Enfield Safeguarding Children Board

Annual report

2016 – 2017

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

Contents

Introduction from the chair

As the Independent Chair of Enfield Safeguarding Children's Board (ESCB), my starting point is to thank all of those colleagues right across our partners and agencies for the work done each and every day to keep the children and young people of Enfield as safe as possible. All the agencies (the principle three being the local authority, the metropolitan police and the clinical commissioning health group) work hard together to recognise the risks being experienced and then to reduce them.

Enfield has an influential voluntary sector and many other organisations also support this work. This includes schools, nurseries, the probation service, domestic abuse organisations, addiction services and several others. The Annual Report gives an account of the work undertaken by all of these organisations. Important responsibilities are shared by families, agencies and communities all working together to protect children and enable them to thrive.

This work is demanding and challenging, often national and local press headlines can infer that if only certain steps had been taken all would be well. However, there is often a complexity involved which can be tricky and sometimes difficult to grasp away from the national sound bites. We are all aware of the real budgetary pressures being experienced and this does stretch existing resources, and in some instances the streamlining of services that is still underway does impact on what may be available. However, as an LSCB it is our responsibility to keep talking together and to create opportunities for continuous improvements to continue.

2016-2017 has been another demanding and stretching period. The ESCB website and Twitter and Facebook pages are routinely updated, and I just want to select some important themes that we as a Board have focused on during the last year.

All 32 London Borough Boards work in conjunction with a London-wide Board, and this provides a regional coherence to safeguarding activities. Over this last couple of years Child Sexual Exploitation (CSE), Female Genital Mutilation (FGM) and Prevent (early detection of vulnerability to terrorist influences) have all been under the national spotlight and therefore all London Boroughs have increased our activities in these areas. We have in Enfield kept a watchful eye and whilst none of these seriously concerning areas have been totally eradicated, we are confident that as a Board with all our partners working together, we are approaching and managing these areas in a coherent and purposeful way.

I do however want to highlight some of the areas that we still need to increase our attention on to measure any significant impact. The first of these is the thorny problem of children being affected by living in households where Domestic Abuse is present and also violence to young women and girls. We are working closely with colleagues from Community Safety and the police as well as voluntary groups to join up existing services and to do more to prevent this violence.

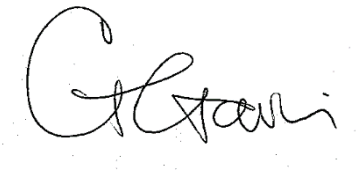
Children experiencing neglect are also particularly vulnerable and again this will be focused on during 2017-18. National headlines have usefully alerted us to the significant pressures on young people with

mental health problems. Appropriate treatment facilities are in short supply and very occasionally police custody suites or Adult hospital beds have been used to temporarily house children. These facilities are far from ideal and all of us working with children are seeking other solutions.

Safeguarding children's work whilst done well in Enfield amongst and across partnerships, is an area where we can never be complacent as new risks are being identified all the time. The ESCB takes its responsibilities seriously and I would commend this Annual Report to all as a good illustration of the range of issues being experienced and dealt with regularly.

2017-2018 will undoubtedly bring new and increased challenges, national legislation will have an impact on how the agencies will be expected to work together, and central guidance whilst delayed by the June General Election is expected in the Autumn.

My concluding comments echo my starting point, all staff and colleagues work hard together and a big Thank You from all of us connected to the Enfield Children's Safeguarding Board. Keeping children and young people safe in Enfield is a role taken seriously and this needs to be supported and continued.



Summer 2017

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 **83,773 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

