Enfield Safeguarding Children Board

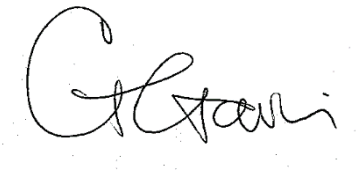
Annual report

2016 – 2017

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

Contents

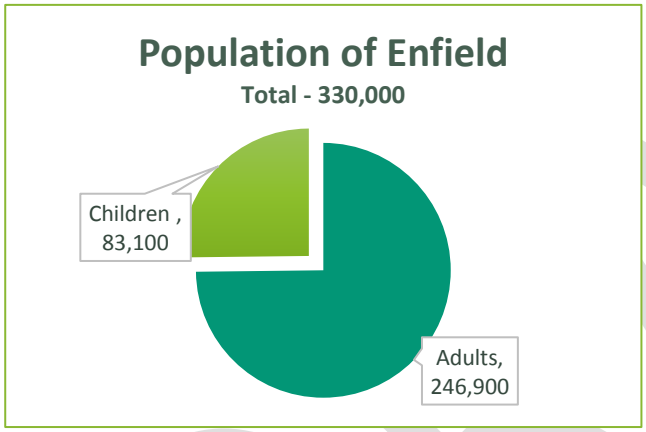
Introduction from the chair

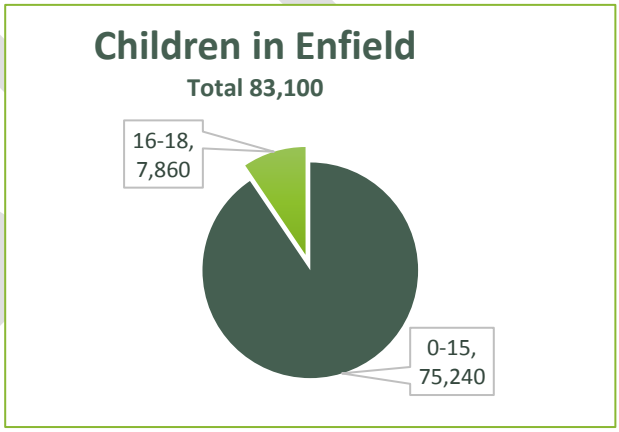


Enfield – a snapshot

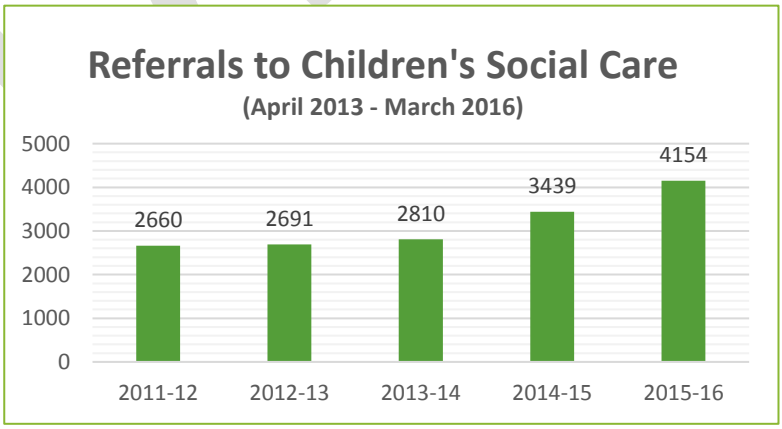
The London Borough of Enfield is London's most northerly and fourth most populous borough. The overall population is currently approximately 333,00 and this is predicted to rise to around 350,000 by 2020. There are currently approximately **83,100 children** (aged under 18) living in Enfield, making up **26% of the borough's population.** Enfield has a relatively young population with the number of children and young people aged 0-15 representing approximately 23% of the total population (compared to a London average of 14%).[1] Data from The Income Deprivation Affecting Children Index (IDACI) 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 has the largest number of children affected in poverty of any London borough.[2]

Enfield continues to experience significant changes to its overall population which includes an increase in overall numbers and a continued increase in the number of children in Enfield who affected by poverty. There is a high level of migration into Enfield both from other parts of the United Kingdom and from other countries, particularly from Eastern Europe.





Predictably, the numbers of 'contacts' and referrals that come into Enfield's Single Point of Entry (SPOE) have continued to rise. In 2015/16 there were 4154 referrals for children in Enfield which is almost 1500 more than five years ago, in 2011/12



[1] GLA London Datastore https://data.london.gov.uk/demography/

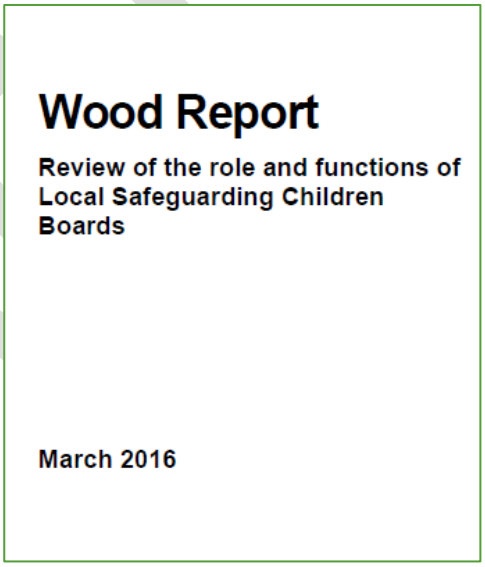
[2] English indices of deprivation 2015 https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

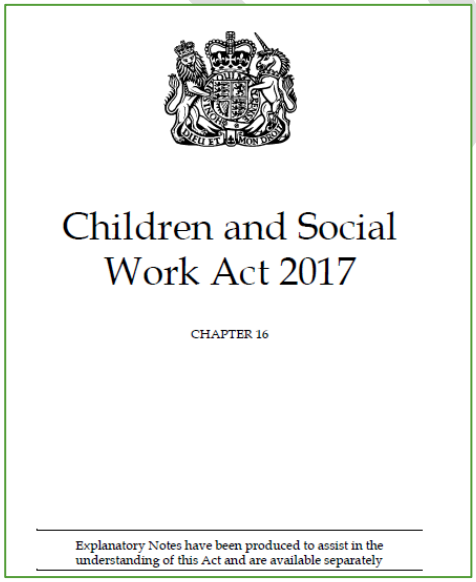
This has continued to bring increased pressure on services across Enfield in a climate of reduced resources in all areas and has led to an increase in the numbers of children who become subject to Child Protection Plans and who are 'looked after' by Enfield. You can read more about data relating to safeguarding and what the local response has been in the **ESCB Dataset section below**.

