

Enfield Safeguarding
Children Board

Annual Report

2013-14



www.enfieldscb.org

Enfield

Safeguarding
Children Board

...because safeguarding children
is everybody's business





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Foreword from the Chair

As I write this introduction in the summer of 2014, child abuse headlines and court cases are constantly in the national news. There have been a series of announcements about government led enquiries to look at so called 'historical child abuse' and various other reports are still in the pipeline. The message seems a clear one, all involved need to 'up our game', a phrase heard and used over and over again in recent weeks.

What does this mean to those of us involved in Child Protection, many staff across the partnerships might well say 'don't we work hard enough already'.

Without doubt staff (police officers, health visitors, GP's, teachers, probation officers, social workers, nurses, ambulance staff, voluntary groups and others) do try to give their best yet we are beset with national headlines such as 'Child Protection System in disarray', calls for a clean sweep of current methods and a 'start again' approach. Social Workers and in particular the quality of social work training courses have been negatively portrayed. Other national headlines describe insufficient mental health resources for children, inadequate safeguarding systems across schools and academies. GPs who report ever increasing caseloads within already existing time pressures, Accident & Emergency Departments with queues of ambulances outside? What are we to make of this by and large negative attention and how does the Enfield Safeguarding Children Board (ESCB) respond?

During 2013-14 the ESCB has continued to meet on a regular basis. We identified the main areas of concern in our Business Plan and made sure we focused on these. We have introduced a slimmed down Board and reduced some of the former bureaucracy. The ESCB has contributed to Serious Case Reviews in neighbouring Boroughs.

The ESCB is clearly an active partnership, but the 'million dollar question' remains 'are we doing enough together to prevent harm to children within the Borough, and when harm is identified, do we make the required changes. Do we as a Board know exactly what impact the ESCB has?

Reviewing 2013-14 I am pleased the Board has helpful dialogue with the Clinical Commissioning Group, the Safer and Stronger Communities Board, and the Health and Wellbeing Board. Of course we all share a common aim, protecting and preventing harm to children. We are getting better at direct communication with young people via the Young People's Board and other forums.

We are making progress in tackling issues such as sexual exploitation of children and young people and female genital mutilation across the Borough and also importantly creating much needed networks with local community groups. We have kept abreast with the various changes in the NHS, Metropolitan Police and London Probation Trust. Public Health colleagues are fully engaged with our agenda and are making significant contributions.

'I would like to thank all staff for their continued focus and energy on reducing harm to the children and young people in Enfield. There is evidence of skilled, able and effective work going on a daily basis...'

This Annual Report is mainly about progress made, though I am also aware of where and what we need to do better. This includes safeguarding across all educational establishments, a better focus on joint work with the Adult Board, and a relentless need to keep improving frontline practice.

I would like to thank all staff for their continued focus and energy on reducing harm to the children and young people in Enfield. There is evidence of skilled, able and effective work going on on a daily basis, I continue to see this on my regular visits. However those national messages do need reflecting on, there is no room for complacency and all of us involved across the child protection landscape must review and refresh our practice. We are being encouraged to innovate and consider new ways of working which will be an ongoing challenge in the year ahead.

Geraldine Gavin
Independent Chair
ESCB July 2014

'...there is no room for complacency and all of us involved across the child protection landscape must review and refresh our practice. We are being encouraged to innovate and consider new ways of working which will be an ongoing challenge in the year ahead.'



Introduction from the Author

In my second year as Business Manager the ESCB has continued to change and develop. The Board has been ‘refreshed’ with a greater focus on outcomes, a slimmer structure and new processes and procedures aimed at encouraging greater discussion and debate to influence and where necessary change or modify multi-agency practice. All this is taking place in an environment of changes in many of our partner agencies and a backdrop of LSCBs for the first time being subject to inspections by OFSTED in their own right.

These changes to the ESCB have been made in line with new guidance from Working Together to Safeguard Children 2013 in which the emphasis is on the difference the Board is making to children, young people and their families. These changes have already started to make a difference since the new Board structure was implemented in January 2014 by encouraging agencies to challenge one another and implement changes necessary to improve safeguarding in Enfield.

All Board members have a shared commitment to improvement and this report outlines the key areas of work the Board has undertaken in 2013-14. The Board however also recognises that challenges remain and this will be taken forward to the new Business Plan 2014-2016.

This annual report therefore aims to answer the question – ‘What difference has the ESCB made to the children, young people and their families?’

Alison Cutler
ESCB Manager

‘The Board has been ‘refreshed’ with a greater focus on outcomes, a slimmer structure and new processes and procedures aimed at encouraging greater discussion and debate to influence and where necessary change or modify multi-agency practice.

‘All Board members have a shared commitment to improvement...’



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Executive summary

This report represents an update on the work of the Enfield Safeguarding Children Board for 2013-14 as required under the terms of Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children. (HM Government 2013). The report provides a summary of Board activities and its effectiveness in assessing and challenging safeguarding practice across partner agencies. This includes a focus on the challenges that the Board has faced, what it has done to tackle these and what further needs to be done.

The Board has a number of sub groups all of which are well supported by partner agencies. These sub groups are the key mechanism for challenging practice and any gaps or weaknesses in service provision. It is also via these groups that the operational aspects of the Business Plan are implemented.

The Board has undergone a transformation and change in 2013-14, with more streamlined structures and processes in place. This report considers the impact of these changes on safeguarding practice.

This report also shows that the Board is carrying out its statutory duties and that there is evidence of greater challenge and change to tackle issues.

Key highlights

- Board restructure leading to greater challenge and tackling of issues This has included involvement of hospitals in referring cases of FGM, use of the early help form to pass cases to the Single Point of Entry and the role of the voluntary sector in the provision of Early Help
- Completion of key areas of work of the sub groups and thus achievement of the Business Plan
- Development of a learning and improvement framework to support the Board’s drive towards continued improvement across safeguarding practice – this has a greater focus on showing how the Board has made a difference to children, young people and their families
- An updated and redesigned website and community handbook making safeguarding information accessible to all

- Section 11 audits with a focus on challenging practice via panel discussions
- Flexible and responsive Board able to meet the needs of a changing environment including a refocus of work on for example Child Sexual Exploitation
- Positive impact of the Single Point of Entry to deal with multi-agency referrals and thus implement changes to support families at an early stage
- Launch of Young People’s Board to further include the views of young people in service planning and in ensuring that the work of the ESCB accurately reflects safeguarding concerns of children and young people
- Greater cross Board and cross Borough working including a joint Serious Case Review with Haringey, and contributing to Serious Case Reviews and Domestic Homicide reviews in Brent and Hertfordshire.

Areas for further development in 2014-15

- Ensure that the ESCB dataset is more closely linked to the business plan outcomes so that the Board can better measure the difference it is making and identify any areas that need improvement or further support
- Implement future SCR’s or learning reviews via a systems approach as set out in Working Together 2013 – this will ensure learning is embedded and incorporates the views of practitioners in order to make necessary changes to practice
- Continue to encourage the voice of the young people, children and their families in all reviews and via the work of the Young People’s Board
- The focus on learning and improvement will be developed further in 2014-2016 as part of the next two year Business Plan. The ESCBs learning and improvement framework (Appendix 1) sets out how the Board will achieve improvement. This includes effective use of data, training, continued close partnership working and challenge and implementation of the use of audits and reviews in which the voice of practitioners, children, young people and their families is more clearly heard.

Statutory framework

The Board exists as a statutory body and has a range of roles including developing policies and procedures and scrutinising and challenging local safeguarding practice.

Each Board partner retains their own existing line of accountability for safeguarding. (Working Together to Safeguard Children, 2013). Our Board members include representatives from:

- Police
- Health
- Probation
- Voluntary Sector
- Education
- Social care
- Community Safety

We also work with other partners such as Adult Services, Fire Service, Higher Education, Fire and Rescue Service, Housing and Leisure.