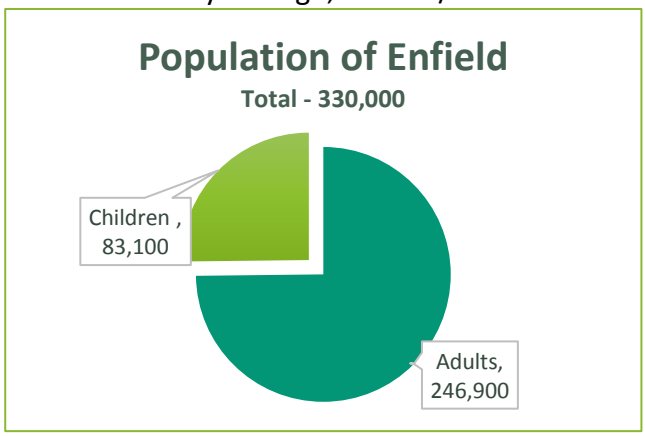


Figure 1 Population of Enfield

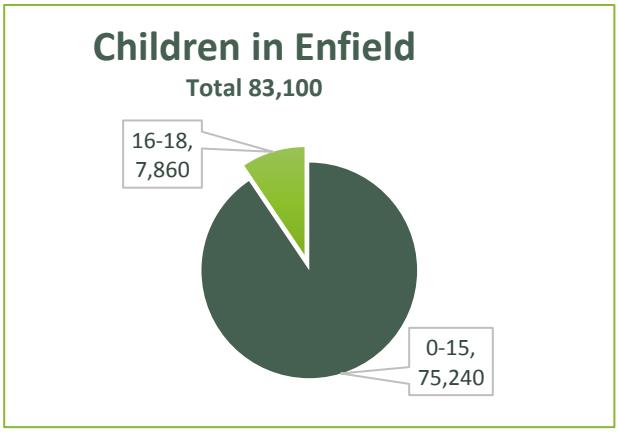


Figure 2 Children in Enfield

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**.

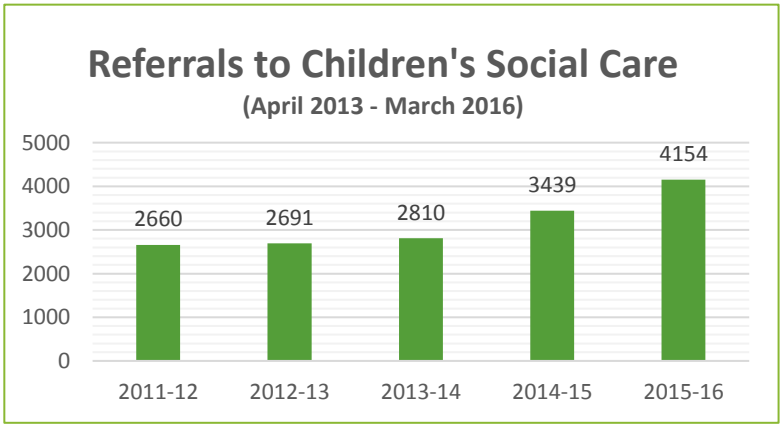


Figure 3 Referrals to Children's Social Care

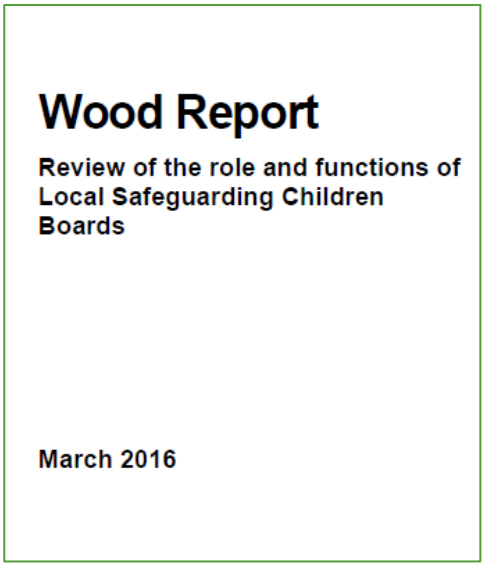
[1] GLA London Datastore https://data.london.gov.uk/demography/

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

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'.

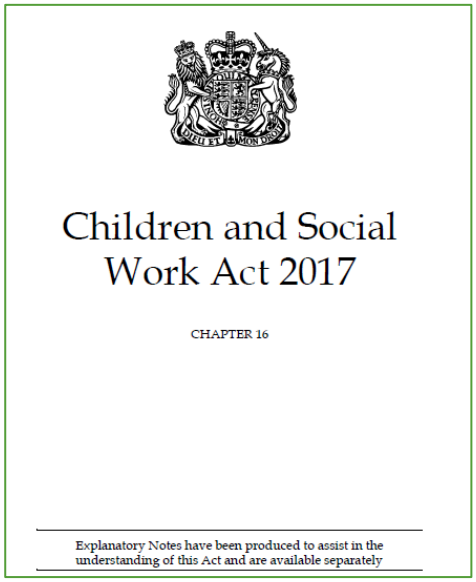
ESCB in context

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 a number of 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 discussed 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 was 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-committees 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 a number of 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 a number of 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