In Education, there is a mixed picture of grant maintained schools and academies and across the borough 97% of schools are judged by Ofsted to be 'Good' or 'Outstanding'.

ESCB in context

2016-2017 has been another very busy year for the Safeguarding Children Board. It has, to some extent, been a year of uncertainty following the publication of the Alan Wood review of local safeguarding children boards in May. The review recommended significant changes to the way safeguarding arrangements were structured across the country. The reason Alan Wood was asked to conduct the review was the perception by the Department for Education that Local Safeguarding Children's Boards were ineffective in delivering their key objectives. This was based on the fact that Ofsted, in their reviews of LSCBs under the Single Inspection Framework (SIF) had judged a large number of boards to 'require improvement' or to be 'inadequate'. The Enfield board was inspected as part of the SIF that took place here in March 2015 and was judged, along with Children's Social Care to be 'Good'. The Wood report made several recommendations including suggested changes to the way Serious Case Reviews (SCRs) are managed and the way the Child Death Overview Panel (CDOP) functions. These recommendations are referenced in those sections of this report but the most fundamental and significant recommendation made by Wood was that the government should make provision to abolish LSCBs and replace them with alternative local structures which would be less prescribed than LSCBs and would be the responsibility of three key agencies; the local authority, the Police and Health, to establish and manage. There recommendations became law with the publication of the Children and Social Work Act 2017 which received royal assent in April 2017.





Enfield Response

The ESCB has considered the report and subsequent Act on numerous occasions to plan a way forward which will both satisfy statutory requirements and continue to ensure that children and young people continue to be safeguarded effectively. There have been some specific changes to the structure of the board, which are discussed in more detail below but broadly our response has been to ensure that business is conducted as usual; that partners continue to come together regularly to discuss local challenges and how best to respond to them and that Training and Learning, including the dissemination of key points from local and national Serious Case Reviews, continues to be prioritised and undertaken effectively.

Executive Summary

As in previous annual reports the purpose of this executive summary is to give an overview of activity and progress made against the priority areas identified in our Strategic Business Plan. The current plan has been compiled with input from all partner agencies of the Board. The priorities have been identified from case reviews, statutory duties, local issues, and national as well as London-wide areas of concern. The work is carried out via the sub-groups of the Board and progress will be reviewed regularly. The overall objective of the ESCB is, as always, the coordination of what is done by each person or body represented on the Board for the purpose 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 (Section 14 Children Act 2004)

There are many tasks and activities which are part of the Core Business of the ESCB which are addressed over the course of the year in a variety of ways and outcomes and effectiveness are monitored through the subcommittees and the Board itself. There are also specific safeguarding themes which have been identified from local and national issues and drivers including Serious Case Reviews and the activity of the ESCB subcommittees which have been included among the priorities

Overall this has been a very positive year for the board despite significant changes and challenges. Importantly there remains a very strong commitment to the board and its activity from all its member agencies and organisations. This is evidenced both from the strong collaborative ethos and commitment to working together as well as by the single agency safeguarding activity undertaken by all members which is detailed in the Statements from ESCB partner agencies section below.

The Business Plan is 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.

Effective responses to specific safeguarding concerns

Child Sexual Exploitation / Missing / Trafficking

There has again been much activity and positive progress in this important area in 2016/17. An important development for the ESCB has been the establishment of a new subcommittee; the Vulnerable Young People (VYP) subcommittee which met for the first time toward the end of the year. The VYP replaces the Trafficking, Sexual Exploitation and Missing (TSEM) group which had been in place since 2012.

Given the progress made on tackling CSE and Missing in Enfield and 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 was proposed and agreed in early 2017 that the good work is built upon and expanded as part of a new **Vulnerable Young People** group. The new group was established in March 2017 and includes a focus on additional areas. These include:

- Gang activity in relation to young people

- A sharpened focus on Trafficking and Modern Slavery
- Radicalisation and the Prevent agenda
- Children & Young People involved in or at risk of Harmful Practices (including Female Genital Mutilation, Forced Marriage and Honour Based Abuse)
- Young people who are at risk of or experiencing Domestic Abuse.

The group oversees and closely supports the work of the Multi-Agency Sexual Exploitation (MASE) group which this year, has changed its focus to become more strategic looking predominantly at locations, themes, trends and cross border issues with discussion about individual cases covering only essential actions. This year the MASE has been involved in initiatives including;

- A Police 'Test purchase' operation with local hotels to check local responses to potential CSE issues. The responses were largely positive and the operation was followed by a training workshop for hotel staff.
- Targeted Police, Community Safety and youth worker activity around a local park where significant Gang and drug activity had been identified as well as CSE. This has led to a number of arrests and increased intelligence about the local picture

In July 2015, the *Missing Children Risk Management Group (MCRMG)* was established. Whilst not an ESCB subcommittee the work of this multi-agency group is linked closely to the VYP and MASE. The group is made up of representatives from all relevant agencies to enable and promote an enhanced service to ensure children and young people, who are or have a history of going missing from home, local authority care or education, are identified, safeguarded and supported. Initially the group primarily discussed young people who were missing from education but increasingly in the last year as the work of the group has become more widely understood, it has focused on high risk young people many of who go missing regularly. The active involvement of the Police has been key to the group's success.

