Enfield Safeguarding Children Board

Annual Report

2015-16

Enfield
Safeguarding
Children Board
...because safeguarding children
is everybody's business

Contents

Introduction from the Chair

The challenges for all of us involved in the safeguarding children's world are numerous. We live in a constantly changing society which, whilst full of opportunities inadvertently can bring increased risk and danger to young people. Keeping children safe (this can range from crossing the road to unwanted intrusion from the Internet) across Enfield, involves a number of different agencies. The major three being; the Local Authority, the Metropolitan Police and The National Health Service.

Other important contributing partners include colleagues across Education, Probation, Children's and Family Court Advisory and Support Services, the London Fire Brigade and also many concerned and active voluntary groups. On the Enfield Board we also have two excellent lay members who represent the community, and the Lead Councillor for Children and Families attends. At each meeting we may welcome other individuals such as members of the Youth Parliament and other involved groups. There are also many providers from private businesses including hospitals and children's homes and regular contact is maintained.

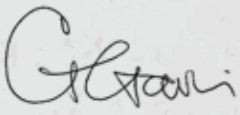
This report summarises the work undertaken by the ESCB between April 1st 2015 to March 31st 2016. It charts the progress made in relation to Child Sexual Exploitation, Female Genital Mutilation as well as tackling the growing concerns of increased radicalisation. There are many other situations where children can be harmed and these include living with carers who have addiction problems, where housing and financial pressures and poverty can result in neglect. Some young people have family members in prison, and we are aware of knife and gun crime which adds to the dangers being experienced.

A key role of the ESCB is communication and holding all agencies to account in relation to making continuous improvements. As the Independent Chair both on my visits and indeed at Board Meetings I consider the communication between partners to be good though of course there are no grounds for complacency.

The ESCB currently operates across Enfield only, there are 31 other London Boroughs and there is a London-wide Safeguarding Children's Board. It is important that we stay alert to specific local concerns, London concerns and then of course governmental concerns across the UK. National headlines can sometimes drive or distract from local issues and this needs to be carefully balanced.

A major area of focus for the ESCB during 2016-2018 is Domestic Abuse, children are too often subjected to violence in the home and there are increasing concerns that the resources needed to really get to grips with this serious and damaging problem are shrinking. We need to strengthen our existing links between the Health and Wellbeing Board, Community Safety, the Adults Safeguarding Board and work together to highlight where practice is good and importantly make improvements when gaps are identified. All agencies need to learn from each other and the issues behind Domestic Abuse cross many partners desks, how we manage these issues needs our attention. We will also focus on and continue to support and monitor the good work that is undertaken in Enfield to safeguard disabled children.

Finally a huge Thank You to each and very staff member across all the agencies who work in this demanding and very challenging arena. Your skills, energy and commitment are appreciated by the ESCB, and your work whilst often invisible to most when all goes well is undertaken with purpose and pride.



Geraldine Gavin
Independent ESCB Chair

About Enfield

Situated approximately twelve miles north of London, Enfield is London's most northern borough and is a place of contrasts, having some of the most deprived and some of the most prosperous wards in London and indeed England. There are approximately **82,200 children** (aged under 18) living in Enfield, making up **26% of the borough's population** (Source GLA estimate). Enfield has a high number of children living in poverty and although the infant mortality rate has decreased in recent years to 4.6 per 1,000 live births, this is still higher than the England London averages of 4.1 and 3.9 per 1,000 live births respectively.

The overall population of Enfield is approximately 321,000 with a population of children and young people in the borough of approximately 73,500. Enfield has a relatively young population with the number of children and young people representing approximately 23% of the total population.

Enfield has experienced significant change over the last few years in terms of the size and nature of its population; this has included an increase in the baseline child population together with an increase in the numbers of children in Enfield who are living in poverty.

As well as the increase in child population, Enfield has also been significantly affected by the changes associated with the Welfare Reform agenda. The most recent available data from IDACI (The Income Deprivation Affecting Children Index) measures the proportion of all children aged 0 to 15 living in income deprived families. Their data concludes that Enfield is the 13th most deprived borough nationally and the 5th most deprived in London. The London Boroughs with greater levels of deprivation than Enfield have smaller baseline populations, meaning that Enfield now has the largest number of children living in poverty of any London borough.

As might be expected, there has been a significant increase in the number of 'Contacts' being made to Enfield's Single Point of Entry (SPOE) in the last few years. Enfield is currently receiving approximately 50% more referrals than three years ago. This inevitably creates a considerable amount of pressure on available services.

2015/16 saw an increase in children subject to **Child Protection plans** in the first half of the year peaking at **302** in August 2015. However, there has been a steady decrease month on month from November 2015 with **233** children subject to plans at the end of March 2016. The decrease from August 2015 to March 2016 is significant at 23%. A number of factors have impacted upon the reduction of children subject to child protection plans. Firstly the partnership overseen by Enfield Safeguarding Children Board has embraced Signs of Safety (SoS) Practice Model which is an internationally recognised model for direct work with children and families. *(Read more about work related to Signs of Safety on page 19)*

Secondly the local specialist CSE team became operational in July 2015 and by the end of the year referrals were being held within this team with strong child in need plans in place thus reducing the need for child protection plans. *(Read more about work related to CSE and Missing Children on page 12)*

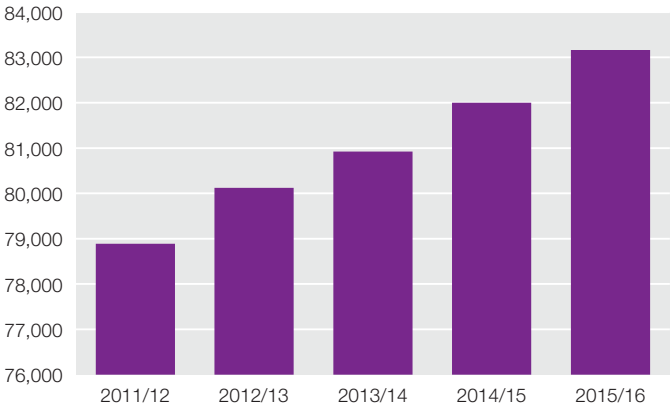
There was a small rise and then a fall in the number of **Looked After Children** during 2015/2016 but the overall number remains approximately the same at the end of March 2016 (359) as it was in March 2015 (358). There was a significant increase in the LAC population 3 years ago and this has remained consistently high over the last 2 years.

The number of unaccompanied asylum seeking children (UASC) looked after at the 31st March 2016 was **69** this is a significant area of pressure as there were **49** UASC looked after children at the 31st March 2015, this represents a 40% increase over the year.

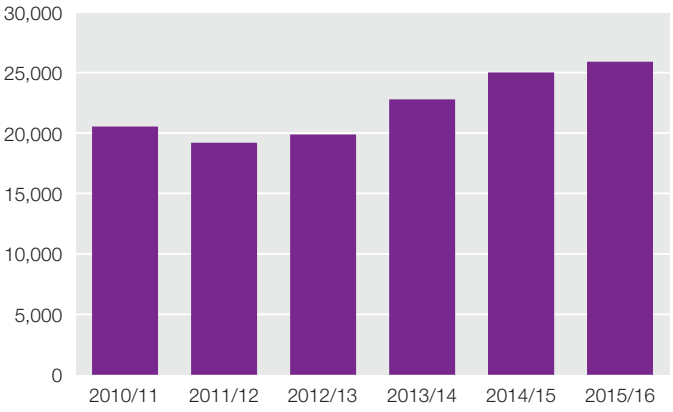
60 children returned from care to parents or relatives with parental responsibility during the year 15/16 (this does not include Special Guardianship Orders or Child Arrangement Orders).

Further data relating to Safeguarding activity across the partnership can be found in Appendix A.