The role therefore of the Board is to have an independent coordinating and challenge role around safeguarding practice across its partner agencies. Within Enfield this is carried out via each of the sub groups. These are:

- Child Death Overview Panel (statutory)
- Serious Case Review Panel (statutory)
- Learning and Development
- Trafficking, Sexual Exploitation and Missing Children
- Quality Assurance and Performance
- Female Genital Mutilation – multi-agency task and finish group

In addition, OFSTED now also inspect Safeguarding Boards. The emphasis on the inspection is on the difference LSCBs can make to multi-agency safeguarding practice and thus the impact on children, young people and their families. The ESCB has implemented a leaning and improvement framework which sets out all the ways in which the Board continues to monitor its activities and ensure that it is making a difference to frontline practice across all agencies.

Section 14 of the Children Act 2004 sets out the objectives for the LSCB as:

To coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area and;

To ensure the effectiveness of what is done by each such person or body for these purposes.



The local context

The Safeguarding Board takes into consideration its local context when deciding on priorities for its areas of work and setting the Business plan and work of the sub groups. Key factors for the Safeguarding Board to consider are:

■ **Child poverty**

In Enfield, there are approximately 80,000 children and young people under 18 i.e. 25% of the total population and 32.5% of children live in poverty. Enfield has been ranked 64th most deprived out of the 326 local authority areas in England, with 10 of the 21 wards in the East of the Borough amongst the worst 10% in the country.

■ **Domestic violence**

This features in 73% of child protection plans in the Borough.

■ **Diversity of the population**

In the 2013 School Census conducted by the local education authority (LEA), Enfield pupils recorded themselves under 96 different ethnic codes. There are 775 disabled children and young people in receipt of services from the Joint Service for Disabled Children and there are 1,400 with Statements of Special Educational Needs. There are also approximately 1,000 young carers in Enfield, 300 of which are supported by the charity DAZU who run the young carers project. Work is already underway to help DAZU provide more extensive support to wider numbers of carers in the future.

■ **Contrasts between deprivation and areas of prosperity**

Enfield is a Borough of sharp contrasts between areas of privilege and prosperity and areas of severe deprivation and poverty. The gap between the prosperous and deprived neighbourhoods of the Borough is widening and its population, diversity and deprivation are all increasing. An increasing number of vulnerable groups, including single parent households and disabled people, are moving into the Borough. (taken from Enfield's Child and Family Poverty Strategy 2012)

■ **Gangs and knife crime**

Enfield faces challenges in terms of youth violence and gangs. Total figures provided by the Metropolitan Police show that overall, Enfield had, in the year ending 31 March 2014, 38 gang-related incidents involving serious violence against children and 128 children and young people who were victims of knife crime. Eight young people and children were recorded as being accused of knife crime.

In quarter four i.e. January – 31 March 2014 Enfield had four young people accused of knife crime and 28 knife victims. Enfield had the 8th highest number of reported knife victims out of 32 London Boroughs. In terms of number of gang-related incidents involving serious violence against children, Enfield ranked the 2nd highest out of the London Boroughs with 16.

■ **Future pressures on the Borough**

Population in the Borough in 2013 is now at 320,500 which represents an increase of over 43,000 since 2001. This is predicted to rise by 14 – 50,000 between the period 2014-2024. With this comes a pressure on housing and employment provision. 28% of all households in 2013 are on housing benefits already.



Enfield Safeguarding Children Board Priorities

How has the ESCB taken these local issues into consideration?

The ESCB continues to develop its work priorities to tackle safeguarding issues within this local context. This work is also carried out in conjunction with other partners for example the Community Safety Unit and gangs workers, Police, Domestic Violence Strategic and Operational groups and Public Health and Housing. This work is also reflected in the priorities for the Business Plan and will continue 2014-16.

The ESCB recognises the diverse nature of the Borough and works closely with the voluntary and community sector to ensure safeguarding messages are disseminated in the community, as well as that concerns are fed into the work of the ESCB. The creation of the Community Handbook which contains essential information on a wide range of safeguarding issues and incorporates details of support organisations has been a key way of informing the community about safeguarding.

www.enfield.gov.uk/enfieldscb/info/3/parents_and_carers/226/enfield_community_handbook

This handbook was developed in conjunction with all statutory partners, the community sector and young people to ensure that it met the needs of the community in understanding their role in keeping children and young people safe.

The development of a Young People's Board further ensures that concerns from young people in the Borough are also included in the work of the ESCB. This also includes the views of young people who have participated in the child protection process. Projects are being led by Young People which link to the Business Plan of the ESCB e.g. bullying. Such projects are important for engaging children and young people in safeguarding issues which directly affect them. The impact of this work will continue to be monitored in 2014-15.

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One of the areas identified for action in 2012-13 was to consider how the Board could be more effective given the changing environment in which it operates and the local challenges and context in which it sits. Also, how it could respond to the statutory requirements but also in an environment of reduced resources and change across many of its partner agencies.

This work formed the basis of discussions and work at the Board development day in Summer 2013 with consultation and work continuing in readiness for full implementation of the changes in January 2014.

The agreements reached by Board members as part of this consultation were to:

- Make the linkages between the Board and its sub groups clearer i.e. include clearer reporting processes and schedule in regular updates to the Board. Also clearer processes for escalating concerns
- Revisit the membership of the Board – reducing the number of attendees would encourage more challenging and focussed discussions amongst partner agencies. (Appendix 2, agency attendance, reflects this change as well as the removal of the Executive group)
- Remove the Executive group as it was felt this was an unnecessary middle layer if the sub group reporting line could be improved
- Promote the work and purpose of the Board by a much improved website on which key messages could be placed
- Involve Young People via the Young People's Board

Impact of these changes

These changes have made an impact on the work of the ESCB:

- Greater challenge between Board members – this has included tackling FGM, communication about the closure of Chase Farm, use of the referral process, and capacity and involvement of the voluntary sector in referrals and early help processes.
- Streamlined less bureaucratic reporting process with a calendar of meetings and report schedules in place. This has ensured that reports are timely and all sub groups are able to clearly report activities to the Board so that members are aware of the work of the sub groups and concerns. This is to be consolidated further in 2014-16.
- The Young People's Board is working on projects linked to the ESCB business plan, has consulted on the development of the website to ensure that it meets the needs of young people and kept the Board informed of issues of concern to children and young people. This has meant that the work of the Board can be directly linked to supporting children and young people.



Activities of the Sub Groups

- The new website – www.enfieldscb.org – was launched in November 2013 and is proving to be an invaluable source of information for the community as well as those working with children, young people and their families. The website is promoted in training across agencies and will form the basis of a further communications campaign in 2014/15 aimed at raising safeguarding awareness amongst the community.
- Feedback about the website has been positive and has enabled the Board to answer queries and put individuals in touch with organisations who can support them. Training bookings have also increased as all courses are promoted on the website.
- The community handbook has also been well received and is being used by practitioners to direct the families they are supporting to further help and also offer safeguarding information to the community.

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The work of all sub groups this year has been to complete the Business Plan for 2013-14 but also to respond to other requests and requirements. This has meant greater flexibility in work plans and also the formation of a new task and finish group to tackle Female Genital Mutilation. Each of the groups have submitted reports to the ESCB outlining their key areas of work and the impact in line with the development of the ESCB Learning and Improvement framework.

Learning and improvement is an ongoing theme for all sub groups under the new Business plan for 2014-16 which has been streamlined and has an even greater focus on what difference each area of work is likely to make to keeping children and young people safe.

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Quality Assurance and Performance Sub Group

The group is further developing the multi-agency data set to link to the improvement priorities in the Business Plan so that areas of concern can more clearly be seen and reported to the Board. This will ensure that the data that is gathered is useful, fit for purpose and is easily understood. Agencies have been challenged to provide data where there are gaps and this work will continue in 2014-15.