You can read more about work undertaken in this area, including data and statistics in the Vulnerable Young People (VYP) subcommittee section below.

Domestic Abuse / Violence Against Women & Girls (VAWG): The board has continued to monitor and support activity related to VAWG throughout 2016/17. Iterations of the new Domestic Abuse strategy have been presented to the board on three occasions and board members have offered advice, direction and guidance. In early 2016 the new Joint Targeted Area Inspection (JTAI) framework was introduced. The purpose of this framework it to understand how effectively agencies in a local area are able to respond to specific issues. From September 2016 to March 2017 the theme was children living with Domestic Abuse. Whist Enfield was not inspected there was much activity across the partnership to map, understand and enhance our response to Domestic Abuse in Enfield. You can read more about work undertaken in this area in the Quality Assurance section below.

Radicalisation and Prevent

The board has continued to work closely with the Prevent service in the Community Safety Unit to ensure there is a high level of understanding of issues relating to Radicalisation and the response to it in Enfield. A key move has been incorporating a focus on Radicalisation as part of the new Vulnerable Young People subcommittee, recognising that this is one of many potential challenges and issues that young people in Enfield face.

Early Help

The board has closely monitored the development of the Enfield Family Resilience Strategy which is the basis for the local response to Early Help. Board members have offered scrutiny, challenge and direction as the strategy has developed. The ethos of the strategy is that we want all our children to be safe, confident and happy, with opportunities to achieve through learning and reach their full potential as they become adults.

Effective safeguarding structures & systems

As referenced above there have been come changes to the way the ESCB is structured both in response to national changes (the Wood Report and Children & Social Work Act) and a local shift in the way we are trying to address the challenges and issues experienced by young people in a consistent and joined up way (Vulnerable Young People subcommittee.)

NORTH MIDDLESEX HOSPITAL EMERGENCY DEPARTMENT PRESSURES – SPRING 2016

In the Spring of 2016 the Emergency Department at NMUH became so busy that patients were asked to leave unless their conditions were extremely serious. The issue made headline news both locally and nationally. Senior Paediatric staff were asked to assure the ESCB that safeguarding children issues were not being missed because of these pressures

In December 2016, the board had a presentation on an extensive audit that looked at every case where a child had left without being seen in the month of March.

The Board was assured that child protection issues are routinely picked up at triage stage and young children with head injuries are always treated as a priority.

The Board heard that there had many changes at NMUH including an increase in number of doctors; improved teaching programme for trainee doctors; and improved supervision. In summary, most patients who left without being seen could have been seen at a GP surgery

The Board was reassured by the very thorough audit, that there was no evidence that safeguarding issues were being missed despite the very significant pressures the Emergency Department has been experiencing.

MET POLICE HMIC INSPECTION – SEPTEMBER 2016

HMIC undertook a Safeguarding inspection across the Met in September 2016. The outcome was poor and identified concerns in relation to the Met's approach to protecting vulnerable young people. ESCB members from Enfield Police provided an update on activity being taken to address the problems and advised the board of activity taking place across the force. The new Police and Crime Plan for London 2017-2020 has three priorities:

- Tackling violence against women and girls;
- Keeping children and young people safe; and
- Standing up to extremism, hatred and violence.

Borough policing will move to a new model and pilots are currently running in other boroughs. Enfield is expected to merge with Haringey. The board was given assurance that safeguarding is at the forefront of all police work. A programme of safeguarding training for all officers across London has commenced. An action plan has been developed. The ESCB will continue to monitor progress both locally and across the Met.

Our Quality Assurance subcommittee continues to monitor data relating to safeguarding across the partnership and to oversee audits on a range of relevant topics. The group has pushed forward our Section 11 / Section 175 structure and programme this year to ensure we have the widest possible understanding of safeguarding activity across all agencies including in our schools. We have conducted a range of 'challenge interviews' all of which have concluded with feedback and action plans where required. You can read more about activity in the area and view some of the data considered by the QA group in the Quality Assurance section below.

The board itself has effectively offered challenge to partner agencies throughout the year and sought assurances that action was taken to ensure children and young people are safeguarded. You can read more about some of these in the sidebars.

Communication & Learning

The Board has continued to lead on and steer the direction of the Signs of Safety across the borough. We began our Signs of Safety implementation journey in the autumn of 2015 and since then a tremendous amount of progress has been made towards fully embedding the model within children's services and among partner agencies in Enfield. Over 800 professionals across the borough have not attend a Signs of Safety training or briefing session and there have many structural and process changes which have helped ensure the model and its principles are a core part of the way we work with children and families across Enfield. You can read more about Signs of Safety in the Enfield Children's Social Care section

This year the board has taken the innovative step of merging tis Learning and Development subcommittee with that of the Safeguarding Adult Board ensuring consistency, reducing duplication and improving quality. There have been a number of joint ventures including joint Domestic abuse sessions and a joint conference on Modern Slavery. There has once again been an extensive 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 once again delivered training and learning sessions to well over 1000 people professionals. Read more about training in the learning and the development section.

We 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 800 followers.

Conclusion and Challenges for 2016/17

2016/17 has again been another busy year for Enfield Safeguarding Children Board. It was a year that brought considerable uncertainty but we have made sure we have remained focused on our priorities and goals and have maintained an unrelenting focus on supporting our partner agencies and driving improvement and quality.

This report clearly demonstrates that safeguarding activity is being maintained across the partnership in challenging times and the that the ESCB continues to have 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 remains 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.

2017/18 will inevitably bring more change; we are likely to see statutory changes to the way Serious Case Reviews and child death processes and managed. We will ensure we stay abreast of developments and will seek and utilise 'best practice' examples both in these areas and as new safeguarding structures emerge across the country.