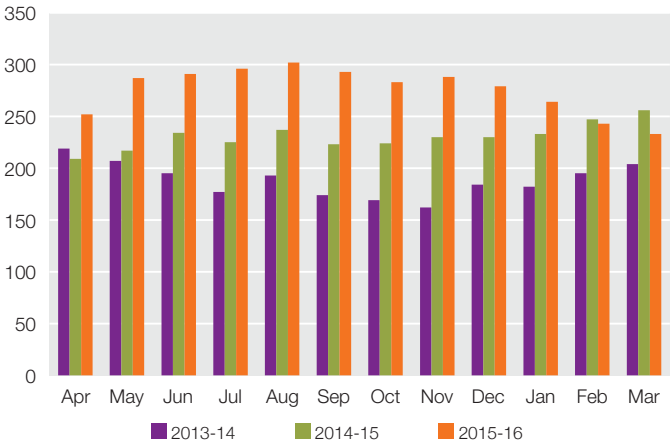
Enfield under 18 population



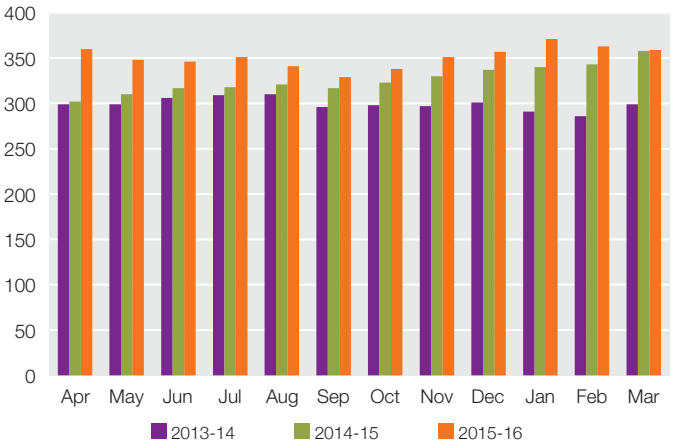
Contacts recorded

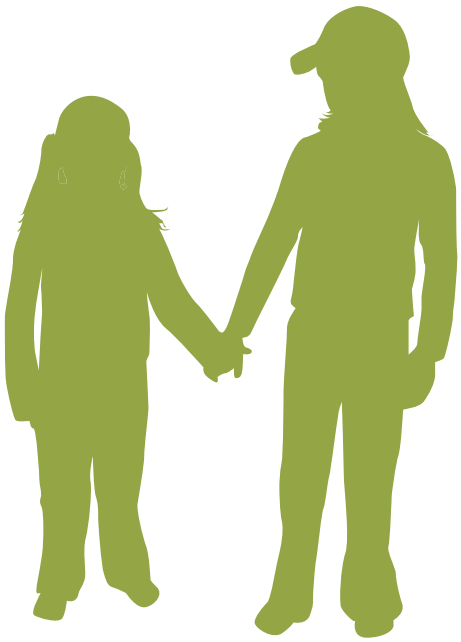


Child Protection Plans (April 2013-March 2016)



Looked After Children (April 2013-March 2016)





Executive Summary

This Executive Summary summarises the Annual Report covering 1 April 2015 to 31 March 2016 focusing predominantly on activity and progress across the year against the priority areas as outlined in the ESCB Business Plan which was developed at the end of 2014-15.

2015-2016 has been a successful year for the work of the Enfield Safeguarding Children Board (ESCB). There is an effective response to safeguarding concerns with good systems and structures in place across the partnership. The commitment to workforce development remains strong with a comprehensive learning and development programme and a clear performance management framework in place.

ESCB Business Plan 2015-2016: Summary of achievements

The Business Plan was divided into four sections with each section focusing on a priority area for development and activity. The priority areas are listed below along with some of the key achievements made this year. Many of the achievements contain hyperlinks which lead to the relevant page(s) of the Enfield Safeguarding Children Board's website.

1 Effective responses to specific safeguarding concerns

- A great deal of progress has been made in our work in supporting the identification, assessment and safeguarding intervention of children at risk of sexual exploitation. Activity includes the establishment of a dedicated multi-agency Child Sexual Exploitation Prevention Team, the development of an elected members CSE Task Group and a focused cross-border project in collaboration with our neighbours in Haringey, to help improve our responses to CSE and other vulnerabilities.
- Much positive work has been undertaken to support our work to support children and young people who go Missing. This included the development of a new protocol covering processes for children who go missing from Home, Placements, Education and Health and the establishment of a new multi-agency Missing Children Risk Management Group which has quickly led to a significant reduction in the number of children who are missing education. *Read more about work related to CSE and Missing Children on page 12.*
- We have worked with local groups from the voluntary and community sector to update our strategy and protocols relating to the identification, assessment and safeguarding of children and risk of Female Genital Mutilation in line with national developments. *Read more about work related to FGM on page 14.*
- We have strengthened our links with the Community Safety Unit in relation to RADICALISATION and the PREVENT agenda. The board receives regular updates on activity in this area and has commissioned a series of training sessions to help raise awareness and understanding.

2 Effective safeguarding structures and systems

- The Board has overseen and endorsed some key changes in relation to how Early Help arrangements are structured and how referrals to children's social care are managed during the course of the year. Two Early Help audits were undertaken which were used to inform the new Early Help strategy (currently in draft) and the board has helped to raise awareness of changes training sessions and updated information on the website.
- The Enfield ESCB Threshold Document and Information Sharing Protocol have been completely refreshed to reflect current practice and procedures and have been circulated across the partnership.
- Work has continued to strengthen links between ESCB and related boards and groups including the Safeguarding Adult Board and the Health and Wellbeing Board. The Learning and Development subcommittee not operated jointly with the adult board ensuring consistency and improved effectiveness and the FGM subcommittee now reports directly to the Health and Wellbeing Board whilst maintaining strong links to the ESCB.

3 Communication and learning

- The Safeguarding Board has played a key role in shaping and promoting the implementation of the Signs of Safety practice model across the borough. This strengths-based and safety-focused approach to child protection work is grounded in partnership and collaboration and aims to improve outcomes for children and their families. The Board has fully endorsed the model and has overseen the delivery of briefings and training over 500 professionals. *Read more about work related to Signs of Safety on page 19.*
- We have again delivered a comprehensive programme of Safeguarding Training across the partnership, ensuring that all staff have access to good quality training, which helps support sustained improvements across all safeguarding services. Across the year we delivered training and learning sessions to well over 1,000 people, a significant improvement on previous years, at no additional cost. *Read more about work related to Learning and Development on page 20.*
- Enfield was one of the areas selected by the DfE for funding to support a national Child Abuse Awareness Campaign aimed at encouraging people in the community to be able to recognise the signs of abuse and to report it promptly. The campaign ran across the borough through the spring.
- We have continued to raise the **profile** of ESCB by developing and maintaining the ESCB website, getting articles into the local press, and developing our social media presence of both Twitter and Facebook where we now have over 500 followers.

4 Performance management and quality assurance

- We have continued to develop and improve our **Section 11 programme** which gives us the opportunity to seek assurance from our partners regarding their Safeguarding processes and activity and to offer challenge where appropriate. This year we have focused on improving the support and scrutiny we are able to offer our schools and have been very pleased with the high levels of engagement and the evidence provided of effective safeguarding structures.
- We have continue to refine and enhance our **Safeguarding Dataset** which is used to routinely scrutinise partners performance, to make it as informative and effective as possible and have used the findings to make changes and enhancements to practice and systems.
- The **multi-agency audit** programme has been expanded to include priority areas such as Missing and Child Sexual Exploitation and findings have continued to drive improvement. *Read more about work related to Performance Management on page 10.*

Conclusion and Challenges for 2016/17

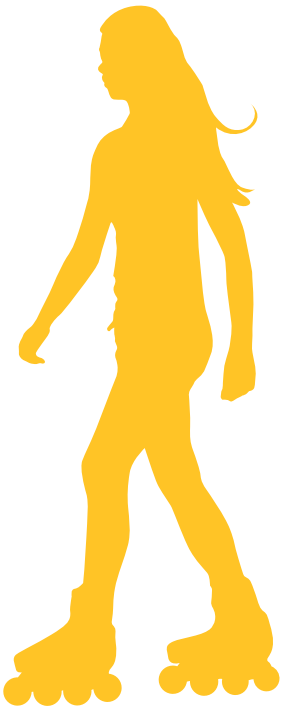
2015-2016 has again been a very busy year and productive for the ESCB. We hope that this report provides readers with reassurance of our firm commitment to ensure there are effective, joined-up local arrangements to safeguard and promote the welfare of children in Enfield.

This report demonstrates that safeguarding activity is progressing well and that the ESCB has clear agreement and focus on the strategic priorities and ongoing challenges. Reports from our partners demonstrate that statutory and non-statutory members are consistently working towards the same goals as part of the multi-agency partnership and within their individual agencies.

The Board is committed to a programme of scrutiny, monitoring and, quality assuring the quality of safeguarding activity across Enfield, and this programme of robust analysis and challenge will continue to ensure that children and young people are kept safe. The Board is proud of its successes but of course there is no room for complacency, the economic situation and organisational change affecting public services in Enfield and across the country continues to be a challenge for the Board.

2016/17 will see us continuing our focus on Child Sexual Exploitation and Missing Children and exploring ways of effectively bringing these issues together with other factors that affect vulnerable young people to offer a holistic and robust approach to our work with older children. We will have a renewed focus on Domestic Abuse both on the ways parental domestic abuse can impact on children and on abusive relationships between young people. We are very keen to improve our engagement with young people and will renew our commitment to ensuring Enfield young people's voice are heard at the board and explore new and innovative ways of achieving this.

We hope that you find this report interesting and helpful. There are many hyperlinks throughout the report which lead to relevant pages of our website. We continue to work hard to ensure our website is as relevant and useful, both for professionals and members of the public and we are also striving to maximise our use of social media to promote our work and engage with others. If you are a Twitter or Facebook user please follow us by clicking on the links. Your feedback and thoughts are always important to us. You can get in touch with us through our social media channels or through the website www.enfieldlscb.org.uk/contact.



Messages for Readers

Board Members

Identify and act on child protection concerns.

Work effectively to share information appropriately.

Collectively make decisions about how best to intervene in children's lives where their welfare is being compromised, and collectively monitor the effectiveness of those arrangements.

Staff working in Board partner agencies

Book onto ESCB Multi-agency training and learning events relevant to your role.

Be familiar with the Pan London Safeguarding Procedures.