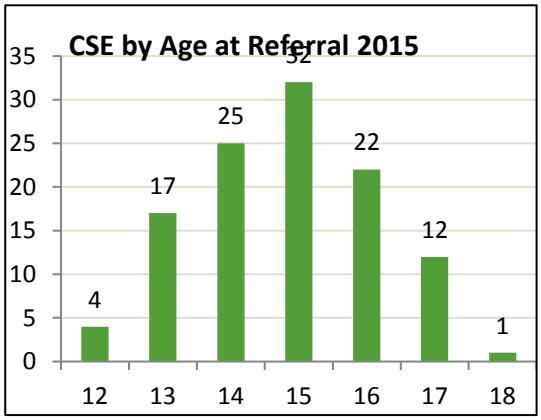
Overall this has been a very positive year for the board despite significant changes and challenges. Importantly there remains a very strong commitment to the board and its activity from all its member agencies and organisations. This is evidenced both from the strong collaborative ethos and commitment 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. During the year **111** young people were identified as either experiencing or being at significant risk of CSE. This figure is very similar to the last full year analysis where **112** young people were identified in 2015.



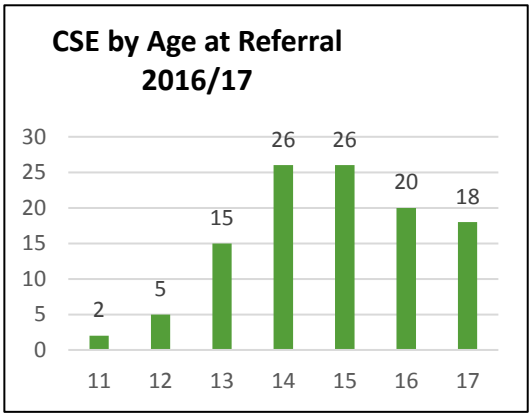
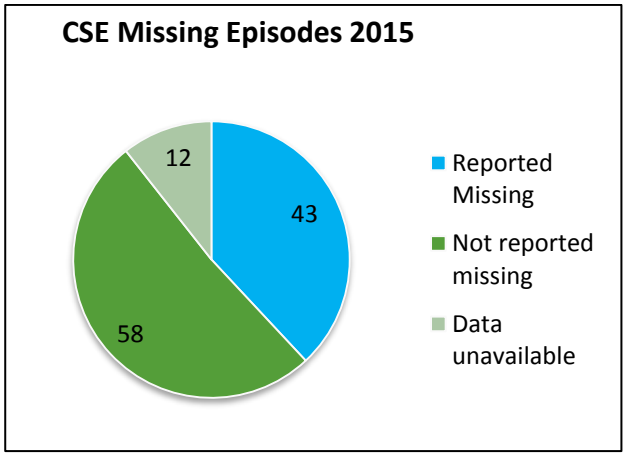
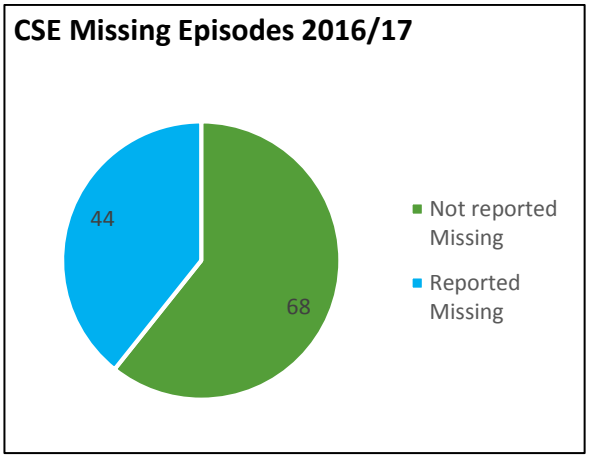


Figure 4 CSE by Age

There is no noticeable difference in age range. There has been an increase in the amount of boys who are identified as experience in CSE. In 2015 there were 105 girls and **8** boys and in 2016/17 there were 99 girls and **13** boys. This represents a positive shift in understanding that boys can be victims of CSE as well as girls. Data relating to the ethnicity of young people experiencing CSE in Enfield and the parts of the borough in which they live has not changed significantly with White British young people remaining the single most vulnerable group and the N9, N18 and EN3 postcodes featuring post prominently.