We will of course continue our focus on vulnerability and on issues that affect young people including; Child Sexual Exploitation, Missing, Trafficking and gang activity and will continue to explore ways of effectively bringing these issues together in a meaningful way to improve our response to them. We will maintain our focus on Domestic Abuse both on the ways parental domestic abuse can impact on children and on abusive relationships between young people.

We remain keen to enhance 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 will refresh our Strategic Business Plan and publish a new version if it, outlining our priorities and planned activity in the autumn of 2017

We hope that you find this report interesting and helpful. You will note that 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 wither through our social media channels or through the website www.enfieldlscb.org.uk/contact

Enfield's Lead Member for Children Services, Cllr Ayfer Orhan attends every board meeting and continues to challenge the work of the ESCB through discussion, asking questions and seeking clarity. This provides a consistent and continued scrutiny and challenge function to the Board whilst at the same time ensures the work of the board is fully understood and supported by the Council.

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 comprised of relevant representatives from all partner agencies.

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 two very active 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.

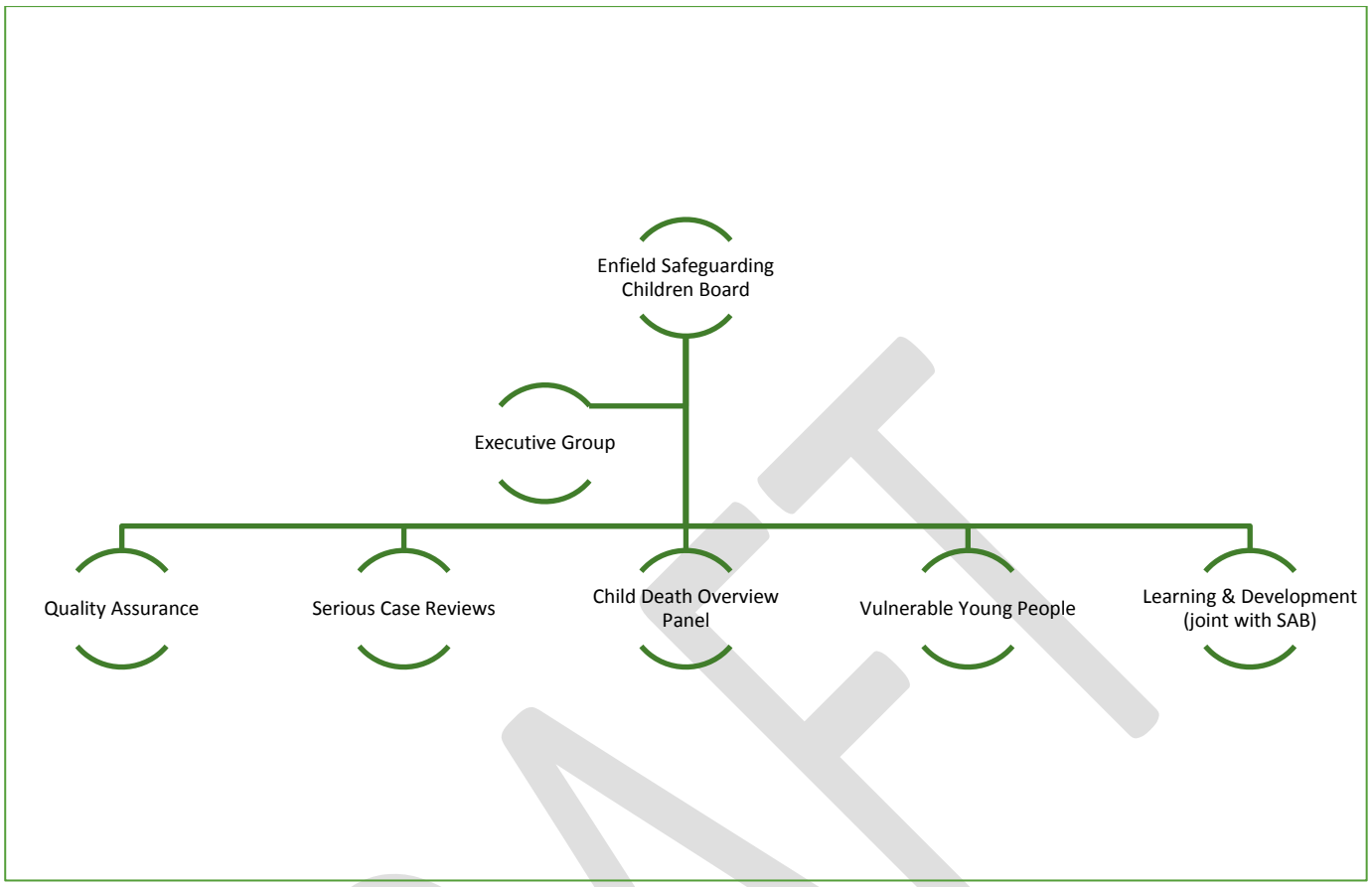
A key element of the ESCB's work is the provision of information to and from the public, potential and actual service users, staff working in partner agencies and others interested in children's welfare. We work hard to ensure our website www.enfieldlscb.org is as helpful and up to date as possible.

Governance, Structure and Accountability

The Children Act 2004 places a duty on every local authority to establish a Local Safeguarding Children Board (LSCB). Although, as mentioned above, the Children and Social Work Act 2017 makes provision to abolish LSCBs and establish alternative arrangements. Given the fact that the Enfield board has continued to operate effectively and efficiently with positive and proactive engagement of partners there are no immediate plans to make significant changes to the governance and structure of the board. This year we have reduced the number of times the full board meets. In 2016/17 it met on five occasions, and in 2017/18 it will meet four times. This decision was taken in consultation with partners, many of who are part of other LSCBs and all of whom are engaged with the ESCB in range of ways. We have established an **Executive Group** made up of the chairs of the ESCB's subcommittees which meets four times a year. The core functions of the Executive group are to; agree the priorities for the board and ensure that agreed actions are clear and completed. There have also been some changes to the way our subcommittees are structured including the creation of a **Vulnerable Young People** subcommittee and the amalgamation of the Learning & Development subcommittee with the equivalent committee of the adult board. You can read more about the activity of the subcommittees in the ESCB subcommittees section of this report

It is important to remember that the ESCB does not commission or deliver direct frontline services. Whilst the board does have not have the power to direct other organisations it does have a clear role in identifying where improvement is needed and steering agencies accordingly. Each Board partner retains their own existing line of accountability for safeguarding. You can read about some examples of where the board has identified potential safeguarding issues and sought assurance from partner agencies in the Executive Summary of this report.