Be familiar with the Threshold Document to ensure an appropriate response to children and families.

Find out who your agency representative is to make sure the voices of the workforce, children and young people are heard.

Children and Young People

You are at the heart of the child protection system. We want to make sure that your voices are heard and that we know how you are experiencing the services in our Board partner agencies. If you would like to know more about how you can influence the work of ESCB please contact us.

www.enfieldlscb.org.uk/contact

Chief Executives and Directors

Show ESCB that your agency is committed to a culture of safeguarding.

Ensure your workforce contributes to the provision of ESCB multi-agency safeguarding training.

Have an open dialogue about any barriers that may impact on your organisations ability to safeguard children and young people.

Local Politicians

In 2015/16 Councillor Ayfer Orhan was lead member for children and families, making sure their voices are heard by the LSCB. She continues to fulfil this role in 2016- 2017, widely promoting the work of the Board to members communicating the core priorities and key safeguarding messages that everyone needs to be aware of.

All politicians should keep the protection of children and young people at the forefront of thinking when scrutinising and challenging any plans for Enfield.

The Community

You are in the best place to look out for children and young people and to report any of your concerns.

Safeguarding children and keeping them free from harm is everyone's responsibility, if you are worried about a child or young person please follow the steps on the Enfield LSCB website.

Follow us on Twitter and Facebook.

Role of the Board

Enfield Safeguarding Children Board is made up of statutory and voluntary partners. These include representatives from Health, Education, Children's Services, Police, Probation, Children and Family Court Advisory and Support Service (Cafcass), Youth Offending, the Community & Voluntary Sector as well as Lay Members.

Our main role is to coordinate what is done locally to protect and promote the welfare of children and young people in Enfield and to monitor the effectiveness of those arrangements to ensure better outcomes for children and young people. The effectiveness of ESCB relies upon its ability to champion the safeguarding agenda through exercising an independent voice.

Safeguarding children is everybody's responsibility. Our purpose is to make sure that all children and young people in the borough are protected from abuse and neglect. Children can only be safeguarded from harm if agencies work well together, follow procedures and guidance based on best practice and are well informed and trained.

A key element of the ESCB's work is the provision of information to and from the public, potential and actual service users, staff working in partner agencies and others interested in children's welfare. We work hard to ensure our website www.enfieldlscb.org is as helpful and up to date as possible.

Metropolitan Police – Total Policing

Enfield Council

Cafcass – Children and Family Court Advisory and Support Service

London Community Rehabilitation Company – Probation

Enfield Safeguarding Children Board ...because safeguarding children is everybody's business

London Probation Trust

LFB London Fire Brigade

Children & Young Persons' Services

Royal Free London NHS Foundation Trust

Barnet, Enfield and Haringey NHS Mental Health NHS Trust

North Middlesex University Hospital NHS Trust

Governance and Accountability

The Children Act 2004 places a duty on every local authority to establish a Local Safeguarding Children Board (LSCB).

The Government's Statutory Guidance, Working Together to Safeguard Children (2015) defines safeguarding and promoting the welfare of children as:

- protecting children from maltreatment
- preventing impairment of children's health or development
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- taking action to enable all children to have the best life chances.

This is to enable those children to have optimum life chances and enter adulthood successfully.

LSCBs do not commission or deliver direct frontline services although they may provide training. Whist LSCBs do not have the power to direct other organisations they do have a role in making clear where improvement is needed. Each Board partner retains their own existing line of accountability for safeguarding.

The Board met 8 times during 2015/16 and was attended by senior managers from statutory and voluntary organisations, and by Lay Members. Enfield's Lead Member for Children Services, Cllr Ayfer Orhan attends each board meeting and continues to challenge the work of the ESCB through discussion, asking questions and seeking clarity. This provides an important scrutiny and challenge function to the Board and further ensures the Board is supported by the Council.

Where there has been insufficient attendance or engagement at the Board, this has been appropriately challenged by the Independent Chair.

There are currently five Subcommittees operating within ESCB, in which a significant amount of the board's work is progressed. As with the full Board, membership is multi-agency. All Terms of Reference have been updated within the last year and there is recognition by all Chairs that the effectiveness and thoroughness of the Board requires that the work of each Subcommittee interacts with that of the others.

Key Relationships

Health and Wellbeing Board (HWB)

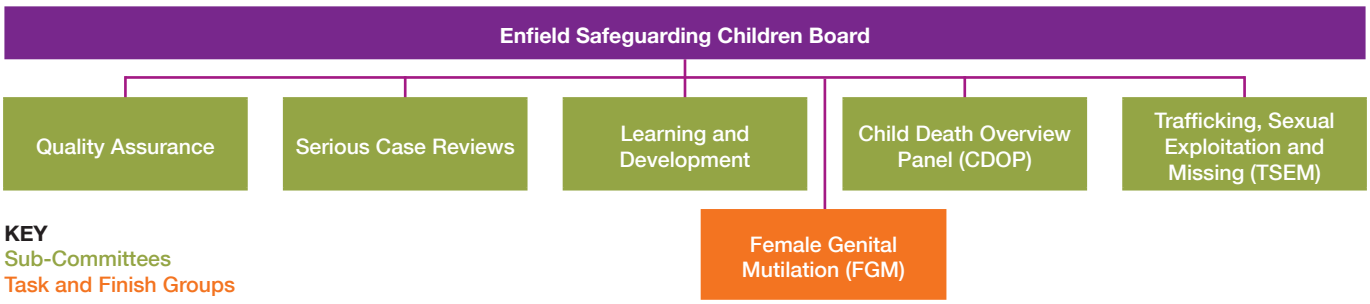
The HWB assumed its full statutory powers in April 2013 and the ESCB Chair is now a participant observer, increasing the influence of the Board by strengthening the relationship with this key strategic group. Clearer lines of accountability have been developed over the year and ESCB report regularly to the HWB and continue to make sure key safeguarding issues are addressed.

Safeguarding Adults Board

The ESCB Chair is a participant observer on the Adult Safeguarding Board and the Chair of the Adult Safeguarding Board has been a participant observer at the ESCCB.

Member Agencies Executive Management Boards

Board members are senior officers within their own agencies; this provides a direct link between ESCB and the various agencies' Boards.



Monitoring and Evaluation

This section provides some analysis of the work that has taken place in terms of developing a robust approach to Quality Assurance and Performance Monitoring. There are summaries of some of the key learning arising from our audit activity and detailed information on the ESCB's effectiveness in monitoring the safeguarding system, including **Section 11 Audits, and Management of Allegations of Adults working with Children**.

There continues to be a healthy and effective culture of accountability and challenge across the ESCB and the Quality Assurance Sub Committee continues to work to improve the quality of service improvement and delivery of outcomes consistently across the partnership. The majority of monitoring and evaluation of multi-agency practice is monitored through the subcommittee which meets on a six-weekly basis. The group's key areas of focus are:

- To monitor and ensure compliance with the ESCB Performance Dataset and to report key findings and areas of concern to the board;
- To ensure partner agencies' compliance with Section 11 Audit Tool;
- To commission and oversee focused audits regarding performance and compliance with procedures and policies as necessary;
- To closely monitor compliance with performance around the child protection processes, such as agency attendance at conference and core groups, numbers of children subject to CP Plans;
- To oversee the development and review of multi-agency policies and protocols and sign them off when completed;
- To monitor and scrutinise partner agencies internal Safeguarding activity and Quality Assurance work to ensure it is of a high and consistently standard.

Developing our approach to Section 11...

ESCB conducts annual Safeguarding audits under **Section 11 of the Children Act (2004)** which deals with the duty to make arrangements to safeguard and promote the welfare of children in the local area by seeking assurance that agencies have effective and robust arrangements in place.

Last year, for the first time, return of the completed Section 11 templates was followed by a panel Section 11 challenge interview. The panel was chaired by the ESCB independent chair who was joined by LSCB members. At the conclusion of the meeting a short summary of the discussion was drawn up along with an action plan for the agency identifying where improvement and/or clarification was required.

This year we have continued to build on and expand this activity with a specific focus on our schools. Section 175 of the Education Act (2002) requires local education authorities and governing bodies of maintained schools and further education institutions to make arrangements to ensure that their functions are carried out with a view to safeguarding and promoting the welfare of children. In addition, those bodies must have regard to any guidance issued by the Secretary of State in considering what arrangements they need to make for that purpose of the section.

The ESCB developed a **Schools Safeguarding Checklist** to assist schools to assure themselves, and the Safeguarding Children Board, that they are compliant with Safeguarding requirements. It was sent directly to all schools and to governing bodies. The response from schools has been excellent with over 90% of our schools returning the checklist. Phase Two of the process has been to offer support visits to schools to help them review and strengthen their safeguarding arrangements with a particular focus on current challenges such as CSE and Radicalisation. So far six schools have either been visited or have arranged visits and the feedback has been extremely positive. We will continue to expand this approach in 2016/17 and will start to target those schools where concerns about safeguarding have been identified or raised.