The number of young people who have had episode of being missing and have also experienced CSE has not risen significantly but there clearly remains a correlation between these issues.





During the course of the year **62** young people were removed from the CSE list. This indicates effective inter-agency work to reduce the risk of CSE for those young people.

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 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.

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 a number of 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

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.

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. There is a strong focus on safeguarding individuals from supporting or becoming involved in terrorism. To do this there has been work with teachers, social care staff and a number of other organisations to offer support to those who are deemed to be at risk.

There is regular and ongoing proactive contact with the Office for Security and Counter Terrorism (OSCT) and Police's Counter Terrorism Command (SO15) on Prevent work and keep them regularly updated on trainings, details of project delivery and visits made to local community groups.

A key element of Enfield's Prevent support is through the Channel programme, which has similarities to a multi-agency safeguarding panel. The panel receives concerns about vulnerable individuals and the needs are assessed along with any risks that the police may highlight suggesting terrorism or radicalisation concerns. The support is voluntary and where this is accepted the panel is able to bring to the table unique Home Office approved intervention providers who have experience in tackling the radicalisation of individuals and are able to offer one to one support and mentoring. The Channel panel receives regular representation from Children Services and where required from appropriate teachers and social workers. Read more about activity relating to Prevent and Radicalisation on our Tackling extremism & radicalisation webpage.

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.)

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 its 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 a 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 those 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.

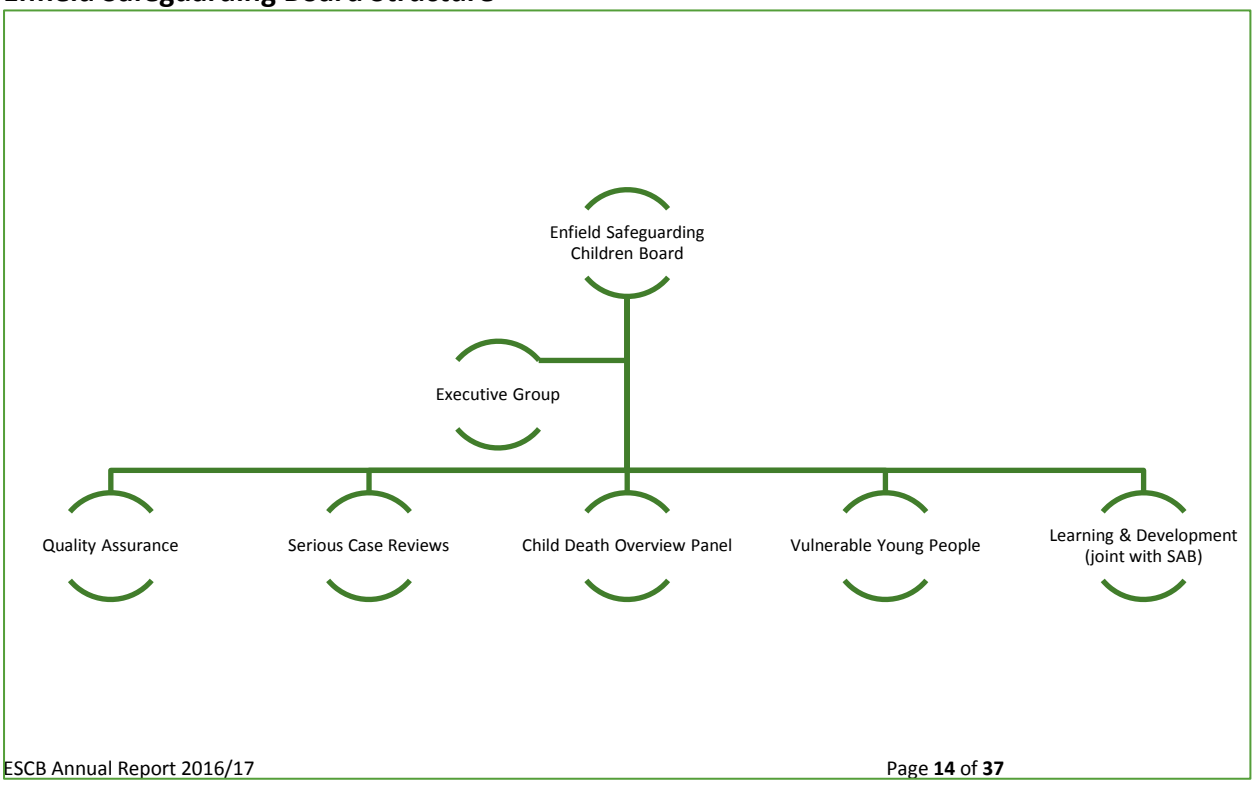
A key element of the ESCB's work is the provision of information to and from the public, potential and actual service users, staff working in partner agencies and others interested in children's welfare. We work hard to ensure our website www.enfieldlscb.org is as helpful and up to date as possible.

