[17] of safeguarding and looked after children services in Tower Hamlets reported that "the effectiveness of services to ensure that children and young people are safe and feel safe is outstanding "[18]. The report recommended more consistent use of "step down" processes when interventions are transferred from Children's Social Services (CSC) to universal services so that appropriate non-statutory support is provided for families and that support continues to be provided when CSC have ceased their involvement. It also recommended more effective engagement of GPs in safeguarding children. The report suggested improving capacity for lower level support to young people with emotional and mental health needs and reviewing how the wishes and feelings of children who enter the child protection system can be considered at case conferences.

A national Safeguarding performance framework (Department for Education, 2015) has been introduced and social care is beginning to report on a new set of measures.

A monthly performance report is provided for the LSCB based on data provided to Children Childrens Social Care Management Team in order to support the identification of areas for improvement.
The data in the report covers the following areas:

1. Performance Indicators - a summary of key national and local performance indicator, compared to previous years and benchmarked to other areas where possible;
2. Activity - Monthly and rolling year view of contacts, referrals and assessments and child protection activity;
3. Profile of Children – Looked After Children, Children in Need & Child Protection Plans profiles for Tower Hamlets

Safeguarding data can be difficult to interpret. For example, a reduction in referrals to children's social care (CSC) could mean that that universal services are being more effective in identifying children with additional needs and referring to other appropriate support services which avoid referral to social care, or that eligibility criteria for referral to social care have become harder to reach, or that the local demography is changing with fewer children in need.

Impact on indicators

Public Health Outcomes Framework

1 .03	Pupil absence
1.11	Domestic Abuse
1.12i	Violent crime (including sexual violence) - hospital admissions for violence
1.12ii	Violent crime (including sexual violence) - violence offences per 1,000 population
1.12iii	Violent crime (including sexual violence) - Rate of sexual offences per 1,000 population
2.04	Under 18 conceptions: conceptions in those aged under 16;
2.07i	Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years);
2.07i	Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years);
2.07ii	Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24);
2.08	Emotional well-being of looked after children

[17] "Inspection of safeguarding and looked after children services. London Borough of Tower Hamlets (July 2012 Care Quality Commission and Ofsted)

[18] "Inspection of safeguarding and looked after children services. London Borough of Tower Hamlets (July 2012 Care Quality Commission and Ofsted) paragraph 9

4.01 Infant mortality

NHS Outcomes Framework
Domain 5.
Treating and caring for people in a safe environment and protecting them from avoidable harm
Overarching indicators
5a Patient safety incidents reported
5b Safety incidents involving severe harm or death
5c Hospital deaths attributable to problems in care

Improvement areas:
Improving the safety of maternity services
5.5 Admission of full-term babies to neonatal care
Delivering safe care to children in acute settings
5.6 Incidence of harm to children due to 'failure to monitor'

4. What is the perspective of the public?

Taking the wishes and opinions of children and families into account when designing services is one of the key recommendations of the Munro Review of Child Protection.

Inspectors from Ofsted and the Care Quality Commission (2012) found evidence in Tower Hamlets that wishes and feelings of children and young people were routinely asked for and there was evidence of ensuring that needs of families from minority ethnic communities were fully taken account of. The increasingly widespread use of the Signs of Safety approach and family group conferencing is enabling children and young people and their carers/parents to contribute more actively to risk assessment and identifying the strengths within families.

The London Borough of Tower Hamlets has adopted the three key principles of UNICEF UK's Child Rights based approach in the design and delivery of services in the borough. Three core principles are at the heart of service delivery - participation, transparency and accountability and taking a holistic, child-centered approach.

It would be useful to gather more structured feedback from service users, for example:
- Reviewing and consulting with young people and families with regard to the impact upon them of going through the child protection process;
- Evaluating participation by key stakeholders attending case conferences.

5. What more do we need to know?

1. Feedback from children, young people and families about participation in the safeguarding process.
2. Evidence of early intervention by front line practitioners and its effectiveness.
3. Whether the relatively small number of CAF referrals from community health services is a problem.

6. What are the priorities for improvement?

1. Continue to implement the neglect strategy
2. Further develop the child sexual exploitation strategy; and continue to raise awareness of child sexual exploitation
3. Embed the signs of safety approach across children's social care and community health services
4. Finalise the full set of LSCB data incorporating information and analysis from partner agencies, including relevant accurate data from acute and community health services

5. Consider whether more can be done to reduce incidence of emotional abuse, the most common category under which children are subject to child protection plans
6. Consider development of quality measures in relation to protection of children with disabilities
7. Continue to monitor "step down" arrangements from social care involvement with families to universal services with early years support
8. Reprocure TH Health Visiting and Family Nurse Partnership Service following transfer of commissioning in October 2015 to public health; ensuring that they are well placed to provide effective early years support