Themed Case File Audits

Each year a range of themed case file audits are undertaken through the ESCB focusing on key areas of safeguarding activity. Some audits are undertaken by managers from within children's social care and our agency partners whilst others are completed by external, independent auditors. Audits undertaken in 2015/16 include:

- The **distance from their home** Looked After Children are placed
- Children who go **Missing** who are open to Children's Social Care
- **Private Fostering** Cases
- **Child Sexual Exploitation** (CSE)
- **Early Help and the Team Around the Family** (TAF)

As we would expect, a range of strengths and areas for improvement were identified through the audits and actions plans have been developed where necessary.

Some of the actions that have been implemented as a consequence of these audits include:

- Ensuring that **chronologies** for Looked After Children are up to date and include a meaningful overview of the case
- Ensuring all **Direct Work** undertaken with children is recorded clearly and consistently
- Development of a new **ESCB Threshold Document** for use across the partnership with particular focus on assisting decision making in the Single Point of Entry (SPOE)
- Development of a new Early Help Assessment Form to be used by agencies to refer to the SPOE. The new form both ensures that information is captured clearly and succinctly and adheres to the newly implemented **Signs of Safety Practice Model** that is being implemented across Enfield.

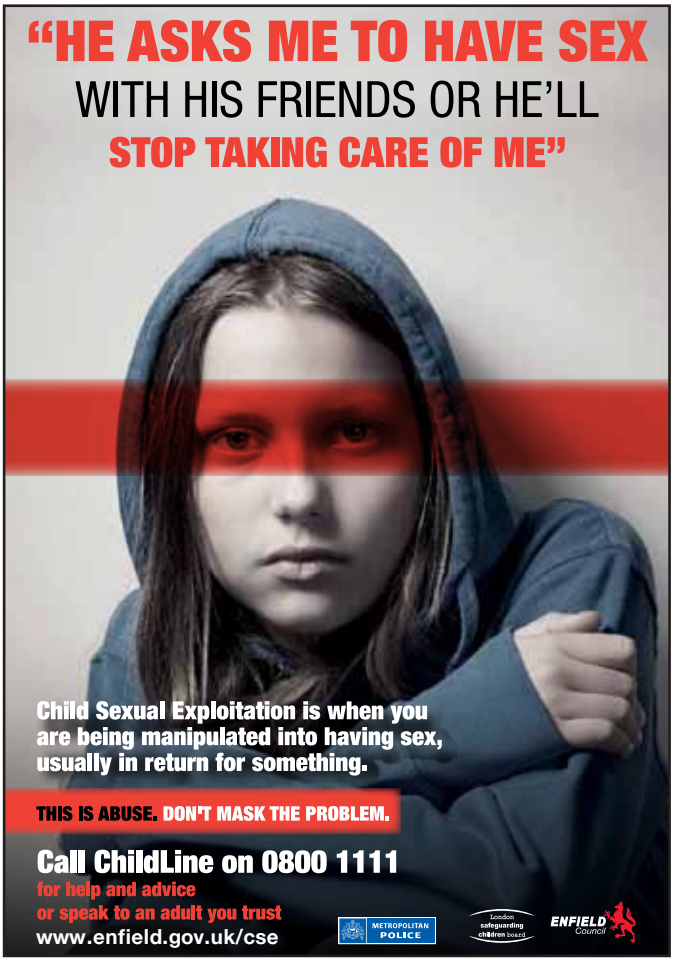
Child Sexual Exploitation and Missing Children

This has again been a very active year in relation to our work to identify and tackle Child Sexual Exploitation (CSE) and the links with children and young people who go missing. We were very pleased to endorse and support the establishment of a multi-agency Child Sexual Exploitation Prevention (CSEP) Team in July 2015. The team consists of Social Workers, Police officers and support workers who manage and/ or provide support for all cases where CSE is an issue.

The Trafficking, Missing and Sexual Exploitation (TSEM) sub-committee, continue to oversee our CSE strategy and action plan which has evolved and developed as our understanding of needs and requirements have grown. We have updated both our CSE and our Missing children operating protocols and published them on our website. For the first time our Missing Protocol covers guidance on what to do when working with children who go missing from Education and Health as well as from Home and Care.

At the start of year we joined with Haringey Safeguarding Children Board to successfully bid for funding from the Department for Education Innovation Fund to develop a **Cross Borough Vulnerable Young People's project** which looked specifically on the needs of children and young people at risk of child sexual exploitation (CSE) within and across the two boroughs. The project aims, all of which are on track are to:

- Increase responsiveness to and prevention of, CSE, trafficking, gang activity and missing children incidents across the two boroughs through improved intelligence and analysis of the needs of vulnerable children and young people.
- Improve the quality of joint working across the two boroughs and explore cost efficiencies in relation to safeguarding vulnerable children and disrupting and prosecuting perpetrators.
- Monitor, record and share learning about models of joint accountability and joint working across the LSCBs particularly to tackle CSE, trafficking, gang activity and missing rates to better safeguard children and young people.



The Project will run to June 2016 and will culminate in a Bi-Borough Learning event for partners to ensure learning and new processes and systems are fully embedded in both boroughs.

A member's CSE task group was established in June 2015 and meets four times a year offering strong leadership, oversight and scrutiny for the work undertaken to tackle CSE across the borough. The Task Group is due to report to the full council in May 2016.

The Borough has been part of the MsUnderstood North London Cluster – a project which brings together the six authorities within the cluster (Barnet, Camden, Enfield, Hackney, Haringey and Islington) supporting the collective focus on thematic issues of concern and enabling the sharing of relevant information across boundaries to build a cluster-wide problem profile of CSE (and within this peer-on-peer abuse and exploitation).

Training and Awareness Raising

We have continued to work with Safer London Foundation to provide training and awareness raising in relation to CSE. As part of the **Cross Borough Vulnerable Young People's project** we arranged a number of targeted training sessions for specific professionals across the two boroughs. Professionals benefiting from this training include, Social Workers, Police officers, and Community Safety unit staff, Pupil Referral Unit staff and Health Visitors and School Nurses.

Next Steps

Given the progress made on tackling CSE and Missing in Enfield and given the growing understanding nationally and locally of the complex, often intertwined issues that young people face and how they can impact on young person's life it is proposed that the good work achieved by the Trafficking, Missing and Sexual Exploitation sub-committee is built upon and expanded to include a focus on a number of additional area including; Youth Crime and Violence including gang related activity, Radicalisation and the Prevent agenda and Domestic Abuse and Violence Against Women and Girls.

The new group would link closely with other forums where these topics are already discussed and look to develop and implement a Vulnerable Young People's Strategy and Action Plan which would provide a cohesive and joined up approach to addressing the wider challenges vulnerable young people face. The group would of course retain a sharp focus on issues related to CSE and Missing but by also considering other issues the opportunities to develop wide ranging strategies and support mechanisms for vulnerable young people would increase. Timescales and full details are yet to be decided but it is expected that the new group will be operational in 2017.

Female Genital Mutilation (FGM)

In 2014, the public health team in Enfield estimated that 2,823 girls and young women under-18 years old were at risk of being subjected to FGM and 3,000 women in the borough had probably already fallen victim to this form of abuse. In 2015, City University published a study which estimated that there were 3491 women in the borough that live with FGM. This equates to an estimated prevalence of 21.6 per 1,000 women. This compares to 5.0 per 1,000 women in England and 21.0 per 1,000 women in London.

The Council formed a multidisciplinary group in 2013/4 which in the 3 years of its existence has overseen work to identify the number of women and girls in the borough at risk of FGM. Recently the team have provided training to social workers and members of the CCG. In addition partners in the voluntary sector continue to train professionals and deliver community development work with affected communities.

Iris – an FGM clinic located at the North Middlesex Hospital became operational in autumn 2015. It is staffed by a female Gynaecologist and specialist midwife. The clinic provides care and support for women who are experiencing problems as a result of FGM, and women are invited to discuss their health needs in a sensitive and non-judgmental environment. Interpretation is available on request and is confidential and private. Psychological and social support, and deinfibulation (reversal) are provided, as well as general gynaecology, sexual health and contraception advice. Over 250 women have attended since it opened and approximately 75% are Somali.

A half day workshop with all stakeholders took place in March 2016. This was held to consider a draft action plan and develop a strategy for FGM, given the FGM mandatory reporting guidance had been issued and the FGM chapter of the London Child Protection Procedures had been refreshed.

To take the work forward, the strategy is being developed. There is an action plan accompanying the strategy and the actions have been assigned. The majority of the actions are ongoing and there is an intention to hold a further workshop to agree the strategy. The strategy includes:

- Mapping services and the roles of the various voluntary sector organisations
- Refreshing protocols including clinical and referral protocols
- Working to co-ordinate better with the acute sector, including the IRIS clinic and the clinic being set up at Barnet
- Addressing an identified gap for health visitors and school nurses working with families affected by FGM and helping to devise a protocol for them.

Radicalisation and the PREVENT agenda

Prevent is part of the Government's CONTEST strategy and the Prevent strand is aimed at preventing people from becoming terrorists or supporting terrorism. Enfield is one of the Prevent "priority" authorities in London, which is reflected in the fact that we receive additional resources from central Government.

The Prevent duty placed an ownership on named sectors from July 2015 to recognise and refer vulnerable individuals for further Prevent support.