Existing Protocols and Procedures have been reviewed and updated in line with current practice and legislation and have been made easily accessible on the website: www.enfield.gov.uk/enfieldscb/info/4/publications

Protocols reviewed include:

- Model Safer Recruitment Policy
- Children with Disabilities Protocol
- Child Sexual Exploitation Protocol
- Elective Home Education Protocol
- Children Missing from Care and Home Protocol

The impact of this is that practitioners now have clear and up to date guidance to support their work. This also includes the development of a new multi-agency escalation policy so that all staff understand where to raise concerns if they feel a case is not being adequately addressed.

This work is ongoing to ensure that all policies and procedures are reviewed annually and therefore reflect changes and updates both locally and nationally.

The Quality Assurance Group has also completed four peer inspections during this period to ensure that learning from cases is shared amongst practitioners and areas for improvement identified. Some areas where changes have been made include: improved SMART (Specific, Measurable, Achievable, Realistic and Timely) staff supervision

and Children in Need assessments leading to clearer and more focussed actions which are regularly reviewed to avoid any drift in cases. Social care staff feel also more supported and there is greater management oversight of cases.

The group has also been involved in the pilot peer inspection child protection arrangements and championed the Young People's Inspection team. These activities have ensured that Young people play an active role in the ongoing development of Child protection practice and policies.

Feedback from young people has led to recommendations including:

1. More children and young people should be encouraged to attend child protection conferences and be supported to speak and take part
2. Children and young people should regularly feedback to managers and social workers their experiences of the child protection system and make recommendations for improvement
3. Children and young people should be routinely involved in the recruitment and selection of social workers and managers

These will be implemented and monitored into 2014-15. Future work also includes looking at attendance at A&E of young people to consider where further improvements can be made.

The group also raised the issue of under 18 stabbings in the Borough with the Safer and Stronger Communities Board. As a result, work will be undertaken to instigate a multi-agency response to tackle this issue and this forms part of the ESCB Business Plan for 2014-15.

...practitioners now have clear and up to date guidance to support their work.

Trafficking, Sexual Exploitation and Missing Children (TSEM)

The Trafficking and Sexual Exploitation sub-group covers the Council's strategic and operational response to Child Trafficking and Sexual Exploitation and Missing Children (TSEM). The group is now an established sub-group of the Safeguarding Children Board and well attended by up to 30 professionals from different organisations.

The group has:

- Reviewed the University of Bedfordshire's Toolkit and responded to Consultations. These included the Consultation on Children's Homes and on Children who go missing from Care or home for the Department of Education and the Pan London CSE Operating Protocol. This ensures that the experiences of young people and the work in Enfield is incorporated into national initiatives to tackle Sexual Exploitation
- Made professionals aware of the Abduction Warning Signs from the Police and informed all agencies of the National Referral mechanism and the routes in to this. This ensures that staff know what processes to follow and how to identify cases of sexual exploitation
- Developed a CSE Strategy for Enfield which has been ratified and made links with Community Safety Unit and Domestic Violence
- Produced a brand new Child Sexual Exploitation leaflet for Enfield. This ensures that practitioners as well as the wider community are aware of the signs of sexual exploitation.

Further work includes:

- A series of multi-agency training sessions presented by the Police and the Head of Safeguarding was implemented and attended by nearly 90 representatives of the private sector and Foster Carers. A follow up training session has now taken place with another 30+ providers taking part. This

ensure that practitioners are equipped to be able to deal effectively with young people at risk of sexual exploitation

- Multi-agency sexual exploitation meetings (MASE) are in place and agencies are now working together and sharing information and intelligence to combat CSE both within the borough and with neighbouring boroughs
- The Child Sexual Exploitation list is regularly reviewed. This identifies children at risk and allows specialist practitioners to intervene
- A part time CSE lead to coordinate activity and lead on prevention work for 2014-15 will be employed
- A well-attended multi-agency conference took place on the 24th February 2014 and multiple training opportunities have been set up to ensure that practitioners are aware of Sexual Exploitation and have the tools to assist them in tackling this
- The Board is working with the MsUnderstood Project with 6 other North London Boroughs to look at peer-on-peer and gang-associated sexual exploitation. This will help to implement a coordinated response to tackling exploitation both within and across Boroughs
- A further sub-group has been set up address the issue of Female Genital Mutilation within the Borough, This group is multi-agency and includes health, police and the voluntary sector. The work commenced in 2014 and will continue into 2015 and beyond. The ESCB is working closely with Public Health also to support an audit of FGM in Enfield which will support longer term strategies to tackle this issue.

The wider impact of the work of the group has been cited by group members as the ability to network, share ideas and gain contacts so that sexual exploitation can be tackled as a multi-agency issue. The ongoing training has been well received and the development of an e learning programme available to all practitioners will further enhance the knowledge of staff to identify and tackle sexual exploitation.

Serious Case Review Panel

Meetings have continued at two/three monthly intervals, attendance is good with all partners playing a full role. The Independent Chair of the ESCB continues to chair one SCR panel, which is being jointly reviewed with Haringey SCB.

The ESCB has also contributed to SCRs in Brent and Haringey. Learning from these cases was explored at the ESCB on 25th November. Whilst attendance has been good at the SCR meetings held during the year, there have been frequent changes in the personnel involved. The designated Doctor from Chase Farm Hospital left mid-year, the Assistant Director for Safeguarding at Barnet, Enfield and Haringey Mental Health Trust left in late autumn, the named nurse at North Middlesex Hospital was permanently appointed to in December 2013. Whilst change as well as loss can bring new thinking and refresh the group, continuity also brings with it shared memories and a history of the cases under review. A head-teacher attends the group and the panel are considering how best to widen the work within schools. Changes to the Probation Service will also need incorporating into the group's future.

The SCR Group has met 5 times during 2013-14 and an additional meeting was held in February 2014 to specifically look at one case in detail. Planning is now underway for the publication of the joint SCR with Haringey This has been a complex report with 23 independent management reports (IMR) from different agencies and an appeal against conviction still outstanding. The sub-committee has also agreed on a SCIE (Social Care Institute for Excellence) case review as Working Together 2013 requires all boards to develop their own 'Learning Framework' and future SCRs need to be a systematic look across incidents rather than the 'old-style' IMR and chronology analysis. Discussions have taken place with the Social Care

Institute of Excellence (SCIE), who will be mentoring and guiding this piece of work, a case has been selected and planning is now underway for the case examination. The SCR sub-committee and the Child Death Overview Panel (CDOP) are both working on behalf of the ESCB and their overlapping agendas will be under scrutiny in the Systems Light review.

A joint action list is kept of the recommendations from the reviews. Alison Cutler, the Business Manager of the Board, co-ordinates this activity and the progress made gives the ESCB an audit trail of this critical work. These actions are monitored, added to and removed when completed. The CH SCR brings several national as well as local recommendations and these will be a particular focus during 2014-2015.

The main concerns across many local and national SCRs continue to be parental mental health, addictions, domestic violence, poverty and neglect, unstable and overcrowded housing, violence amongst young people, and gang related activities. This is not an exhaustive list and clearly each case needs to be individually analysed and reviewed. The SCR sub-committee of the ESCB will continue to meet, review cases and make sure all opportunities to reduce harm to children are widely disseminated. Other activity will be to:

- Make sure actions and changes to practice from SCRs are monitored regularly
- Continuously review cases and the need for ongoing improvements across all partners to be owned
- Improve how the SCR experience is perceived by all staff by their involvement in the new style of SCRs
- Make sure all agencies are open and able to acknowledge when mistakes have been made
- Keep raising awareness across the agencies of the need to 'Work Better Together'.

Child Death Overview Panel

The panel this year has undergone changes of chair due to organisational restructure however it has continued in its statutory duty of reviewing all child deaths. The Panel is chaired by Public Health and includes members from the voluntary sector, health, education, police and social care.