Enfield Safeguarding Board Structure



Key Relationships

Health and Wellbeing Board (HWB)

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

Safeguarding Adults Board (SAB)

The ESCB Chair is a participant observer on the Safeguarding Adult Board and meets regularly with that board's new Chair, Christabel Shawcross to ensure there is dialogue and mutual understanding of priorities and initiatives. This year the Learning & Development subcommittees of the two boards have merged to improve and enhance the training programmes of both boards and to co-commission and co-deliver training where relevant. You can read more about the work of the Joint Learning and Development subcommittee below.

The subcommittees and related activities

This section provides some detail about the work and achievements of the five ESCB subcommittees. It includes some commentary and analysis of some activity that may be beyond the specific remit of the

committees but is directly connected to their areas of focus. For example, the Vulnerable Young People subcommittee section highlights the very wide range of work undertaken across the borough to tackle Child Sexual Exploitation (CSE) and related issues.

Quality Assurance (QA)

The Quality Assurance subcommittee meets every six weeks and is chaired by the Designated Nurse from Enfield CCG. Its primary functions are a) to implement, monitor and scrutinise a robust programme of audit and analyse the dataset to ensure safeguarding activity across the partnership is effective and b) to assure itself that safeguarding work undertaken by its partner agencies is of a consistently high standard.

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 2016/17 include;

- Missing Children
- Domestic Abuse
- Child Sexual Exploitation (CSE)
- Child in Need Plans and Decision Making
- Child & Family Assessments
- Signs of Safety
- Child Protection Plans for young people of 15 and over

Section 11 / Section 175

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.

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 201/17 and will start to target those schools where concerns about safeguarding have been identified or raised.

Serious Case Reviews (SCR)

The subcommittee's primary function is to undertake Serious Case Reviews for cases that meet the criteria as defined in Working Together to Safeguard Children 2015

A serious case is one where:

(a) abuse or neglect of a child is known or suspected; and

(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

The group also considers and discusses a range of other cases where concerns have been identified and follows up on actions previous Serious Case and Independent Management Reviews, both within and beyond Enfield to ensure that any lessons learned are implemented.

In January 2016 Enfield Safeguarding Children Board published a Serious Case Review for **'AX'** a 17-year-old male who was killed following an altercation with three other young men at the end of 2013. There were a number of learning points from this SCR relating the work undertaken with him by Youth Offending Units in both Enfield and a neighbouring borough and by the Police. Learning points and recommendations related to; lack information sharing, agencies not seeing or having the 'full picture', the significance of transitions and the importance of ensuring cases are transferred in an effective and timely way.

Learning and actions from this SCR along with key messages from an SCR published in 2015 were incorporated into a bespoke Training session on Enfield SCRs which was a core part of the ESCB Training programme for 2016/17. In addition to the delivery of four bespoke sessions during the year briefings on the learning from both SCRs was included in workshops delivered to the Youth and Family Support Service and providers of semi-independent accommodation. Reference to Enfield and other SCRs is a core part of the Designated Teacher Training programmes.

There have been three Serous Incident Notifications (SIN) submitted to Ofsted this year and one Serious Case Review has been undertaken. This involves the sad case of an Unaccompanied Asylum Seeking Child (UASC) who sadly took his own life very soon after arriving in this country. The review has been completed and the recommendations, which related to the board assuring itself that robust processes are in place for the effective communication between agencies of risks to young people, has already been actioned. Publication of the review however, has been delayed as a consequence of a coroner's inquest into the death.

A number of other high-profile or otherwise noteworthy Serious Case Reviews from across the UK have been discussed at the subcommittee for each of these briefing papers have been produced and disseminated to multi-agency partners. These include; a Serious Case Review in Cumbria which involved the sexual abuse of a young girl, two serous case reviews relating to Special Guardianship orders in Birmingham and Oxfordshire and a review undertaken in Hackney concerning children abused by their Foster Carers. This SCR was considered to be of particular relevance for Foster Carers and for Social Workers who work directly with them. As such the Head of Looked After Children produced an action plan

detailing a number of activities to ensure that a) Foster Carers and social workers were aware of the SCRs findings and b) that any relevant identified recommendations were also implemented locally.

In July 2016 Haringey Safeguarding Children Board published an SCR concerning a baby who was found to have been killed by his father. The SCR made a number of findings and recommendations in relation to the functioning of the Haringey Emergency Duty Team (EDT). As a consequence, a review of EDT arrangements in Enfield was undertaken and a restructure is currently in progress.

Child Death Overview Panel (CDOP)

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 multi-disciplinary Child Death Overview Panel (CDOP) which is chaired by a Consultant in Public Health.

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 ESCB or other relevant body so that action can be 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.

Vulnerable Young People (VYP)

The Trafficking, Sexual Exploitation and Missing (TSEM) subcommittee of the LSCB was established in early 2012. Its key function was overseeing Enfield's operational and strategic response to Missing and Child Sexual Exploitation (CSE). Meetings provided a forum for agencies to share operational issues with each other and also to provide transparent information on issues within their own agencies and to develop a strategy and protocols where required to deal more effectively with the issues and highlight any specific areas of risk. It has representation from all agencies working with children and young people in Enfield.