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.

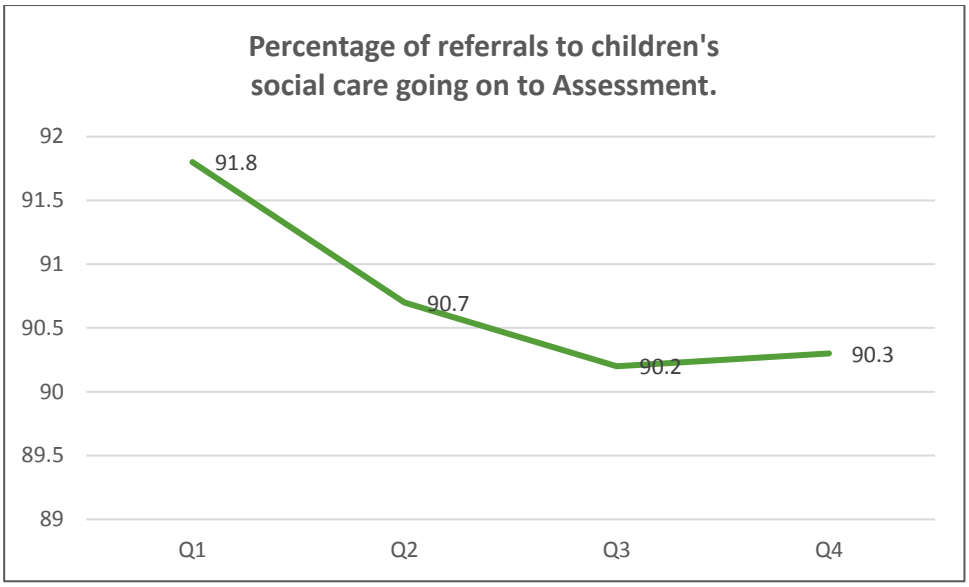
Quality Assurance (QA)

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 data analysis 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.