The panel held a development day to review its effectiveness and the way it was operating. The outcome of this was a review of membership and a streamlining of process. This now means that the role of members has been clarified further in the terms of reference and ante natal deaths are reviewed by a panel group comprised of those most involved with the case. This has led to more efficient use of the meetings to discuss cases which are potentially more complex

There is also greater synergy between Serious Case Review (SCR) Panel and CDOP to ensure that cases are escalated and considered appropriately. CDOP is now a standard agenda item for SCR panel to ensure that cases causing concern by CDOP can be considered in light of serious case review guidance. The CDOP chair also attends the SCR panel to facilitate communication between the two groups.

There were 28 child deaths notified to Enfield Child Death Overview Panel between 1 April 2013 and 30 March 2014.

The Child Death Overview Panel met four times between April 2013 and March 2014 and a total of 37 deaths were reviewed by the Panel between 1 April 2013 and 30 March 2014, of which 20 were deaths recorded between April 2012 and March 2013.

One review was completed on the death of a child that occurred in 2011/12 where the child did not usually reside in Enfield and one review was undertaken for the death of a child that had left the borough to live abroad.

Of the deaths that were reviewed in 2013/14, eight of the deaths were found by the Panel to have been caused by modifiable factors. These are where the panel have identified one or more factors which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths (as defined in Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children 2013). Of those deaths, the majority were Sudden Unexpected Death in Infancy (SUDI). Enfield CDOP continues to work with Haringey in running awareness sessions about SUDI for practitioners so that staff are better able to advise and support parents.

There is also greater synergy between Serious Case Review (SCR) Panel and CDOP to ensure that cases are escalated and considered appropriately.

Learning and Development Sub Group

Focus for this year again was on ensuring a robust, comprehensive and flexible training programme which linked to the business plan, themes from learning reviews and serious case reviews and practice issues. Courses are in place as well as conferences, learning events, workshops and short 'lite bite' sessions on key practice areas. All these also complement and link to single agency learning and ensure that for example there is no duplication of courses being offered to staff.

Training sessions included child protection awareness, diversity, online safety, domestic violence, working with resistant parents, substance misuse, parental mental health, child sexual exploitation and neglect. Areas covered as learning events include sexual exploitation, familial sexual abuse and lessons from Serious Case Reviews, all of which were well received and positively evaluated.

The launch of the website as a focus of information and promotion of the training has had a big impact with more staff attending than previous years with increases especially from the voluntary sector and Police. As a result, over 800 staff have attended multi-agency learning events and courses – this is an increase of over 200 from the previous year.

Breakdown of attendance on training and learning events by agency:

Agency	Training courses	Learning events
Local Authority	91	141
Education	149	81
Police	23	4
Health	45	82
Mental Health	9	12

Independent/Voluntary	124	37
Out of Borough	0	2
Other	1	8
Total	442	367

Monitoring is in place with all staff sent a follow up questionnaire up to 3 months post course to gain examples of how the training has impacted on practice. Positive feedback has been received so far.

Training audits are also being carried out across all agencies, and are included in section 11. This is to ensure that agencies are providing adequate safeguarding training for their staff.

The learning and development group meets quarterly and has good multi-agency attendance. This group monitors and sets the annual core training programme as well as supports and implements further learning that is identified via actions from the Business plan during the year.

A very positive step forward is that Enfield Homes now also sit on the sub group. The result of this is that housing staff have started to attend the courses and learning events and have an awareness around safeguarding which is important when they are visiting families. This was as a direct result of questions being raised at Board about cases causing concern where housing was an issue.

Members of the sub group also run learning events and training, reducing the need to use external trainers and ensuring that the learning is focussed on local issues.

An example of impact of the programme was expressed by one delegate as follows:

'I currently support families from a wealth of backgrounds and I am therefore now able to reflect on what I learnt on the course and put it into practice and use within my role as a Keyworker. Therefore this has enhanced the outcomes for my families that I am trying to support.'

Female Genital Mutilation

This group was set up in March 2013 to tackle the issue of FGM in the Borough. The group is made of representatives from social care, public health, police, health, schools and the voluntary sector. This group has already delivered training for professionals and awareness raising sessions in the community, updated the FGM protocol and commissioned a health needs analysis from Enfield Public Health to estimate the prevalence of this practice in the Borough.

Cases are now being referred to social care and there has been anecdotal evidence from men in the community who stated they were unaware of the extent and impact of the practice until they attended training. Local Imams and healthcare professionals have delivered training and spoken about FGM at local mosques during Friday prayers. It is hoped that this will encourage men to become involved in the campaign to put a stop to FGM.

Further work will continue 2014-15 with FGM a key part the ESCB business plan in partnership with Public Health. Future projects include a pilot in schools to inform and educate children and young people about FGM, and the introduction of support for victims such as counselling and medical services.

Other activities of the Board

As well as its sub groups, the Board undertakes other duties and oversees Licensing, the work of the Local Authority Designated Officer (LADO) and Private Fostering. Regular reports in these areas highlight any concerns and actions required.

Licensing

The legislation under the Licensing Act 2003 promotes four statutory objectives which must be addressed when licensing functions are undertaken, namely:

- The prevention of crime and disorder;
- Public safety;
- The prevention of public nuisance; and
- The protection of children from harm.

In the period 1 April 2013 to 31 March 2014 the Enfield Safeguarding Board received notice of 90 licence applications for the sale of alcohol.

The premises included:

- 19 Restaurants
- 17 Public Parks
- 14 Supermarkets
- 8 Public Houses
- 8 Clubs including a football club and snooker club
- 4 Service Stations
- 3 Off Licences

The rest were various other venues such as mini markets, Community Centres etc.

There were 5 applications where children under 18 were not admitted therefore no conditions necessary.

The 90 applications included 9 reviews of licences:

- 1 club closed – prevention of crime and disorder – public safety
- 2 mini markets – protection of children from harm – underage sales
- 1 off licence – licence revoked – protection of children from harm – underage sales and prevention of crime and disorder
- 2 public houses – prevention of crime and disorder
- 1 public house closed – prevention of crime and disorder – public safety
- 2 restaurants – public nuisance – noise nuisance

Not all applications included the sale of alcohol but related to the public showing of films /videos which are restricted to the recommendations of the British Board of Film Classification. Some of the applications were with regard to changes in opening hours.

In addition, there were 10 applications for Gambling Licences. There were 3 in the previous year. Children under the age of 18 years are not permitted on the premises.

Summary of LADO activity

Total number of allegations referred to the Local Authority Designated Officer (LADO) for period 1st April 2013 and 31st March 2014 was 69. (For detailed breakdown see Appendix 3) This has been a significant increase from 56 in 2012-13.

In addition to these referrals, the LADO has been consulted for advice on a regular basis when the threshold for a referral was not met.

There has been appropriate liaison with OFSTED and the Barring Service when this has been warranted.

Workshops/training around managing allegations has been provided to several services/agencies, to ensure compliance with national and local procedures and guidance and to increase confidence in dealing with these allegations.

The referrals were considered in line with the London Child Protection Procedures chapter 15 and the local Enfield protocol, and triggered by:

- Behaviour which had harmed or may have harmed a child or young person
- Possible criminal offence against or related to a child
- Behaviour towards a child or young person in way which indicated professionals or volunteers were unsuitable to work with children or young people.

Private Fostering

There has been sustained activity in the area of Private Fostering during the last year. At the end of March 2013, there were 7 Private Fostering cases open within the Children in Need Service. At the end of March 2014 there were 15 open cases. It is suspected that these figures do not adequately convey the level of private fostering arrangements in the borough Between April 2013 – March 2014, children's social care received 25 new notifications where assessments were undertaken under the Private Fostering Regulations.

We have been able to offer some improvements, during the last year, to the level of support provided to young people who are privately fostered. Enfield's Children in Care Council (Kratos) has now extended its offer of advice and support to all privately fostered young people (and children who are subject to child protection plans). Plans are in place to develop a computer-based questionnaire that can assist us with better understanding the wishes and views of privately fostered young people. This will be a key development for us in 2014/15.