The subcommittee oversaw and steered the development of a number of key pieces of work in 2016/17 including the CSE and Missing operating protocols, the CSE strategy and Action Plan, the CSE Champions group, the Cross Borough Vulnerable Young Person's project, a comprehensive and expanding CSE Training programme and a number of awareness raising projects and campaigns including ongoing commitment to Operation Makesafe.

The subcommittee has played an important role in the development of Enfield's Multi-Agency Sexual Exploitation (MASE) meetings that have been in operation since 2013 and has provided support and

direction to Enfield's multi-agency Child Sexual Exploitation Prevention (CSEP) Team which was established in July 2015. TSEM has had strong link with the Missing Children Risk Management Group (MCRMG) which was established in Jul 2015.

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 was proposed that the good work is built upon and expanded to include a focus on a number of additional areas. These include:

- Gang activity in relation to young people
- A sharpened focus on Trafficking and Modern Slavery
- Radicalisation and the Prevent agenda
- Children & Young People involved in or at risk of Harmful Practices (including Female Genital Mutilation, Forced Marriage and Honour Based Abuse)
- Young people who are at risk of or experiencing Domestic Abuse.

There is already significant work to address these issues being undertaken in the borough. Much of this work is led by the Community Safety Unit (CSU). The Gangs Partnership Group (GPG) meets fortnightly and focuses on young gang nominals in the borough and helps to coordinate the work that to provide support and intervention. The Channel Panel meets regularly to consider referrals for young people for whom there are concerns related to radicalisation. Channel considers risk and coordinates plans and interventions for vulnerable young people. The Domestic Violence Strategic Group (DVSG) oversees the boroughs Domestic Abuse strategy and action plan and coordinates activity in relation to Domestic Abuse and Violence Against Women & Girls (VAWG)

The new Vulnerable Young People (VYP) subcommittee will not attempt to replace or replicate the work of these groups but instead to link closely with them and ensure that there is robust communication, closely allied work programmes and effective representation at the new subcommittee from the CSU groups.

Learning and Development (L&D)

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 & 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 **1118** places have been filled at ESCB learning events this year compared with **553** last year.

Attendees have been from the following sectors:

Total Attendees		%
Education	228	20.4
CAMHS / EPS	49	4.4
Children's Social Care	261	23.3
YFSS	129	11.5
Health	118	10.6
Independent and Voluntary	178	15.9
Other LBE	80	7.2
Probation	6	0.5
Police	17	1.5
Foster Carers	10	0.9
Out of Borough	31	2.8
Other	11	1.0
Total	1118	100

Comments

1. Enfield has a very active Independent/Voluntary sector which, as in previous years, has been well represented and attends multi-agency training events
2. Attendance from Health and Education settings is significantly higher than last year,
3. 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

The ESCB is funded through annual contributions from partners.

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 2016/17 and what impact it has had on the lives of children and young people. Each agency is asked four questions;

Enfield Clinical Commissioning Group

What did we do?

- Organised a Child Sexual Exploitation event with the ex LSCB chair from Rotherham
- Expanded the Identification, Referral to Improve Safety (IRIS) project for Domestic Violence to Community Pharmacists, Dental surgeries and Optometrists
- Co-ordinated and delivered 4 level 3 safeguarding children updates for GPs
- Facilitated quarterly safeguarding lead GP forums
- Continued to hold quarterly strategic safeguarding committees for Named leads from each health organisation, including independent health organisations
- Organised a 2-day safeguarding supervision skills course for Named leads in health organisations
- Ensured regular partnership meetings with social care to improve collaboration and representation of health views in child safeguarding cases
- Undertook a primary care safeguarding audit

How well did we do it?

- Child sexual exploitation training event positively evaluated by delegates including GPs, health visitors, school nurses and CAMHS staff
- Increase in the number of IRIS trained GP practices from 25 to 37

- 205 additional staff trained in the identification and management of Domestic Violence and abuse across GP practices, community pharmacists, and optometrists
- 95 GPs trained to Level 3 with quarterly updates on safeguarding children, adults at risk and Prevent
- 18 named safeguarding leads in children and adults at risk trained in safeguarding supervision across health organisations
- All GP practices participated in the audit of safeguarding

How did we make a difference?

- Improved knowledge through CSE event on the complexity of the recognition and management of child sexual exploitation
- Increased understanding of practitioners on the recognition of Domestic Violence and abuse and the referral pathways for victims/survivors
- Ensured named leads for each organisation, including the GP safeguarding leads had opportunity to meet regularly to share practice issues and receive updates on developments in local and national guidance
- Ensured named leads for safeguarding were equipped with the necessary skills to deliver effective safeguarding supervision of staff in their organisations
- CP medical pathway developed following discussion at partnership meetings
- Developed action plans for GP practices where gaps were identified within the audit process

What are we going to do next year?

- Organise a safeguarding conference for the health economy covering safeguarding children, adults and Prevent
- Continue to work with the IRIS project lead on increasing the numbers of referrals for services and the GP practices trained
- Embed the changes planned to review the deaths of children with a learning disability
- Raise awareness around Prevent and its links with children
- Increase representation and views of health professional in safeguarding assessments
- Increase capacity for input into child protection medical assessments
- Implement and monitor the action plans for individual GP practices following their audit

North Middlesex University Hospital

What did we do?