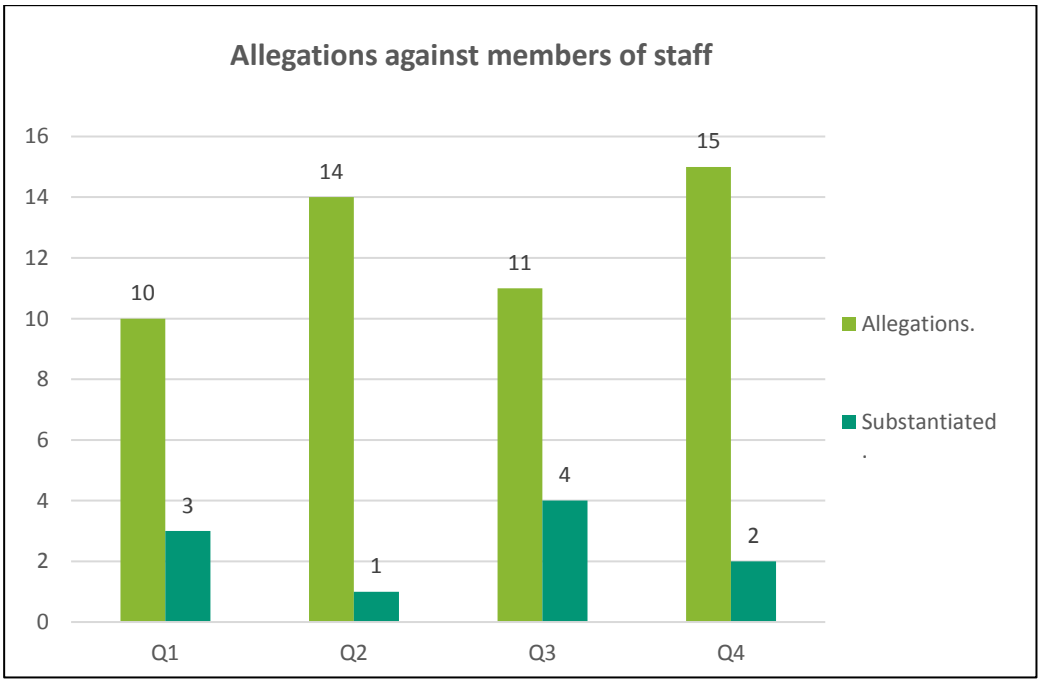
The Dataset

The QA group monitors a dataset from partner agencies providing information relating to safeguarding. At each meeting, the dataset is discussed and any issues and concerns are identified and fed back to agency representatives. Sample data items are included below;

The table below shows the percentage of referrals to Children's Social Care that subsequently went onto an assessment. The figure was consistently high across the year indicating that appropriate decisions are being made by the Single Point of Entry (SPOE) team regarding contacts they receive. Where the team believe the situation reaches the threshold for social work intervention they will record a referral and pass it to the Referral and Assessment Team. Of 4,090 referrals between 01/04/2016 and 31/03/2017,3,692 progressed to an Assessment



This table shows the number of allegations against staff members from across Enfield that were received by the Local Authority Designated Officer (LADO). 50 allegations were received in total of which 10 were substantiated. This is very similar to last year when 48 allegations were made of which 12 were substantiated. You can read more information about the work of the LADO and related data in the Annual LADO report on the ESCB website.



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

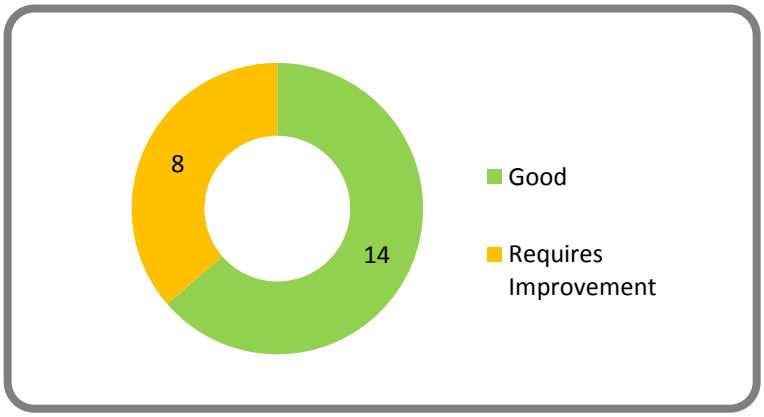
- Domestic Abuse
- Child Sexual Exploitation (CSE)
- Child in Need Plans and Decision Making
- Child & Family Assessments
- Signs of Safety
- Child Protection Plans for young people of 15 and over

Auditors use a standard template to assess and rate different aspects of work using the standard Ofsted judgement structure; *Outstanding, Good, Requires Improvement and Inadequate*

All audit documents are sent to relevant social workers and managers on completion with clear recommendations for any required actions. The audit document is also uploaded to the Social Care casefile system ensuring it can be easily accessed. The scores and comments from each audit are collated into summary reports which are then shared with the workforce to ensure learning is widely shared and necessary improvement actions are taken. Below are some example audit findings from an audit that focused on Child in Need Plans.