The Board continues to inform the community of the need to register such arrangements and this features as part of the Community Handbook information on the website.



Role of the Lay Member

The ESCB has two lay members who play a vital role in supporting activities of the Board and providing the ‘voice of the community’ in challenging the Board on particular issues. The ESCB also led a workshop at the annual London Board conference in December 2013 to support other LSCBs in engaging with lay members.

Our lay members Rick Jewell and Irene Ridley are an important link between the ESCB and the community. Rick describes their contribution as follows:

‘The internet explosion has opened up the world of communication more than we could ever have imagined, and young people use it to the max, unfortunately, so do some people who wish to gain some of that access to our youngsters.

Poverty and the effects that it has on children and young people in Enfield is a very serious issue with 29% of children in our borough living in poverty. Enfield comes 8th in the London Boroughs for children living below the poverty line. What do we do about them?

Exploitation and Trafficking of Children is a major concern and there have been several high profile cases around the country about the sexual exploitation of young people. What are we doing to make sure Enfield doesn’t become one of those high profile cases?

Female Genital Mutilation seems to be getting the attention it quite rightly deserves and I am glad to see that there is a move to prosecute those responsible for allowing this barbaric procedure to be forced upon young girls.

And what about the sort of cases that made me want to become part of this board the Victoria Climbié’s or the Daniel Pelka’s and Baby P’s of this world. How can this happen in today’s

world where we are all supposed to be vigilant and looking out for these situations. How do we ensure that no young person living in Enfield has to suffer the treatment that these young people did?

We get involved! We start taking an interest in things that we would normally just whisper about.

I have found that my time on the board has been a real eye opener for me and I am proud of the way that Enfield has developed the lay member role. My fellow Lay member Irene Ridley and myself have immersed ourselves deeply in the work of the board. We spend time with the different partner agencies that fall under the umbrella of the board. We take time to visit the partners and spend time with them to observe and learn what they do when initial concerns are raised about children and young people. We ask questions about their work and tell them what our role is. It is important that a transparent approach is taken as we represent you, the community. Hopefully we ask the questions that many of you would ask. Sometimes they are difficult questions and people have to go and gather that information for us, but they do.

Enfield’s approach to having Lay members has developed over the past couple of years. Last year I was asked to co-facilitate a workshop at the London Safeguarding Board Conference on how to Maximise the effectiveness of Lay members and I think we were pretty surprised at how we work in Enfield was received by other Lay members in London. Both the Lay members in Enfield have played important roles in the Section 11 audits and also in putting together the business plan for the board.

I look forward to my continuing work with the board and representing the community I live in.’

‘This is my third year as one of the Lay members on the Children’s Safeguarding Board for Enfield and I have to say I am still as eager to play a part as I was 3 years ago.

‘The safety of Children and Young people in our community should be something we all take very seriously and should be at the heart of everything we do. The world is changing very quickly and the dangers that children face is very different from the ones we faced when we were younger (talking about myself here having just hit 50). The stranger in the car pulling up next to you or the person approaching you and telling you that your mum has sent them to pick you up have now been replaced by faceless individuals that get into your children’s lives via technology.’

Rick Jewell
Lay Member

Measuring Impact under a Learning and Improvement Framework

The learning and improvement framework (Appendix 1) sets out the commitment from the ESCB to learning and improvement as well as some of the mechanisms and measurement tools used to drive improvement. These will continue to be developed in 2014-2016 under the revised Business plan which also focuses on ‘improvement outcomes’ as opposed to ‘objectives’.

Lessons from Serious Case Reviews and peer reviews will continue to be shared and disseminated both via wider multi agency workshops as well as incorporated into individual agency learning and training. A further action has been to take on board feedback from the Serious Case Review session held in early 2014 which also raised national themes. This led to more tailored workshops in team meetings for social workers as well as an awareness raising programme about the work of the SPOE and wider dissemination of information specific for schools via newsletters. All of this will continue into 2014-16. In this way, the Board is ensuring that it is continually supporting staff in their roles to better support the children and young people under their care.

The Board continues to challenge areas of work of its partners via the Section 11 Audit and this has led to improvements in practice e.g. more training for staff at private hospitals, and recruitment of staff in safeguarding also as a result of learning from a Serious Case Review. One of the key features of the Section 11 audit this year was inviting agencies to complete the form but then also attend an interview with the panel which comprised the Independent Chair, Lay Member and Head of Safeguarding or the Business Manager. The independence of the Panel and the participation of the Lay Member meant that meaningful and challenging questions could be asked of respondents and suggestions made in terms of improving practice.

Additional areas for the Board to monitor this year was Missing Children and the ongoing development of the SPOE – Single Point of Entry. Both these areas have highlighted the benefits and outcomes of effective multi agency practice. Some examples from the leads of these areas are highlighted as follows.



Budget

Children missing from education (report to the Board from the lead):

'A positive improvement has been the introduction of a 'tear-off' reply letter; which highlights elements of 'Every Child Matters', 'Children's Act' and British Medical Association' around working together to safeguard children. This letter is sent as a follow-up request to G.P surgeries and Health Centres who have not responded to first requests for information and has proven to be very successful, with all responding promptly and providing the information requested.

There has been an extremely positive and effective development in inter-agency working with the Finance, Resources and Customer Services Team and Senior Enquiry Officer; which has been beneficial in three cases so far. One of these resulted in the family finally engaging after 18 months of silence and providing evidence of the child being abroad; the remaining two are still awaiting an outcome but initial checks by the Senior Enquiry Officer suggests that the families had fled the property. This joined-up working has also led to positive outcomes for the other team as benefits that were claimed fraudulently have been cancelled and in one case it was found that the property had been sub-let.'

Lead from the Single Point of Entry Team:

'Once accurate names and dates of births had been established for the family, information was collated from Education, Health and Children's Social Care. All information had been gathered within 2 hours of the receipt of query and full information about schools and Health professionals for the family was able to be provided at point of escalation to Children's Social Care (CSC)'

Most recently we have achieved our goal of forging a partnership with Third Sector Services – This initiative has been supported by the Enfield Children and Young People's Service who attends or sends a representative with an umbrella overview of community services and who then "brokers" referrals coming from the SPOE so that we can link families with the wealth of provision available from specialist, faith and community groups in the borough.

Whilst Enfield has an increasing child population that currently stands at 80,400, referrals to CSC in Enfield has not risen in line with this increase. Indeed the referral rate into CSC for 2012/13 is only slightly higher than for the previous year.

Whilst these statistics may be attributed to a number of initiatives, such as the development of an Adolescent Support Service, it is likely that SPOE early intervention processes have also contributed to this fall.

The initial phase of the SPOE development has gone well and much has been achieved over the last year. There is some evidence that the early intervention and prevention response is having a positive impact on outcomes for children, young people and their families and that the MASH process is enhancing safeguarding for the most vulnerable children.'

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The Board continues to focus on value for money and transparency in its finances and has managed to maintain and develop its activities within budget.

Contributions are made from all areas as below:

Income and Expenditure 2013/14

Income:

Agency Contribution	Amount
Metropolitan Police	£5,000
CCG	£5,000
North Middlesex Hospital	£3,000
Chase Farm Hospital	£3,000
London Probation Service	*£0
CAFCASS	£550
BEH Mental Health Trust	£3,000
Enfield Children's Services	£23,400
Total	£42,950

*Nil contribution due as overpayment received in previous year.

Other income:

Carried forward from 2012-13 £40,000

Main Areas of Expenditure:

Expenditure	Amount
Training	£15,065
Catering/room hire	£1,940
Chair	£31,331
Conferences/events	£569
Promotional items	£2,979
Travel	£240
Subscriptions	£186
Total	£52,310

To be noted in general about the budget:

Above figures do not show staff expenditure within the LSCB and paid for by LBE and government grants of approx. £124k.