- Gangs – 2 gangs youth workers in post to cover Enfield and Haringey; additional support provided by the Tottenham Foundation youth workers; additional youth worker to work additional evening within A&E; audit undertaken on review of service which was positive from service users
- Early adopter site for CP –IS which is now embedded within paediatric A&E
- Established the FGM clinic supported by specialist Midwife for FGM
- Established the substance misuse clinic for pregnant women supported by COMPASS
- Development of a vulnerable woman clinic for high risk pregnant women
- Dr Hann gave a presentation to the December 2016 Enfield LSCB Board meeting on children who leave the A&E Department before treatment to give assurances around safeguarding responsibilities
- The NMUH Child Protection Policy was reviewed by the Named Doctor and ratified in April 2016. The Policy has hyperlinks to the LSCB website

- Dr Hann undertook a re audit on skeletal survey's since changing the skeletal survey policy. Comparing 2014/15 to 2015/2016 more skeletal surveys have been performed but more fractures have been picked up on skeletal survey and therefore there is justification for continuing the new policy and expanding our findings to other hospitals.
- Adult mental health services undertook an audit in relation to asking if the client had children to highlight the impact mental ill health will have on children in the family. Findings highlighted that very few were asked about children in the family. A tool has been developed that the question is asked as a mandatory question at assessment. This will support the 'Think Family' model and improve number and quality of referrals for children whose parents present with mental ill health
- An audit was undertaken to find out what adolescents think of the new adolescent grab bags with information on a range of local services such as sexual health clinics and mental health services that are currently being handed out from paediatric A&E -some of the hardest to reach young people who present to the ED. Many young people found the information provided useful and said would use /also share information with friends.
- The team participated in Enfield LA Stay Safe Week with presentations / stalls in the atrium daily - domestic violence; honour base violence; FGM; trafficking adults and children
- The team participated in JTAI preparation work and themed audits with both Boroughs
- The team were nominated and finalists in the Trust annul awards for their support to delivering training across the organisation on child protection
- Supervision with key staff developed and embedded
- Dr Hann has sourced funding for a new multidisciplinary child sexual abuse and sexual exploitation course sponsored by the royal school of medicine which allows trainees to role play with actors how they would go about helping victims to disclose abuse, as Operation Yewtree and abuse in Rotherham, Barnsley and the north showed there was a lack of training in this area. The course has been run 4 times and forensic examiners, youth workers, paediatric doctors and police have attended. Presenting at the International association of medical education August 2017.

How well did we do it?

- The team has seen an increase in the complexity of cases both in paediatrics and maternity. The team has therefore needed to ensure we continue to engage with our partner agencies across Boroughs to ensure voice of the child / unborn baby is paramount. The Named Doctor has formally escalated on individual cases where concerns / disagreements in decision making have arisen.
- Continue to engage with partner agencies with cross Borough initiatives – CSE and Gangs
- The CQC Report following the visit in September 2016 and published December 2016 reported that female genital mutilation (FGM) projects had been well managed and that staff they spoke with were fully aware of these safeguarding issues
- The CQC Report following the visit in September 2016 and published December 2016 reported that that gang-related violence projects had been well managed and that staff they spoke with were fully aware of these safeguarding issues
- Maternity services have seen in increase in the number of complex cases. Maternity services through the work of the Named Midwife and the Safeguarding Midwifery advisor were highlighted as good practice within the Haringey Serious Case review report findings of Child R. "The midwifery staff are to be commended for their persistence in trying to ascertain information about the circumstances for mother"

How did we make a difference?

- Raised awareness in local community and nationally regarding Gangs work

- Improved Staff knowledge and awareness with improved compliance levels
- An example of improved outcomes for a service user was for a parent who attended A&E following what was later deemed to be a domestic incident. Concern was raised by the fracture clinic nurse to the safeguarding advisor as the injury and history were felt not to be consistent. A referral to social care was made which identified that there were previous concerns around honour based violence towards this mother but also concerns following referral raised that this maybe significant domestic violence from the partner and social care therefore were able to undertake further assessment of the family in regards to the risk to the children.
- An example of improved outcome for a young person with a long-term condition who had been admitted with significant self-harm and following referral to the gangs youth worker was themselves associated with gangs although not a member. On-going multi-disciplinary working with all partner agencies by the specialist team managing their care and the safeguarding team has ensure that appropriate support / referrals have been made to support the young person but also the family including the sibling who is at high risk of harm due to gang involvement.
- An example of improved outcomes for a young person affected by gangs was the admission of a 15-year-old male with 6 stab wounds admitted to the ward. Contact was made with the youth worker who was able to see in the A&E department and then the following day on the ward. They were also able to support him with contact / involvement with the Trident police team who were able to work directly with the young person on the ward resulting in a later conviction in Court for the perpetrators. Social care was also able to work with the family and support them upon discharge with the family being re housed into another area for their own safety by police and social care.

What are we going to do next year?

- Domestic violence – the Trust has identified the need for IDVA's to be working in A&E and maternity services and is sourcing funding from CCG / partner agencies
- Continued working with partner agencies around CSE and Gangs
- Development of CSE champions within the organisation
- Development of DV champions within the organisation as part of the Trust DV action plan for children and adult services
- Continued development and expansion of the FGM Iris clinic to support non- pregnant women
- To support the introduction of CP-IS in the maternity service
- To support the introduction of CP-IS in adult A&E for 16 – 18 year olds
- Continue working with partner agencies on the development of perinatal mental health service for pregnant mothers.

Barnet, Enfield and Haringey Mental Health NHS Trust

What did we do?

- We have been successful in securing funding from NHS England to pilot a domestic abuse project which aims to demonstrate the need for Independent Domestic Violence Advisors in mental health settings.
- Domestic Abuse training is given to all staff at Corporate Induction and our referrals to domestic abuse agencies continue to rise
- We have improved oversight of data relating to safeguarding children activity across the Trust for the past 12 months.

- We have worked closely with the patient safety team and patient experience to ensure a triangulated approach to safeguarding.
- We have raised the profile of PREVENT cross the organisation and Healthwrap3 training is included for all staff at Corporate Induction
- The aims and objectives of our safeguarding work plan for 2016-17 (year 1) have been largely achieved.
- We have reviewed our safeguarding children training requirement and expanded the number of staff who are required to complete level 3 training ensuring a competent workforce.
- Level 1 and 2 safeguarding children training has consistently remained at a compliance rate of 85% or above.
- Effective partnership working across the three boroughs of Barnet, Enfield and Haringey has continued.
- We have ensured that appropriate staff undertake specialist Child Sexual Exploitation (CSE) champions training.
- We are compliant with the reporting requirements in regard to FGM.
- We have actively contributed to Serious Case Review learning events and provided training in complex issues such as self-harm

How well did we do it?