In Enfield we have been working to provide training and other resources to schools and similar organisations to have a better understanding of Prevent and to be able to contribute to its aims.

Many organisations have accessed a training tool called Workshop to Raise Awareness of Prevent (WRAP). This training has been provided a wide range of professionals in Enfield including teachers, social workers, housing staff, front line workers and health care workers.

This year a critical thinking project called 'Second Thoughts' was commissioned to support schools in Enfield. The project received favourable feedback from a number of schools on the way it was delivered.

The aims of this critical thinking project were to:

- provide young people with the opportunity to consider their opinions and how their world view is formed
- help young people to think critically about the information they receive and recognise the dangers of stereotyping and misinformation
- help young people to identify bias, propaganda, and symbolism in the media
- illustrate how easily divisions can be created between groups of people, which can escalate into conflict, and how to deal with it.

This project is now being made available to all secondary schools in Enfield.

In Enfield the main aim of the Prevent delivery remains to safeguard vulnerable individuals and to train appropriate staff so they are able to recognise and refer appropriate people for further Prevent support. Prevent referrals are treated in a similar way to other safeguarding referrals and professionals are instructed to complete an Early Help Form if they have concerns about a child.

Child Death Overview Panel

The Enfield Safeguarding Children's Board carries out Child Death Reviews as set out in the guidance 'Working Together to Safeguard Children 2015'. This process is performed by Enfield Child Death Overview Panel (CDOP).

CDOP is a multi-disciplinary subcommittee of the Safeguarding Children's board and is chaired by a Consultant in Public Health (CPH).

CDOP reviews each death of a child normally resident in the borough up to the age of 18, excluding babies who are stillborn and planned terminations of pregnancy performed within the law. Relevant information is collected and collated and each child's case is discussed to determine if the death could have been prevented. The intention is not to assign blame, but to determine if there were any modifiable factors that may have contributed to the death and decide if any actions could be taken to prevent future such deaths. If it is determined that there are such actions, recommendations are made to the Local Safeguarding Children's Board (LSCB) or other relevant body so that action can be taken accordingly.

Where a death is unexpected a rapid response meeting is usually convened. These are convened and chaired by the designated paediatrician and are held as soon as possible. These meetings are held to ensure that all the relevant information is gathered as soon as possible and any relevant actions are taken accordingly.

The panel also has a role in identifying patterns or trends in local data and reporting these to the LSCB. The lessons and trends arising from reviews are compiled and reported to the main Board and information or health promotion campaigns are carried out as appropriate – this has included in the past information events on Sudden Infant Death Syndrome which were held in conjunction with other Boroughs and learning events to inform professionals of the work of the safeguarding board and CDOP.

Due to the time it can take for death's to be reviewed the data for CDOP activity is a year behind. Between April 2014 and March 2015 a total of 17 deaths were reviewed by the Panel. In this same time period there were 5 rapid responses for unexpected deaths.

Of the deaths that were reviewed in 2014/15, three (18%) were found by the Panel to have modifiable factors.

Thirty per cent (5/17) deaths were neonatal/perinatal events and 47 per cent of deaths (8/17) were in children where there was a known life-limiting condition.

Future challenges

The paediatric assessment unit at Chase Farm Hospital and the arrangements for out-of-hours care in the borough are currently being reviewed.

Demographics in the borough are rapidly changing due to new building in the borough, regeneration and an increase in the borough population due to cheaper housing in Enfield compared to surrounding boroughs.

Achievements

A closer working relationship between CDOP and the SCR panel has been developed with an agenda item on each panel to share cases and concerns rather than each panel looking at these in isolation. The Chair of CDOP also now attends the SCR sub-committee.

Work is ongoing on reducing the number of SUDIs in the borough, with the production of a CCG funded booklet on child health that was translated into a number of community languages and the distribution of materials from the Lullaby Trust.

Serious Case Reviews

In England a serious case review (SCR) takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. It looks at lessons than can help prevent similar incidents from happening in the future.

The SCR subcommittee of the ESCB meets quarterly and reviews and follows through actions from previous Serious Case and other Reviews. This ensures that any lessons learned are implemented. Learning events are planned and delivered to agency partners on lessons arising from serious case reviews both locally and nationally.

In 2015/2016 the ESCB has published two Serious Case Reviews. In accordance with guidance, both were anonymised.

In May 2015 Enfield and Haringey Safeguarding Children Boards jointly published the Serious Case Review (SCR) report for **'Child CH'**.

The Serious Case Review concerned the murder by CH then aged 15, of a young man who was unknown to him. The Overview Report stated that the circumstance of the death and CH's involvement, could not have been predicted. However, through looking at the work of all agencies involved with CH and his family, the report recognised that there were a number of areas of learning and improvement for partner agencies as well as evidence of good and effective practice. Agencies could, and should, have responded differently at key points.

In January 2016 the ESCB published the Serious Case Review (SCR) report for **'AX'** which involved the death of a 17 year old male who was stabbed at the end of 2013. AX spent much of his life in Barnet and was engaged with a number of agencies there and so throughout the process of the review Enfield Safeguarding Children Board worked closely with colleagues from Barnet to ascertain what happened and when and to identify how we can collectively learn from the premature death of this young man.

The report concluded that the circumstances and timing of AX's death could not have been directly predicted by any of the agencies with which he had been in contact but did identify possible opportunities for changing the outcome or influencing elements in this and future cases.

For both of these reviews comprehensive Action Plans were developed from the recommendations which have been implemented and monitored through the sub-committee. In both cases the action plans have been completed.

In addition to our own two SCRs the sub-committee has also focused on other related issues. These include:

- Serious Case Reviews undertaken by other local authorities where an Enfield agency had some involvement. In the last year this includes reviews undertaken by Haringey, Barnet, Waltham Forest and Croydon. In all of these cased the sub-committee has monitored the recommendations and actions and supported partner agencies to ensure they are completed.
- Serious Case Reviews from other boroughs across the country where there are issues and recommendations that are relevant to us. These include a review undertaken in Hackney which looked at the sexual abuse of children in Foster Care. In Enfield we used the recommendations to develop an Action Plan to ensure supervising social workers and Foster Carers were aware of failings that the report identified and to assure ourselves that robust processes are in place to prevent such failings happening here.
- Following a new inquest into the death of baby in Enfield in 2011 which changed the previous finding regarding who was likely to have caused his death we wrote to the Metropolitan Police Serious Crime Review Group and successfully requested that they review the case and the Police investigation into it.

Enfield Young Safeguarding Champions

After a very active year in 2014/15 there have been a hiatus in the activity of our young safeguarding champions in 2015/16. This has largely been a consequence of structural changes and diminishing resources within Enfield children's services. However, there is a clear plan in place to ensure there is strong engagement and consultation with young people moving forward which involves engaging with our Youth Parliament and other young people's groups. Representation of young people in the activity of the ESCB will be a core part of our Business Plan for the coming year.

Signs of Safety

Enfield Safeguarding Children Board (ESCB) and its partners, including Enfield Children's Social Care have committed to implementing the Signs of Safety framework. The comprehensive implementation plan has been approved and endorsed and funding has been secured for the next 2 years to help move this important project forward.

This means that we are making some significant changes to the way we work with children, young people and families to ensure they are always at the centre of the work we do.

What is Signs of Safety (SoS) and why we are implementing it in Enfield?

Signs of Safety is an integrated framework for working with vulnerable children and their families, that is underpinned by key principles – developing and sustaining working relationships with children, families and professionals; having a questioning approach, remaining opened minded; and keeping the work grounded in everyday practice.

- SoS is an internationally recognised model for direct work with children and families.
- It is an outcome-focused, strengths-based model with a robust risk management framework & includes a range of principles, processes and tools to guide the work.
- Enfield is currently implementing the SoS to re-position the children's service at the centre of cutting edge social work research and practice (Munro review) and have a clear practice based model that can be used across all professions not just social work.

What we have done so far?

- Established a multi-agency **steering group** and a separate **operational group** which meet regularly to drive the implementation.
- Developed a full project plan which was signed off by ESCB, DMT and Enfield 2017 Design Authority.
- Hosted 2-day Signs of Safety training on 4 occasions delivering in depth training to 120 professionals. Arranged two further 2-day training sessions for October and provisionally booked the specialist 5-day training session for up to 30 professionals in December.
- Delivered SoS short briefings' to well over 400 practitioners across the borough.
- Included half day workshops for partner agencies as part of the annual ECSB Training programme.
- Worked closely with the Enfield 2017 IT team to identify IT changes and solutions required to fully implement the SoS (Smartboards, changes within Liquid Logic).
- Secured the funding through the 'invest to save' for the project to go forward.
- Review relevant policies, procedures, literature and assessment forms and made amendments to ensure they reflect SoS practice model.
- Begun the pilot period for Child Protection conferences in June 2016.

What's in progress?

- Recruitment of a SoS Practice Coordinator to lead the project for the next two years.
- Implementation of monthly practice meetings with Practice Leads and case workers.
- Ongoing review of the success and lessons learned during the pilot period ahead of full go-live in the autumn.
- Development of a Quality Assurance Framework You can find additional information and guidance on our Signs of Safety webpage.