Budget for 2014-15

The projected spend for 2014-15 will be broadly similar and as a result the ESCB has agreed to maintain contributions at their current level especially as the budget already includes carry over from previous year. Plans are in place to fund any Serious Case Reviews that could be instigated in 2014-15, as well as a lead worker to coordinate activities to tackle Child Sexual Exploitation. The contributions will be reviewed during the year to ensure that there is no overspend and that the ESCB can still meet its objectives.

Future challenges and looking ahead

This annual report has highlighted the activities of the Board for 2013-14 and shown that it is having an impact on supporting practitioners as well as improving outcomes for children, young people and their families

The challenges facing the Board are issues arising from the local context and in themes from Serious Case Reviews. These include the impact of gangs, knife crime, domestic violence, substance misuse, potential increase in child poverty and pressures on housing, child sexual exploitation and mental health. Tackling FGM is also a key area of work. The ESCB will therefore continue to work closely with other Boards in these areas to develop joint strategies and action plans.

To develop this further a joint protocol will be agreed between the ESCB, the Adult Safeguarding Board, The Safer Stronger Communities Board and the Health and Well Being Board. Work in conjunction with these Boards has already started and will be built on further in 2014.

The future priorities of the Board are set out in a streamlined, outcome focussed Business Plan for 2014-16. This has multi agency ownership and brings together the work of other Boards and involves young people via the Young Peoples Board. These objectives also reflect the local context in which it operates and future challenges.

The future priorities of the Board are set out in a streamlined, outcome focussed Business Plan for 2014-16. This has multi-agency ownership and brings together the work of other Boards and involves young people via the Young People's Board. These objectives also reflect the local context in which it operates and future challenges.



Business plan 2014-2016 key improvement outcomes

Improvement priority:	Lead group	What difference do we want to make?	How will we measure our success?
To work with partners to develop, deliver and monitor strategies to tackle key areas of concern including Domestic Violence, neglect, substance misuse, child sexual exploitation, Sudden Unexpected Death in Infancy, child poverty and mental health (adult and children)	Joint Children/ Adult Board sub group Involvement of other Subgroups – QA/ Training/SCR/CDOP	To reduce the impact of these issues on safeguarding children and young people	Dataset, case studies, training evaluations
To develop strategies to identify, tackle and raise awareness of FGM	FGM task and finish group, ESCB, CCG and HWBB	To raise awareness amongst professionals and the community to reduce the prevalence of FGM and report it where it does take place so as to reduce occurrence of FGM in future	Have full understanding of the scope of FGM and track reporting and prevalence, training evaluation, ongoing assessment and reporting to the Board by Public Health
Develop active participation tools to encourage the voice of young people in the Board including the Young People's Board	ESCB Business Manager, working with Youth Service	Ensure that the business of the Board incorporates the voice of children and young people so that issues affecting the safeguarding of children and young people can be addressed	The business plan and projects of the Board have input from young people. Feedback sought from the Young People's Board as well as other mechanisms including Viewpoint
To develop strategies and tools to tackle all forms of child sexual exploitation	TSEM	Reduce the prevalence of sexual exploitation by raising awareness amongst the community, young people and professionals	Impact of awareness training, data monitoring, case audits
Develop joint safeguarding protocols and strategies with other Boards including Adult and CCG, as well as other Boroughs where appropriate to ensure that Boards work effectively together to tackle issues such as knife crime, placements, gangs, peer on peer abuse and familial abuse	ESCB	To make better use of resources and learn from others to improve practice and ensure that a holistic approach is taken when considering difficulties in families	Impact of joint initiatives – audits, experiences of practitioners, feedback from young people, case audits
Embed a shared commitment to learning and improvement across the Board and all its partner agencies	ESCB, training group and QA group	To continually challenge and learn from each other to improve practice	Utilise the tools in the improvement framework i.e. section 11, audits, case reviews, training audit and evaluations
To deliver the core statutory duties as defined in Working Together 2013	ESCB	To co-ordinate local work to safeguard and promote the well-being of children and to ensure the effectiveness of that work	Monitor the work of the Board to ensuring all processes and procedures are followed such as for CDOP and SCR

Conclusions

The aim of this report was to set out the work for the Board for 2013-14 and to answer the question – What difference has the ESCB made?

There is evidence to show that the ESCB does make a difference to practice and the community it serves by the implementation of a robust learning and improvement framework that is supported by all agencies and by reviewing all its activities taking into consideration the local context and challenges.

It has achieved this by:

- Identifying the needs of Enfield by the activities set out in the improvement framework including case reviews, data, practice issues, lay members and young people and feedback from the community. This has fed into the Business Plan and activities of the sub groups and directly led to improvements in process and procedures as well as impacted on practice as reported by those who work with families.
- Taking action to challenge practice and request and monitor information to ensure that multi agency practice is effective. The new Board structure has further facilitated this activity.
- Ensuring that practitioners as well as families are supported in safeguarding practice whether this is via training and learning or the dissemination of information via the new website including the community handbook. Such communication continues to be crucial moving forward and the development of the Young People's Board will also enable the Board to actively involve young people in its work.

- A focus on early intervention is making a difference by encouraging all agencies to work together via the SPOE and MASH to best support families, children and young people. This has meant that early help to these families is preventing escalation of cases so children and young people are better protected at an early stage.

There is always more for the ESCB to do to improve safeguarding practice. Therefore the Board will continue to move forward in the coming year in its drive to tackle child abuse by monitoring and reviewing all it does on a regular basis and addressing any areas that need improvement.



Appendix 1: Learning and Improvement Framework for the ESCB

Introduction

This document sets out how the ESCB and its partner agencies meet their duties as set out in Working Together 2013 to create, maintain and measure a framework of continuous learning and improvement.

The ESCB is committed to continual improvement of the way it works and the outcomes for safeguarding practice. This framework outlines the method by which lessons are learned from the different activities of the Board and how they can best be disseminated and embedded in practice. The aim is to meet the challenges of a changing environment and to further improve safeguarding practice across all agencies. The framework is therefore flexible, responsive to changes and an integral part of the creation of the business plan.

The relaunch of the Board in January 2014 including revised reporting processes to the Board from sub groups is also aimed at supporting more open and discussions to challenge practice where needed and more effectively sharing ideas for improvement. Members of the Board are therefore encouraged to model a commitment to ongoing learning and improvement to their different agencies and this is facilitated via networking events and Board development days during the year.

The Board is also committed to continuing to work with other LSCB's and Boards such as the Adult and Health and Well Being Board and the Clinical Commissioning Group to share practice and learn from others.

This document sets out:

- Statutory duties of the Board and its partner agencies in terms of learning and improvement

- Methods of learning and development incorporating:
 - Linkages to the Business Plan and wider work of the Board
 - Dissemination of learning
 - Audit and measurement of impact

As the various methods and tools for learning set out in the framework highlight issues to be addressed, so these can then be tackled and evaluated by using those same tools. The process is thus cyclical and ongoing.

Current work that the Board is undertaking which illustrates this cyclical process includes:

- Scoping the impact and extent of FGM using data and analysis, followed by planning awareness raising and training based on the information from this data.
- Joint initiatives with other Boroughs around gangs, peer on peer abuse and sexual exploitation to learn from each other and share practice.
- The development and implementation of a flexible and responsive learning and development programme which supports and arises from key themes from serious case reviews, practice, peer reviews, dataset trends and feedback from young people and the community.
- Commissioning of a thematic SCIE review on neglect to identify learning from cases which do not fully meet the SCR threshold but where lessons can nevertheless be learned.
- Continued contribution to and attendance at LSCB events and meetings in London and nationally to share practice and learn from others.

Statutory duties of the LSCB

Working Together 2013 defines the work of the Local Safeguarding Children Board. Linked to all of these duties is a requirement to continue to learn and improve. Working Together sets this out as follows:

Local Safeguarding Children Boards (LSCBs) should maintain a local learning and improvement framework which is shared across local organisations who work with children and families. This framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result.