Child in Need (CIN) Plans and Decision making – January 2017

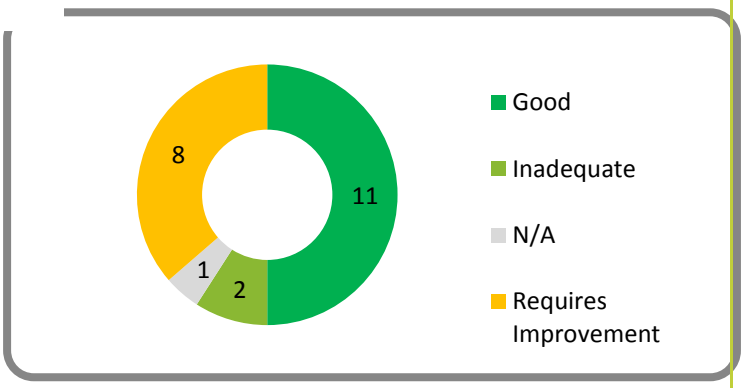
This peer audit looked at a random sample of 22 cases to assess the quality of CIN Plans and related decision making



Overall Judgement

The majority of audited cases were rated as good (14/22), with the remaining 8 cases rated as requiring improvement. No cases were found to be outstanding or inadequate.

There was evidence of some very good and effective direct work with children and young people. Examples include; *'Evidence of the Four Window exercise being completed with x and other techniques being used with siblings to understand wishes and feelings'* and *'there is a youth worker involved doing direct work with the young person and clear records on file of good communication and information sharing between the CSE youth worker and the social worker.'* However, in other cases there is little if any evidence of direct work being undertaken. Two cases were judged inadequate in this respect.



Quality of Direct Work

The Recommendations, actions and outcomes from all audits was compiled at the end of the year and shared across the partnership. Blow are some examples of audits undertaken and the key outcomes and impact resulting from the post-audit action plans

Audit	**Children Missing from Home or Care - July 2016**
Rationale	• To follow up effectiveness of changes to procedures & processes implemented in response to Ofsted inspection in February 2015 • To develop understanding of responses to Missing children and adherence to requirements and guidance across Children's Social Care to inform practice and process improvements
Outcomes / Impact	• The ESCB Missing Protocol was updated and redistributed clarifying roles, responsibilities and expectations in relation to Missing Children and in particular to return home interviews • Series of meetings held with provider of debriefing interviews and improvement plan put in place which included amendments to form used. Monitoring meetings have seen a marked improvement in the analytical quality of these interviews • A further audit, focusing specifically on debriefing interviews, will be conducted in June 2017.

Audit	**Domestic Abuse - October 2016**
Rationale	• To develop understanding of responses to cases where Domestic Abuse is an issue to inform practice and process improvements
Outcomes / Impact	• Immediate action was taken to restructure the SPOE to increase the amount of decision makers in the team • An external review of SPOE structures and processes was undertaken to look at improving efficiency and effectiveness • The Case Summary template was amended to include a heading *Are there any Risks or Warnings?* to improve recording of risk including Domestic abuse

Audit	**Children's Centre Case File Audits - October 2016 – March 2017**
Rationale	• Ongoing case file audit activity to monitor compliance with procedures, identify areas of good practice and areas for development
Outcomes / Impact	• Children's Centre staff are supported to work on increasingly complex cases • Protocols now standardised across all hubs • Appropriate recording systems have been established • Children's Centre Staff are now attending TAF 'Train the Trainer' sessions organised by Change & Challenge.

Audit	**Child Sexual Exploitation -January 2017**
Rationale	• Audit of two cases undertaken in direct response to concerns raised about two young women who were victims of CSE. Identify learning to improve multi-agency response to similar cases.
Outcomes / Impact	• Amendments made to Enfield CSE operating protocol to a) clarify the use of the CSE risk assessment tool and b) clarify requirements for Strategy Discussion for CSE cases • The audit Key Findings had a direct influence on the decision re-structure the CSEP Team and to re-locate it within Children's Services. Plan to co-locate the CSE police officers within the CSEP team to improve co-working has been expedited.