Learning and Development

ESCB has a responsibility to develop policies and procedures in relation to the 'training of persons who work with children or in services affecting the safety and welfare of children…to monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children' *(Working Together, 2013)*

With oversight from the Joint Adults and Children's Learning and Development Subcommittee, a Training Strategy and a comprehensive multi-agency training programme is developed and delivered by the ESCB and this continued in 2015/2016. Issues from national Serious Case Reviews (SCRs) and other case reviews were considered, considered and incorporated to ensure that the content of the training programme related to emerging issues of concern, as well as to core safeguarding learning, that all practitioners working with children and their families need to understand. The decision was taken at the start of the year to merge the adults and children's sub-committees. This has allowed us to identity areas of crossover and ensure that where relevant, such as for training on Domestic Abuse, professionals who work with adults and children are brought together to maximise effectiveness.

It has been a very active year for Training. Key drivers and priorities for the Training Programme have included:

- The implementation of the **Signs of Safety** model
- The development of the **Child Sexual Exploitation (CSE)** Strategy and activity to identify and tackle CSE in Enfield
- Awareness raising around the issue of **Female Genital Mutilation (FGM)**
- Increasing awareness of understanding of gang related issues and links with other issues, such as CSE.
- The development of the **Multi-Agency Safeguarding Hub (MASH)** and the **Single Point of Entry (SPOE)** service
- **Domestic Abuse** and **Violence Against Women and Girls**

A total of **1,118** places have been filled at ESCB learning events this year compared with **553** last year.

Attendees have been from the following sectors:

Children's Social Care	261	23.3%
Education	228	20.4%
Independent and Voluntary	178	15.9%
YFSS	129	11.5%
Health	118	10.6%
Other LBE	80	7.2%
CAMHS / EPS	49	4.4%
Out of Borough	31	2.8%
Police	17	1.5%
Other	11	1.0%
Foster Carers	10	0.9%
Probation	6	0.5%
	1,118	**100.0%**

Comments

- Enfield has a very active Independent / Voluntary sector which, as in previous years, has been very well represented and multi-agency training events.
- Attendance from Health and Education settings is significantly higher than last year.
- Attendance from Police colleagues remains low but is significantly higher than previous years.

Evaluation and Impact

Attendees at all learning events are asked to complete paper evaluation immediately after the event. Completion rates have been very good. In addition to answering questions about their overall perception of the course attendees are asked whether they think the course will be effective in improving their practice.

This data provides extremely helpful information both about the relevance and quality of the course itself and about the skills and knowledge of trainers we commission. Follow up evaluations for selected courses are sent after 6 weeks to develop understanding of how learning events impact on work with children and families and thereby improve outcomes for children. Completion rates have been lower but there have been some returns which offer important insights into how training can improve practice.

The effectiveness of ESCB training is also monitored through the quality assurance and audit programme. Findings are incorporated into ongoing Training Needs Analysis and are used to inform ongoing training and development.

All courses delivered this year have been evaluated positively.

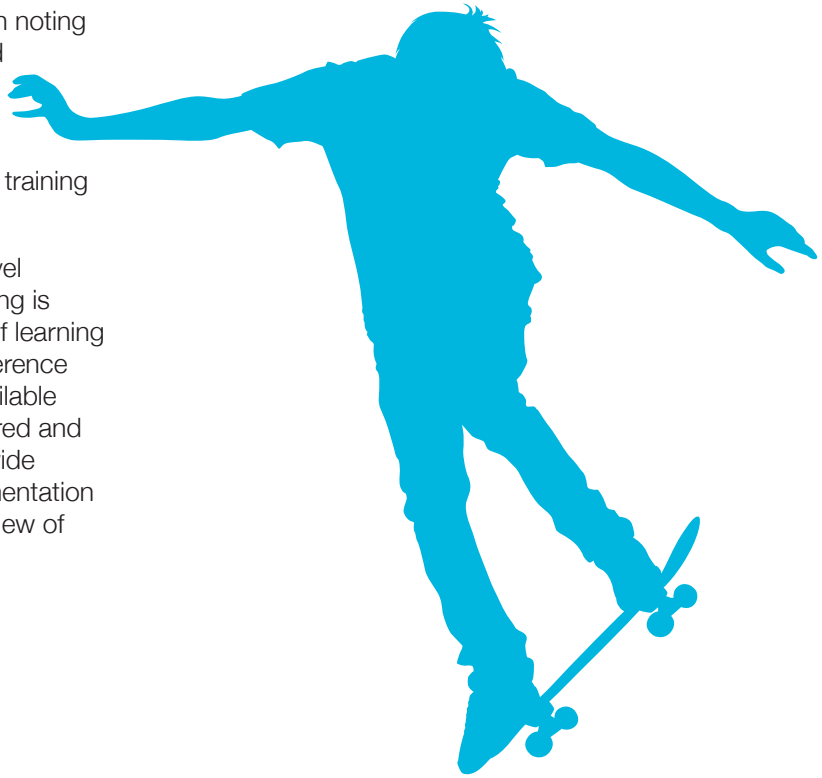
For 2016/17 we are introducing an online evaluation tool which will considerably enhance our ability to understand and measure the impact of our training.

ESCB Finance and Resources

All LSCB member organisations have an obligation to provide LSCBs with reliable resources (including finance) that enable the LSCB to be well organised and effective. Resources include staff time and additional support such as attending Board meetings, co-chairing the subgroups which support the work of the Board, and contributing to Serious Case Reviews.

In 2015/16 the Board had a budget of £184,910 which was made of contributions from our partners. Approximately 78% of the total budget was contributed by the London Borough of Enfield and the CCG was the next highest contributor with approximately 18% of the total budget. It has been noted across London that the level contribution to Safeguarding Children Boards from the Metropolitan Police is significantly lower than that made by the other large urban Police Forces in England. Enfield Safeguarding Children Board supports the ongoing efforts of the London Safeguarding Children Board to address and seek a resolution to this issue.

The ESCB managed to spend within budget during the year primarily because there were no new Serious Care Reviews in 2015/16 which are regularly a high area of expenditure for Safeguarding Boards. 80% of the overall budget was spent on staffing costs including the independent chair and 16% was spent on Serious Case Reviews and Learning & Development. It is worth noting that almost twice the amount of people attended training and Learning and Development events in 2015/16 than in 2014/15 with no increases in measurable cost. This was a consequence of increased use of skilled internal staff to deliver training rather than commissioners external trainers.



For 2016/17 the board is asking for the same level of contributions from its partners to ensure funding is adequate to continue to deliver the wide range of learning and development opportunities including a conference in early 2017, to ensure there is contingency available for any Serious Case Reviews that may be required and to support the transition towards any borough-wide Safeguarding structures that may require implementation following the DfE commissioned Alan Wood Review of Local safeguarding Boards.

Statements from ESCB Partner Agencies

The ESCB is very much a partner organisation. Whilst much of this report focuses on what has been undertaken at a partnership level it is important too to ensure that each member agency is undertaking effective safeguarding work individually. This section focuses on what each partner had achieved in 2015/16 and what impact it has had on the lives of children and young people.

Enfield Clinical Commissioning Group

NHS Enfield Clinical Commissioning Group's (CCG) priority is to ensure children remain safe whilst they are receiving health care in Enfield. This priority remains at the heart of all commissioning planning and decision making. We have continued to work in partnership with all agencies in the health economy to achieve this and make sure that all health providers in Enfield understand their role in the health and wellbeing of children and young people.

Enfield CCG recognises their statutory duties and responsibilities to safeguard children and young people, which include being a statutory partner of the Enfield Safeguarding Children Board (ESCB).

NHS Enfield CCG has a statutory responsibility to ensure that the organisations from which it commissions services provide a safe system that safeguards children and young people. Safeguarding clinical expertise in the CCG is provided through the Designated Nurse and Doctor for Safeguarding children. The CCG has specific responsibilities for children looked after and supports the Child Death Overview Process. The CCG has secured the expertise of a Designated Nurse and Designated Doctor for Looked After Children and a Designated Paediatrician for the Child Death Overview Process.

What did we do?

- Organised a 1 day safeguarding children and adults at risk conference in July, 2015
- Co-ordinated a 1 day safeguarding symposium for Enfield primary care staff
- Supported the Identification, Referral to Improve Safety (IRIS) project for Domestic Violence
- Delivered PREVENT training to GPs
- Delivered safeguarding training to community pharmacists and dentists
- Co-ordinated and delivered 4 level 3 safeguarding children updates for GPs
- Supported the business case for the Female Genital Mutilation (FGM) clinic at NMUH
- Held quarterly strategic safeguarding committees for Named leads from each health organisation, including private organisations
- Facilitated quarterly safeguarding lead GP forums
- Undertook extensive deep dive into safeguarding arrangements moderated by NHS England (London)

How well did we do it?

- 150 delegates from across the health economy trained in safeguarding children and adults at risk at the 1 day conference in Forty Hall
- 80 delegates – mixture of GPs and primary care staff attended with excellent feedback
- 61 GPs trained in Prevent
- 25 community pharmacists and dentists trained in safeguarding
- 102 GPs trained to Level 3 with updates on referral pathways, substance misuse, domestic violence, FGM and Child Sexual Exploitation
- CCG assured as good by NHS England (London)

How did we make a difference?