Each local framework should support the work of the LSCB and their partners so that:

- reviews are conducted regularly, not only on cases which meet statutory criteria, but also on other cases which can provide useful insights into the way organisations are working together to safeguard and protect the welfare of children;
- reviews look at what happened in a case, and why, and what action will be taken to learn from the review findings;
- action results in lasting improvements to services which safeguard and promote the welfare of children and help protect them from harm; and
- there is transparency about the issues arising from individual cases and the actions which organisations are taking in response to them, including sharing the final reports of Serious Case Reviews (SCRs) with the public.

The local framework should cover the full range of reviews and audits which are aimed at driving improvements to safeguard and promote the welfare of children. Some of these reviews (i.e.

SCRs and child death reviews) are required under legislation. It is important that LSCBs understand the criteria for determining whether a statutory review is required and always conduct those reviews when necessary.

It is with these in mind that Enfield Safeguarding Children Board has developed this overarching framework for monitoring and improvement of all its activities.

Methods and tools for learning

The framework covers all opportunities for learning. For the ESCB these include:

- Training and development supported by the ESCB Training strategy
- Serious Case Reviews and Independent Management Reviews
- Peer Audits and Case Audits
- Direct visits to agencies by the Chair
- Consultation with young people
- Section 11 audits
- Training audits
- Dataset
- Child Death Overview Panel

Training and Development

The ESCB has an annual training programme which is agreed via the training sub group. The programme is varied and incorporates courses, short 'lite bite' sessions, workshops, conferences and e learning. The programme is adapted through the year as needs dictate and covers issues arising from Serious Case reviews and other audits as well as priorities set as part of the business plan. It is also based on research and latest training and development practice incorporating reflective practice, sharing of practice and the facilitation of learning communities which continue the learning 'beyond the classroom' (Cutler, A)

The training strategy sets out how the programme is developed, as well as an evaluation framework and incorporating

the learning into supervision and one to ones. The training and the strategy is promoted on the website at the following link:

www.enfield.gov.uk/enfieldlscb/info/5/training

A network for all safeguarding trainers is also being developed in order to share practice and encourage consistency of safeguarding training provision.

Serious Case Reviews and Independent Management Reviews

The ESCB carries out SCR's in line with statutory guidance via the Serious Case Review Panel. Independent Management reviews are carried out in cases that cause some concern and where there is useful learning but do not necessarily meet the threshold for an SCR. There is also representation from CDOP on the SCR panel to ensure that cases from CDOP are brought to the attention of the panel for consideration.

All SCR's are carried out in line with the guidelines in Working Together to use a systems approach and one that is proportionate to the case. Members of the panel have been trained in SCIE methodology so that Enfield can adopt this process in future reviews. It is also intended that at least two members of the panel will be mentored to become lead reviewers by SCIE in 2014. A 'mini' SCIE is planned on a thematic review of cases not requiring an SCR but where the Board has identified potential lessons to be learned.

Learning from SCR's locally and nationally is cascaded via briefings and workshops and promoted on the ESCB website. Action plans arising from local cases or ones the ESCB has been involved in are monitored and followed up and implemented across different agencies as appropriate.

Child Death Overview Panel

The ESCB carries out Child Death Reviews as set out in Working Together 2013. Lessons and trends arising from these reviews are compiled and reported to the main Board. Campaigns are carried out as appropriate – this has included in the past Sudden Infant Death Syndrome which was held in conjunction with other Boroughs.

The CDOP has undergone a review in Enfield of its terms of reference and the way it functions in order for it to be able to analyse even further lessons to be learned. This includes taking part in national research projects and attending pan London meetings to share practice. A closer working relationship between the CDOP and the SCR panel has been developed with an agenda item on each to share cases and concerns rather than each panel looking at these in isolation. This has enabled greater consideration of cases to be made and has led to peer reviews of cases causing concern and the commissioning of a thematic SCIE review around neglect which is planned for Spring 2014.

Peer Audits and Case Audit

Peer audits are multi agency audits looking at a case put forward by any of the agencies on the Board. Multi agency participants attend the meeting and share practice and thoughts on the case and any learning is drawn out. In children's services, case audits are carried out every 6 weeks. Any multi agency issues arising from audits are passed to the ESCB for action and incorporated into the learning and development plan as required. A quarterly reporting process of the findings of such reviews is made to the Board as part of the overall reporting of data and audits. Collating and analysing audits and data from all agencies form the key area of work of the Quality Assurance sub group and themes and

trends are highlighted and reported to the Board as part of an improvement plan.

Direct visits to agencies by the Chair

The Independent Chair of the Board regularly visits agencies and meets practitioners to discuss any issues or areas where improvements can be made so that the work of the Board can also reflect issues raised at the 'front line'. Her reports at the Board feed back issues and these are also addressed either via training, communication of processes or via the website. Such discussions have included awareness around the understanding of thresholds and accessibility of the ESCB website – the latter leading to the development of a shortcut application for all children services workers to easily access the website. The ESCB has adopted the London Thresholds document and this is now on the website and further training around this is planned. Work continues to improve for example reporting back on the progress of a case once a referral is made – all in direct response to feedback from staff.

Consultation with young people

The formation of the Young People's Board should further facilitate consultation and involvement of young people in the development of the business plan and activities of the Board and greater focus on issues affecting young people. Their views have already influenced the website, and the introduction of Viewpoint to record the views of children and young people also form part of the monitoring of the effectiveness of child protection practice. The Young People's Board will also be involved in projects forming part of the business plan so that they can actively contribute to the work of the Board. Regular attendance at the Board by representatives of the

Young People's Board is planned. The draft Business Plan and the workings of the Young People's Board is to be presented at KRATOS (Children in Care Council) in March for consultation and feedback.

Section 11 Audit

The Section 11 audit considers safeguarding practice across all agencies in Enfield. These are carried out as a paper audit as well as follow up interviews with the agencies by a panel including the ESCB chair and a lay member. These interviews challenge and discuss the content of the audit with each agency. Lessons from this and gaps are addressed directly with the agency and also form part of wider learning where needed including changes to practice.

The audit also allows the identification of additional support for agencies to take place and highlights areas where improvements can be made. This mix of activities enables a much more robust and useful discussion with agencies to take place as opposed to simply completing the forms. The audit also serves as a measurement of impact of safeguarding practice across all agencies. Some areas that are currently being addressed include staff training and awareness of safeguarding processes. This was particularly highlighted in discussions with a private healthcare provider in the Borough.

Learning and Development Audit

The learning and development audit is carried out annually with all agencies and this highlights what training is being carried out, how it is evaluated and crucially how the impact on practice is measured. This is then reviewed by the Learning and Development sub group and a report made to the Board. The audit allows the Board to identify any gaps in the provision of

training and to challenge and support agencies as required to address these to meet their statutory requirements around safeguarding. The audit can also highlight any gaps in the provision of multi-agency training and thus contributes to the ESCB training plan.

ESCB Dataset

The ESCB dataset consists of a number of multi-agency indicators, identified and agreed by the Quality Assurance sub-group. The dataset is monitored and reviewed by the QA sub-group and members are tasked with actions as appropriate. An overview of the dataset and any areas of concern will be presented, on a regular basis, to the full board by either the Chair of the QA sub-group or Deputy Chair of the QA sub Group and the Performance Manager, Children's Services. These areas of concern will then be discussed at the Board and the relevant agencies asked to address as appropriate.

The dataset is currently under review to consider how it can best be utilised to support and inform the ongoing improvement plan for the ESCB. All data in the dataset will be directly linked to the outcomes and objectives in the ESCB business plan.