- We are leading on a domestic abuse project to ensure a better response to domestic violence and abuse in mental health settings
- We have a much-improved data set to allow us to interpret and analyse our safeguarding activity.
- We have raised the profile of PREVENT cross the organisation and Healthwrap3 training is included for all staff at Corporate Induction; and we have worked closely with the local Channel Panels to ensure information regarding concerns relating to potential radicalisation of young people is shared effectively.
  A high proportion of our staff are trained at the appropriate level of safeguarding children training

How did we make a difference?

- We have ensured effective partnership working
- We have raised profile of safeguarding children across the trust
- We have strengthened safeguarding arrangements
- We have consistent safeguarding team members in post to support staff
- We have ensured more staff received level 3 training so that they have a better understanding of their safeguarding responsibilities.

What are we going to do next year?

- We will develop our safeguarding intranet site and maximise the communication mechanisms currently in place
- We will continue to raise the profile of the safeguarding champions across the organisation
- We will develop a safeguarding children pocket sized booklet for staff reference
- We will review the function of our safeguarding surgeries as a learning forum.

- We will organise a Trust wide safeguarding conference
- We will continue to ensure that adult mental health workers routinely consider the impact of parental mental health on the wellbeing of children by re- launching a "Think Family" approach
- We will review our safeguarding Children Policy to ensure chaperone requirements are clear in view of Miles Bradbury case & Jay enquiry/Verita check list.
- We will develop a Trust wide FGM policy to ensure staff are aware of requirements

Royal Free London NHS Foundation Trust

Add here

London Community Rehabilitation Company (Probation)

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Enfield National Probation Service (Probation)

Add here

Enfield Children and Young People's Service (ECYPS)

What have we done?

In the past year we have:

- Carried out approximately 444 disclosure and barring checks.
- Offered 43 training programmes
- Had 655 people attend training
- Trained staff from 73 organisations.

Training programmes offered included:

  - Basic Child Protection
  - Child Protection and Diversity
  - FGM
  - The Impact of Parental Mental Health on Children and Young People
  - Child Protection Refresher
  - Mindfulness
  - Suicide Preventation
  - Mindful and Emotional Communication

- We have participated in 7 community events – disseminating safeguarding literature
- We have run 7 subject specific forums which all included safeguarding information.
- We have supported 11 organisations with the development of their policies.
- We have attended weekly SPOE meetings.
- We have become board members of Children England, to increase the ability of the sector to raise issues of concern with government, with the first all-day meeting being held with Jonathan Slater of DfE in the summer of 2017.

- Together with Dazu and Scribeasy, we have developed a mental wellbeing programme linked into a literacy programme for use across primary schools. This is now being modified and developed for commercial use.

How well did we do it?

All training courses are evaluated and there were no negative evaluations of any programmes – but suggestions for future training programmes resulting from evaluations have been actioned and future programmes organised accordingly.
Forum meetings also provide attendees with extensive information packs as well as the opportunity to engage with external speakers.

How did we make a difference?

- The range of training programmes allow staff to upskill and refresh. Training programmes are offered during the day, evenings and at weekends to ensure that we reach the widest possible audience at times that are convenient.
- Staff feel more confident in dealing with families and making appropriate referrals.

What are we going to next year?

- With funding from CCG, we are expanding our mental health training throughout the autumn to include self-harm, bereavement, resilience and mental health first aid, to enhance the current programme.
- We are planning the roll out of our Scribeasy mental wellbeing programme across local schools, prior to the product being available nationally and internationally.
- Our standard safeguarding training offer will remain unchanged with the addition of a new standalone training programme on domestic abuse.

MET Police Child Abuse Investigation Team (CAIT)

What did we do?

- The CAIT team based at Barnet Police Station covers Barnet and Enfield Boroughs.

- The team investigated over 1500 crimes against children in the reporting period - 750 of these cases had a venue in Enfield Borough. The number includes numerous allegations of rape and sexual assault. The majority of the sexual assault cases were non-recent which bring complications and lack of investigative opportunities. Every case involving children has a strategy discussion prior to a S47 decision and deployment. Numerous referrals were made and Police Conference Liaison Officers attended multi agency meetings to share information and decide action plans on all children on child protection plans. Daily liaison was made with CSC health and education partners

How well did we do it?

- CAIT officers have all received bespoke training and attend multi agency meetings demonstrating an acute understanding of safeguarding and legislation available to partners to protect children.

- High risk cases are monitored on a daily basis at the Daily Management Meeting held at 10am every day. Actions are handed out at DCI / DI level to ensure effective progress in cases. Cases likely to receive media attention are discussed at Chief officer level at "Met Grip and Pace" meetings held at 11am, 4pm and 9pm daily. DI's attend bi monthly performance meetings where performance in many areas is scrutinised seeking to achieve annual targets set by MOPAC/ MPS**.**

How did we make a difference?

- The protection and safeguarding of children is difficult to quantify in figures. The MPS have directed CAITs to concentrate on safeguarding rather that focus of sanction detection rates or convictions. However, in order to protect children across Enfield police have used theier powers daily. Children are regularly taken into police protection, powers of arrest and prosecution used in conjunction with partners in the CPS.

- As above all investigations are joint with CSC to ensure the best outcomes for children and families.

What are we going to do next year?

- During the course of 2017/ 2018 the investigation of Child Abuse for the children of Enfield is likely to be transferred from the CAIT teams to new multi Borough Protecting Vulnerable People (PVP) hubs. Following a report by Her Majesties Inspectorate of Constabularies (HMIC) which noted that there was no specific officer with the lead responsibility for the safeguarding of children across London it is likely that a PVP lead will be appointed.

- This transitional period could be difficult to manage depending on timings as the CAIT teams are finding recruitment and retention of staff challenging due to the uncertain future.

MET Police Enfield

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