- Maintenance and meaningful updates of level 3 safeguarding training for all healthcare staff
- Improved quality of safeguarding care and knowledge through GP engagement and case discussions
- 207 referrals to IRIS service
- Increased understanding of referral pathways to Single Point of Entry and Compass
- Increased awareness of FGM and FGM clinic
- Ensured named leads for each organisation, including the GP safeguarding leads had opportunity to meet regularly to share practice, hear updates and developments in local and national guidance

NHS
Enfield
Clinical Commissioning Group

North Middlesex University Hospital

What did we do?

- Gangs – 2 gangs youth workers in post to cover Enfield and Haringey; official opening of service November 2015 1 year on; Gangs audit undertaken; Named Doctor presented at National conference (RCPCH)
- Early adopter site for CP – IS
- Development of FGM clinic supported by specialist Midwife for FGM
- Training on FGM delivered in local schools to teaching staff and at national Quality and Diversity conference by Named Doctor
- Training delivered to local youths working with Gangs youth workers by Named Doctor and Safeguarding Advisor
- Development of a substance misuse clinic for pregnant women supported by COMPASS

How well did we do it?

- Engaged with partner agencies with cross Borough initiatives – CSE and Gangs
- Local and national links with FGM, Gangs
- Received press coverage local and national for Gangs work
- Supported cross Borough initiative for 'keep safe bag' for young people attending A&E
- Received press coverage local and national for FGM services offered

How did we make a difference?

- Raised awareness in local community and nationally regarding Gangs work
- Improved care pathways – CSE, Gangs
- Improved information sharing between health colleagues – co -located with Liaison Health Visiting teams Enfield and Haringey
- Improved Staff knowledge and awareness with improved compliance levels

Barnet, Enfield and Haringey Mental Health NHS Trust

Overview 2015 -2016

Barnet, Enfield and Haringey Mental Health NHS Trust remains committed to safeguarding all our service users, their families and carers. We recognise that effective safeguarding is a shared responsibility which relies on strong partnership and multi-agency working. Over the last 12 months The Trust has strengthened its safeguarding arrangements in many ways including the recruitment of a full-time Head of Safeguarding. We are continually improving systems and processes; and developing a clear strategic approach to safeguarding across all our services.

Internal governance arrangements

Our aim is to ensure there is a whole organisational approach to safeguarding patients and service users, their families and carers. In order to do this we have developed an Integrated Safeguarding Committee (ISC). The ISC is chaired by the Executive Director of Nursing, Quality and Governance and provides strategic leadership and oversight. The work of the ISC is informed by our newly developed Safeguarding Strategy and overarching work plan. The ISC meets each quarter and is accountable to the Trust Quality and Safety Committee. The Executive Director of Nursing, Quality and Governance is the Executive lead for safeguarding and provides bi-monthly safeguarding updates to the Trust Quality and Safety Committee. In addition an annual safeguarding report is provided to the Trust Board. Safeguarding is a standing item for each of the Borough Clinical Governance meetings.

Safeguarding Children work undertaken and key achievements in 2015-2016

- The Domestic Violence and Abuse Policy has been updated.
- Domestic Violence and Abuse training have been included in Corporate Induction for all staff and is usually delivered by an IDVA.
- The Trust Safeguarding Children Policy has been updated to ensure it is in line with Working Together 2015 and the revised London LSCB Procedures.
- A safeguarding inbox has been set up to allow improved monitoring of safeguarding referrals made by Trust staff and a screen saver has been established to prompt staff to use it.
- A safeguarding dashboard has been designed to enable easier monitoring of safeguarding activity.
- A prompt to consider safeguarding has been included in the Trust incident reporting system (Datix).
- Prevent Training has been included in Corporate Induction for all staff.
- An Integrated Safeguarding Committee has been established with clear terms of reference.
- A safeguarding strategy has been completed with key aims and objectives.
- A safeguarding training strategy has been completed.
- We have met the target of 80% of eligible staff attending Safeguarding Children Training at each level.
- The safeguarding surgeries have been recognised as good practice.
- The safeguarding team champions meetings have been re-established in each borough.

Key Challenges

- Safeguarding practice is complex and varied. The challenge of collecting accurate meaningful data is recognised. Work continues to ensure data is captured and analysed effectively.
- To continue to develop and improve systems to promote effective lessons learnt from safeguarding incidents and inter-agency case reviews.
- To increase the number of staff undertaking level three training to help ensure that safeguarding children is embedded in everyday practice and is everybody's business.
- To ensure the challenge of working across three borough Safeguarding Children Boards and their associated sub-groups is managed effectively.

Safeguarding children work planned for 2016-2017

The work of the Integrated Safeguarding Committee is informed by an overarching work plan which underpins the Safeguarding Strategy. The Strategy has five broad aims which form the overall framework of work going forward:

- To ensure safeguarding is everyone's business across the Trust
- Develop a dataset of information that allows effective monitoring of safeguarding activity and outcomes
- Develop a culture of learning with robust internal systems to support this
- Promote early help to prevent abuse from happening in the first place
- Develop seamless pathways that promote joined up working at every level.

Barnet and Chase Farm Hospitals NHS
NHS Trust

Royal Free London NHS Foundation Trust

What did we do?

- We continue to strengthen our governance structure through the Integrated Safeguarding committee and the relevant Trust committee's and Trust Board.
- Two Safeguarding Children Advisors (SCA) joined the safeguarding team one based at Barnet hospital (BH) covering Barnet & Chase Farm (CF), the other based at the Royal Free hospital (RFH) both, along with a specialist midwife, have received supervision training.
- The Trust now hosts three Independent Domestic & Sexual Violence Advisors (IDSVA's) in collaboration with Camden SafetyNet, Solace, and Victim Support. Two cover BH and one at the RFH. This training can be accessed by external Health colleagues.
- We continue to deliver a high quality safeguarding training to over 10,000 staff across the Trust.
- We have trained 4 CSE champions.
- We have contributed to 3 SCR's in the last year and have implemented the recommendations where applicable.
- We have continued to use audit to develop and strengthen safeguarding.
- Continued Policy development.
- We hosted an Integrated Safeguarding conference for 150 internal and external colleagues.
- We have harmonised domestic violence screening for the midwives across all three sites and community clinics.

How well did we do it?

- The SCA's are able to focus on frontline case work and make daily links with clinical areas. This has been very successful in supporting referrals but also providing external agencies with a point of contact.
- Since starting in July 2015 to March 2016, the IDSVA's have received 253 referrals:
  - 88% were female and 11% were male.
  - 49% came from RFH, 45% from BH, and 5% from CF, Edgware or other sites. We do not currently have an agreement to host an IDSVA at CF
- Our training figures for March 2016 have increased across all areas with level 1 87%, level 2 79% and level 3 85%.
- We have provided extensive training to staff at level 3 about identifying deliberate self-harm and the impact of social networks for children and young people. This learning is as a result of one of the serious case reviews we were involved in.
- We commissioned our internal auditors to review practice in our Outpatient clinics to see how robustly we identified children subject to Child Protection Plans. The audit identified some areas for improvement and we are currently implementing processes in clinic preparation to ensure we are able to identify which children have a CPP and ensure the allocated social worker is copied into the clinic letter.
- The safeguarding conference was evaluated as excellent by those who attended.

How did we make a difference?

- One of our IDSVA's and the named midwife for safeguarding children, along with a consultant obstetrician and a member of the security team received a team award for their 'Outstanding Contribution to Patient Safety 'recognising their management and care of a vulnerable pregnant woman suffering significant domestic abuse.
- We have begun to see more referrals for FGM and CSE being made.
- We have increased to amount of safeguarding supervision we can provide to staff.
- Through training and support staff in the young people's sexual health clinic were able to identify two young girls who were being sexually exploited, one a missing child, one a LAC child , and access emergency services to ensure the girls were taken to a place of safety.
- Our safeguarding children training at all levels is highly evaluated with staff identifying that it will support their practice.

Royal Free London NHS
NHS Foundation Trust

London Community Rehabilitation Company (Probation)

What did we do?

In 2015, London CRC focused on improving safeguarding children practice across all staff grades. Performance was driven by the Strategic Safeguarding Children Lead and the Safeguarding Senior Probation Officer lead.

A London CRC Child Safeguarding Performance Framework was launched in 2015, to measure and evidence the performance of routine tasks. The five key practice areas measured are as follows:

- Initial check to Social Services
- Response Received to Initial Check
- Management Oversight
- Home Visits

A lot of work has been undertaken in the past 12 months to raise awareness of frontline staff regarding London CRC's safeguarding responsibilities as well as their own professional responsibilities.

Work taken to achieve this has included:

- Regular safeguarding children practice messages distributed by the senior probation officer lead for child safeguarding. Subjects including CSE, Missing children, violent extremism, gang affiliation, the impact of parental mental ill-health, the impact of parental substance misuse, the categories of abuse and guidance on making referrals to children's social care.
- Implementation of the safeguarding children performance framework.
- Internal conferences held for children's champions.
- Briefings to middle managers re: safeguarding policies and procedures.
- Development of a Safeguarding Children Briefing pack which will be delivered to all London CRC staff this year 2016 – delivery monitored by the Professional Development and Learning department.