Ongoing dissemination and cascade of learning

All of the learning and findings from these tools are disseminated and incorporated into the day to the day business of the Board and its partner agencies. This takes various forms and includes:

- Specific learning interventions such as training
- Briefing notes and practice workshops
- Development and updating of protocols and procedures
- Development and ongoing review of the Business Plan

- Discussions, debate and challenge at Board level using evidence from these tools to hold agencies to account
- Information on the website
- Cascade of information via all members of the Board and its sub groups
- Linkages to communication channels in other agencies eg newsletters to ensure key messages are disseminated
- Trainer network to commence in Spring 2014 to ensure consistent messages around safeguarding are delivered across all agencies and best practice is shared
- Monitoring and evaluation of impact is ongoing utilising the learning and improvement tools in this framework.

References:

Working Together to Safeguard Children – A guide to inter-agency working to safeguard and promote the welfare of children. HM Government, March 2013

Cutler, A. (2011) Can collaborative, inter-agency learning support the development of inter-agency working relationships between practitioners? (MA research paper, University of Hertfordshire)

ESCB website: www.enfieldscb.org

Appendix 2: Attendance by agency at Board and Sub-Committee meetings 2013-14

Enfield Safeguarding Children Board

Agency	Date of meeting				
	21/05/2013	30/09/2013	25/11/2013	27/01/2014	03/03/2014
Community Health	5	2	3	1	1
Barnet & Chase Farm Hospitals	1	1	1		
North Middlesex University Hospital	2		1	1	1
Public Health				1	1
Police – Child Abuse Investigation Team	1	1	1		
Police – other	1				1
Community Safety Unit				1	1
Probation	1	1	1		1
Education	1	1			
Further Education	1	1	1		
London Fire Service	1			1	
Social Care	3	4	2	1	2
Safeguarding Children & Quality Assurance Service	1	3	3	1	1
Third Sector	1	4	1	1	1
Other London Borough of Enfield	8	8	6	1	2
Enfield Safeguarding Children Board	2	2	2	2	2
Other	2	2	2	2	1
Total no. attendees	31	30	24	13	15

- NB The reduced number of attendees for the ESCB in January and March as shown above represents the restructure of the Board referred to in the report. This was aimed at reducing the number of attendees to encourage more challenging and focussed discussions amongst partner agencies.
- The Executive group was also removed as it was felt this was an unnecessary middle layer if the sub group reporting line could be improved. This change is also reflected in the figures below for the Executive Group. The last meeting of this group was in November 2013.

Executive Group

Agency	Date of meeting			
	07/05/2013	26/06/2013	17/09/2013	05/11/2013
Community Health	1	1	2	1
Public Health	1			
Police – Child Abuse Investigation Team		1	1	
Police – other	1	1	1	1
Community Safety Unit	1	1	1	1
Probation			1	
Social Care	1	1	1	1
Safeguarding Children & Quality Assurance Service	2	1	1	
Other LBE	1			1
ESCB	2	2	2	2
Total no. attendees	10	8	10	7

Serious Case Review Panel

Agency	Date of meeting				
	15/04/2013	17/06/2013	09/09/2013	06/11/2013	21/01/2014
Community Health	3	2	1	2	3
Barnet & Chase Farm Hospitals	4	1	1	1	1
North Middlesex University Hospital	1	1	1	1	2
Child & Adolescents Mental Health Service	1	1	1	1	1
Mental Health	2	1			
Police – Child Abuse Investigation Team	1		1	1	1
Police – other		1		1	1
Community Safety Unit			1		
Probation		1		1	1
Education	1			1	
Social Care	2	3	1	1	4
Safeguarding Children & Quality Assurance Service	1	2	1	1	2
Other London Borough of Enfield	1	1		1	1
Enfield Safeguarding Children Board	2	2	2	2	2
Other			1		
Total no. attendees	19	16	11	14	19

Quality Assurance Sub-Group

Agency	Date of meeting				
	23/04/2013	01/07/2013	14/10/2013	05/12/2013	17/02/2014
Community Health	2	1	3	1	3
Barnet & Chase Farm Hospitals			1	2	1
North Middlesex University Hospital	1	1	1	1	1
Child & Adolescents Mental Health Service	1	1		1	1
Police – Child Abuse Investigation Team	1	1	1		1
Youth Offending Service	1				
Probation	1	1			1
Social Care	2	2	1	1	1
Safeguarding Children & Quality Assurance Service	1	1	1	1	1
Other London Borough of Enfield	4	3	2	3	3
Enfield Safeguarding Children Board	2		1	1	1
Total no. attendees	16	11	11	11	14

Child Death Overview Panel

Agency	Date of meeting			
	25/06/2013	24/09/2013	03/12/2013	11/03/2014
Community Health	2	3	3	2
Barnet & Chase Farm Hospitals	3	3	3	5
North Middlesex University Hospital	2	1	1	1
Public Health	1		1	2
Police – Child Abuse Investigation Team	1	1	1	1
London Ambulance Service		1	1	1
Social Care			1	1
Safeguarding Children & Quality Assurance Service	1	2	1	
Enfield Safeguarding Children Board	1		1	
Other	1	1		
Total no. attendees	12	12	13	13

Trafficking, Sexual Exploitation & Missing Children Sub-Group

Agency	Date of meeting					
	22/05/2013	15/07/2013	16/09/2013	26/11/2013	04/02/2014	31/03/2014
Community Health	1	3	3		2	1
Barnet & Chase Farm Hospitals	1	1	1		1	1
North Middlesex University Hospital					1	
Police – Child Abuse Investigation Team	1	1	1	1	1	1
Police – other		1		4	1	
Youth Offending Service				1	1	
Community Safety Unit	1	1	1			
Education	1	1	1	1	1	1
Social Care	1	2	1	4	3	2
Safeguarding Children & Quality Assurance Service	2	3	2	2	2	2
Third Sector	2	1	2	1	1	1
Other London Borough of Enfield	1	2	1	2	2	3
Enfield Safeguarding Children Board	1	2	1	2	2	1
Other		1	3	2	4	1
Total	12	19	17	20	22	14

Training & Workforce Development Sub-Group

Agency	Date of meeting					
	02/05/2013	04/07/2013	17/10/2013	14/11/2013	10/01/2014	13/03/2014
Community Health						1
Barnet & Chase Farm Hospitals	1	1	1		1	1
North Middlesex University Hospital	1	1	1		2	
Community Safety Unit			1	1		1
Education			1	1		1
Social Care	2	1	3	1	2	2
Safeguarding Children & Quality Assurance Service			1	1		
Third Sector					1	1
Enfield Safeguarding Children Board	1	1	1	1	1	1
Other	2			1	1	
Total	7	4	9	6	8	8

Appendix 3: LADO referrals 2013-14

	Substantiated	Unsubstantiated	Unfounded	Malicious	Outstanding
Primary Schools	4	4	4		
Secondary Schools	8	6	1		
Special Schools			1		
Independent Schools			1		
Health Agencies/Providers		2	1	1	
Nurseries/Playgroups/play schemes		2	2		
Foster Carers (LB Enfield)	1	2	3		
Foster Carers (agency)		2			1
Foster Carers (other LA)			1		1
Faith Groups	1		1		
Child-minders		1	1		2
Children's Centres			2		
Residential/semi-independent units		2	1		
Others	6	1	3		
Total	20	22	22	1	4

Definitions of outcomes

"Unfounded"

No evidence or proper basis which supports the allegation being made or there is evidence to prove that the allegation is untrue.

"Unsubstantiated"

Insufficient identifiable evidence to prove or disprove an allegation. The term does not imply guilt or innocence.

"Malicious"

Implies that an allegation has been made with a deliberate intent to deceive or cause harm to the person subject to the allegation. For an allegation to be classified as malicious it will be necessary to have evidence to prove the intention to cause harm. Care should be taken in dealing with such allegations as some facts may not be wholly untrue; some parts may have been fabricated or exaggerated but elements may be based on truth.

Enfield Safeguarding Children Board Partner Agencies



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**Enfield Safeguarding Children Board
Schools and Children's Services**

August 2014