7. Contacts / Stakeholder Involvement

Contacts

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Tony Stanley, Principal Child and Family Social Worker, London Borough of Tower Hamlets

APPENDIX 1 CATEGORIES OF ABUSE

Definitions from Working Together 2013[19]

Physical abuse:

A form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocation or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

Emotional abuse:

The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or values only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or "making fun" of what they say or how they communicate It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber-bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Sexual abuse:

Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children

Neglect:

The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- protect a child from physical and emotional harm or danger;
- ensure adequate supervision (including the use of adequate care-givers); or
- ensure access to appropriate medical care or treatment

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

[19] Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children (March 2013 HM Government)

Appendix 2

Table 1: Children in need, referrals received and initial assessments 2010/11 to 2013/14[20]

		Children in Need		Referrals		Initial assessments				
		Number (at 31st March)	Rate/10,000	Number	Rate/10,000	Number	Rate/10,000	% of total referrals	Referrals assessed as not in need	% Duration of initial assessment 21 days+
2013/14	England	397,600	346.4	657,800	573.0	308,500	No data	No data	19%	15%
	London	69,100	368.0	88,200	469.6	24,780	No data	No data	14.3%	8.8%
	Tower Hamlets	2,544	430.9	2,549	431.7	No data	No data	No data	0	.
2012/13	England	378,600	332.2	593,500	520.7	441,500	387.4	74.4%	19%	8.3%
	London	67,800	368.4	84,400	458.5	62,300	338.6	73.8%	13.3%	7.3%
	Tower Hamlets	2,231	395.9	2,325	412.6	1,431	253.9	61.5%	0	x
2011/12	England	369,400	325.7	605,100	533.5	451,500	398.1	74.6%	19.1%	7.4%
	London	65,700	361.8	84,300	463.9	64,900	357.4	77.0%	17.5%	10%
	Tower Hamlets	2,394	432.2	1,927	347.9	1,177	212.5	61.1%	0	31.4%
2010/11	England	382,400	346.2	615,000	556.8	439,800	398.2	71.5%	.	.
	London	71,100	419.6	89,200	525.9	65,000	383.2	72.9%	.	.
	Tower Hamlets	2,623	508.3	2,343	454.1	1,411	273.5	60.2%	.	.

. Not applicable
X Numbers less than 5, data suppressed.

[20] https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2013-to-2014

Table 2: Core assessments and children subject to protection plans 31 March 2010-11 to 2013-14[21]

		Core assessments		Subject to protection plans			
		Number	Number/ 10,000 (<18)	Number (at 31st March)	Rate/ 10,000	Number subject to protection plan for >2 years	% subject to protection plan for >2 years
2013/14	England	170,640	No data	48,300	42.1	1,230	2.6%
	London	17,300	No data	7,000	37.4	250	3.6%
	TH	No data	No data	328	55.6	25	7.6%
2012/13	England	232,720	204.2	43,100	37.9	1,400	3.2%
	London	41,580	226.0	6,400	34.8	290	4.4%
	TH	2,166	384.4	328	58.2	14	4.3%
2011/12	England	220,670	194.6	42,900	37.8	1,550	3.6%
	London	36,650	201.8	6,500	35.7	360	.
	TH	1,455	262.7	276	49.8	13	4.7%
2010/11	England	185,400	.	42,700	38.7	2,700	6.0%
	London	34,600	.	6,500	38.6	500	7.7%
	TH	1,631	.	288	55.8	27	10.4%

. Not applicable

[21] https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2013-to-2014

Table 3: Common Assessment Framework referral data (2011 to 2014)

CAFs referring agency	Apr 13-Mar 14		Apr 12-Mar 13		Apr 11-Mar 12	
	Number	%	Number	%	Number	%
Attendance and Welfare Service	165	18.60	196	22.43	114	15.66
CAMHS	0	0.00	0	0.00	0	0.00
Children's Centres	195	21.98	149	17.05	134	18.41
Early years	2	0.23	1	0.11	2	0.27
External Agencies	0	0.00	1	0.11		0.00
Helpdesk	0	0.00	0	0.00	1	0.14
Housing	0	0.00	1	0.11	7	0.96
Others	4	0.45	1	0.11	0	0.00
Police	0	0.00	0	0.00	4	0.55
PRU	52	5.86	3	0.34	4	0.55
Schools	286	32.24	266	30.43	222	30.49
SCYPE	3	0.34	5	0.57	11	1.51
Social Care	5	0.56	3	0.34	27	3.71
Support for Learning Service	41	4.62	53	6.06	111	15.25
TH Community Health Services	38	4.28	63	7.21	4	0.55
Transition Support	47	5.30	90	10.30	1	0.14
Youth and Community Services	49	5.52	42	4.81	86	11.81
Total	887	100.00	874	100.00	728	100.00

Source:
LBTH CSC MI Report