These improvements have been supported by a drive to ensure that all London CRC staff are provided with the necessary training to carry out their role in safeguarding children effecticvely. London CRC:

- Commissioned an independent audit of safeguarding practice across the organisation to inform future improvement plan.
- Commissioned a tailored mandatory training programme to be delivered across all staff grades.
- Encouraged staff to attend training delivered by local safeguarding children boards (LSCBs) and Mental Health and Safeguarding Awareness Training (MAST).
- Two training events for frontline staff and managers focusing on the impact on the impact of parental imprisonment on children were delivered in 2015 by Bernardos.

In December 2015, following an organisational re-structure, London CRC launched a new central MASH process on 7 December 2015. The new process is intended to reduce the amount of Probation Officer time spent on servicing the MASH and to increase the quality of information provided to the MASH in cases where the adult is actively managed by the LCRC. It was necessary to review the process as London CRC is now structured in a Pan-London model as opposed to the previous local delivery model. The new process remains under review and is being monitored closely by the designated safeguarding lead.

London CRC is committed to engaging service users effectively to assist them in complying with Orders set by the court. Where multi-agency work is undertaken in order to protect children linked to our service users, offender managers are expected to engage adults under our supervision throughout this process. In addition offender managers are expected to address safeguarding children concerns in risk management plans when completing OASYS assessments and they are also expected to devise sentence plan objectives with service users to promote positive outcomes with children they care for, or have regular contact with when concerns have been identified.

How well did we do it?

London CRC's performance in relation to completion of initial checks to social services and management oversight of cases with safeguarding concerns was poor at the beginning of 2015. However, by the end of 2015 performance had risen sharply in relation to both checks and management oversight of cases with safeguarding concerns to over 90% of cases.

Response to initial checks from Children's Social Care was lower and concerns have been raised from multiple local boroughs about the volume of checks and the pressure this has placed on local resource. This is being reviewed in collaboration with the London SCB and it is hoped a practical resolution will be achieved in due course.

In relation to home visits, the performance target is set at 60% due to the number of service users who are in custody at any given time and the number who are of no fixed abode. Performance in relation to home visits had improved from a low base to 40% and work is ongoing to continue performance improvement in this area.

Unfortunately due to a recent IT upgrade, we have been unable to use the performance framework to measure progress and have no up-to-date data. However, this is being actively resolved and the framework will be reviewed and refined to increase effectiveness.

Despite some significant improvements made by the CRC, MTCnovo commissioned a London CRC Safeguarding review in May 2015 which recognised the efforts made to improve safeguarding practice, however, also highlighted a number of presenting deficits. In response, the CRC commissioned a series of focus groups of a cross grade group of staff, to enquire into the reasons why efforts to improve practice had not been more effective. The findings of the focus group are being taken forward by the London Child Safeguarding Lead and an action plan will be overseen by the London CRC Child Safeguarding Board when this is set up.

London CRC Senior Leadership recognise that the CRC has made some positive improvements to practice over the past 12 months, despite significant organisational change. However, further improvements to practice and outcomes are necessary and there is a firm commitment to achieving this as a priority which is evident.

How did we make a difference?

A lot of work has been done in the past year to uplift safeguarding children performance and practice across London CRC. Equally, London CRC staff have been on a significant journey through the recent organisational re-structure and it has not been possible to date to evaluate to what extent the strategy and activities we have undertaken have made a difference to the quality of our work.

Quality assurance auditing will be prioritised over the next 12 months. London CRC has developed a new Quality Audit process whereby Senior Probation Officer's will carry out a case audit with each offender manager twice per year. The quality audit tool addresses specific aspects of safeguarding practice and it is envisaged that this will further embed practice improvements over the coming year and will be launched on 31/5.

After the second round of auditing it will then be possible to identify trends in terms of quality of practice and to highlight gaps and weaknesses which need to be addressed.

Enfield National Probation Service (Probation)

What did we do?

The National Probation Service (NPS) is committed to reducing re-offending, preventing victims and protecting the public. The NPS engages in partnership working to safeguard and promote the welfare of children with the aim of preventing abuse and harm and preventing victims. The NPS acts to safeguard children by engaging in partnership working including:

- **Strategic:** As a statutory partner, attending and engaging in Local Safeguarding Children Boards (LSCBs) and relevant sub-groups of the LSCB. Through attendance, the NPS contributes to the formulation of board priorities and the development of strategy, policy and procedures in relation to safeguarding children. The NPS shares knowledge of and skills in the risk assessment and management of offenders and contributes to the development of appropriate multi-agency training packages, which can be accessed by NPS staff. As a member of the LSCB, the NPS contributes to audit and performance monitoring, including contributing, where appropriate, to Serious Case Reviews (SCRs), other child protection reviews and child death reviews, and sharing and embedding into practice lessons learnt from such reviews.
- **Operational Management:** Middle managers must ensure that processes and procedures are in place to support the operational delivery required to safeguard children and to ensure an integrated approach to partnership meetings and multi-agency communication.
- **Operational:** Ensuring that the principles of safeguarding and promoting the welfare of children are integrated into every aspect of the work of the NPS. The NPS will make a referral to the local authority where staff have concerns that a child is in need or is experiencing, or is at risk of experiencing, abuse or neglect. The NPS works collaboratively with the Local Authority and other partner agencies to manage and reduce risks to children and to promote their welfare. This includes attendance at multi-agency professionals meetings and Child Protection Conferences as appropriate.
- **Operational:** Ensuring the identification and assessment of offenders who pose a risk to children and through appropriate and timely information sharing ensure that the Local Authority and other partner agencies are alert to the risks and that the offender is effectively managed to reduce the risk of re-offending. The NPS performs a vital role in providing pre-sentence risk assessment information and reports to the courts and provides assessments and reports for the Parole Board. The NPS is directly responsible for the supervision of those offenders assessed as posing high risk of serious harm during and after their imprisonment and on statutory supervision in the community.

How well did we do it?

Strategic: Regular attendance and engagement at board meetings and section 11 audits as required, dissemination of training from LSCB communicated to all Enfield probation staff.

Operational: Continued professional development of staff through performance objective of mandatory completion of e-learning of child safeguarding issues, this is followed by classroom training on child safeguarding. Enfield national probation service continues to have a dedicated member of staff attached to the MASH and SPOE to ensure information sharing about child safety and concerns is fluid between agencies as required, Enfield probation has a 'children's champion' probation officer who attends multi-agency pan-London safeguarding events to spread good practice and discuss issues pertaining to child protection.

Due to solid links with the SPOE and MASH Enfield probation is at an advanced stage in ensuring that information about children is shared and discussed through use of each other's IT systems and databases in real time from the local probation office- I am not aware of any other borough in London where this is working so well.

Enfield (as part of Barnet, Brent and Enfield cluster) was a top 3 performing cluster in London for 2015/16 in regards to its service level targets, whilst these don't directly measure targets linked to child safeguarding they demonstrate that the borough is performing well in its own right against its set targets.

How did we make a difference?

Through good use of IT systems information sharing is more fluid enabling a better and quicker exchange of information to check safeguarding issues. Through increased knowledge and information exchange the management of high risk offenders and offenders who present a risk of harm to children can be considered to be better managed with more well informed risk assessments and closer multi-agency working.

Through engagement within the MASH and SPOE more Enfield probation staff have attended local authority training events regarding the safeguarding of children leading to more informed and better connected staff.

Through more engagement with partner agencies we can consider ourselves making more of a difference through better understanding of partners' approaches to safeguarding and improving our own assessments and abilities to manage high risk offenders and subsequent safeguarding issues.

London Probation Trust

Metropolitan Police Service (CAIT)

What did we do?

The Child Abuse Investigation team that covers Enfield and Barnet investigated 760 offences against children during the financial year 2015 to 2016. The remit for the team includes all offences committed by family members and those with safeguarding responsibilities against children (including safeguarding professionals).

Hundreds of additional strategy discussion took place to discuss the safeguarding of Enfield children.

Police Conference Liaison Officers attended Initial and Repeat Case Conferences liaising with partners to ensure the best possible outcomes of families with children on Child Protection Plans.

How well did we do it?

In the financial year the team either cautioned or charged 208 cases, an increase of 70 from the previous year. 15 of those detections resulted in charges for rape, an increase in 2 of the previous year.

The team attended 100% of Initial Case Conferences.

How did we make a difference?

Working very closely with partners in Children and Social Care, Education, Heath, parents and together with numerous third party safeguarding agencies, difficult decisions were made daily to protect the children of Enfield. Reacting swiftly to allegations, fast time intelligence gathering and the swift collation of evidence has made a difference to the outcomes for children in Enfield who have been physically and sexually abused by those they previously trusted.

METROPOLITAN POLICE
TOTAL POLICING

Notes

Enfield Safeguarding Children Board
September 2016

www.enfieldlscb.org

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Enfield
Safeguarding
Children Board
...because safeguarding children is everybody's business