Audit	CIN Plans & Decision Making -January 2017
Rationale	• To improve understanding of responses to CIN processes and related decision making. • To inform practice and process improvements
Outcomes / Impact	• Identification in March 2017 of 25 Signs of Safety practice leads from across the workforce to receive enhanced training and coaching in Signs of Safety principles and practice. Practice leads will offer expert support and guidance to colleagues in application of Signs of Safety across all areas of work • Amendments have been made to the C&F assessment / Report for conference and Core Groups templates within the ICS system. Work is continuing to ensure CIN documents also reflect Signs of Safety principles within ICS

Audit	Change & Challenge (Troubled Families) case file audits – February 2017
Rationale	• Ongoing case file audit activity to monitor compliance with procedures, identify areas of good practice and areas for development • To test compliance/effectiveness on 6 key areas including; voice of the service user, timeliness, multi-agency working, and developing a learning culture,
Outcomes / Impact	• Team managers audit cases for the Troubled Families programme in line with guidance from the DCLG, using the 4 key principles. This new system of management audit has seen a significant rise in the number of successful outcomes for Enfield, with many families returning to work. • Signs of safety is now embedded into supervision so that caseworkers come prepared with each open case This gives both managers and caseworkers a clear focus for the direction of work • Introduced time limited reviews for casework to ensure that cases are not drifting and that non-engagement can be addressed. Review work every six weeks (often in supervision) and aim to complete in 3-6 months • Introduced child based tools and have seen positive engagement from children and young people as well as parents gaining a greater insight into the experiences of their children.

Audit	Parenting Support case file audits – February 2017
Rationale	• Ongoing case file audit activity to monitor compliance with procedures, identify areas of good practice and areas for development
Outcomes / Impact	• Introduced monthly group discussion & because of this Early Help assessments have become more thorough and focused. • Parenting Support workers now have reflective cards to use after every intervention and to assist with individual supervision. This has given staff a greater insight into their practice which has enabled them to develop their skills. • After introducing these tools to families Parenting Support workers have seen positive engagement from children young people and their parents impacting on positive outcomes

Audit	Signs of Safety – March 2017
Rationale	• To check compliance with Signs of Safety across Children's Services and understand how effectively Signs of Safety is becoming embedded in social work practice to inform practice and process improvements
Outcomes / Impact	• Identification in March 2017 of 25 Signs of Safety practice leads from across the workforce to receive enhanced training and coaching in Signs of Safety principles and practice. Practice leads will offer expert support and guidance to colleagues in application of Signs of Safety across all areas of work

	• A further audit will be undertaken later in the year to check progress in relation to embedding Signs of Safety across Children's Services and to increase understanding of how well the model is understood and utilised across partner agencies

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 2017/18 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 August 2016 Enfield Safeguarding Children Board commissioned a Serious Case Review following the tragic death of an Unaccompanied Asylum-Seeking Child (UASC) from Eritrea. The focus, as with all Serious Case Reviews, was to explore the circumstances surrounding the death and to identify any useful learning. The report was completed by the end of the year but publication has been delayed because of

a pending coroner's inquest. It is hoped that the review will be published in the autumn. The reviews key findings related to the communication of information between agencies and particularly the identification and communication of any potential risk. An action plan has been developed and implemented ahead of publication and details of actions taken will be published at the same time as the review.

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)

It has been another very busy and productive year for Learning and Development across the partnership. An important change has been the bringing together of the ESCB Learning & Development sub-committee with the Safeguarding Adults Board (SAB) equivalent committee. This was in response to a recognition by both boards that there is overlap in the training needs of both workforces and that, of course, children have parents who are adults.

The two committees were brought together in January 2016. The key functions of the group are a) to work on behalf of the ESCB & SAB to ensure the availability and delivery of high quality training and development on Safeguarding issues and b) to bring together learning and development opportunities for the adults and children's workforces where there are clear synergies and advantages in doing so.

The ESCB programme this year has had a strong focus on training and awareness-raising in relation to the implementation of Signs of Safety, with almost 450 people attending courses on workshops on the model across the year.

Other key drivers and priorities for the Training Programme this year have included:

- A continued focus on the key topic of Child Sexual Exploitation (CSE) with specific focus on specific agencies (e.g. Police and Foster Carers)
- Joint training sessions on Domestic Abuse and its impact on families for professionals who work with both adults and children, increasing awareness of understanding of gang related issues and links with other issues, such as CSE.
- Modern Slavery and Human Trafficking. A joint conference was held on this topic in February 2017 attended by more than 70 professionals from across the partnership

WHAT IS SIGNS OF SAFETY?

Signs of Safety 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 implementing Signs of Safety to re-position the children's service at the centre of cutting edge social work research and practice and to have a clear practice based model that can be used across all professions.

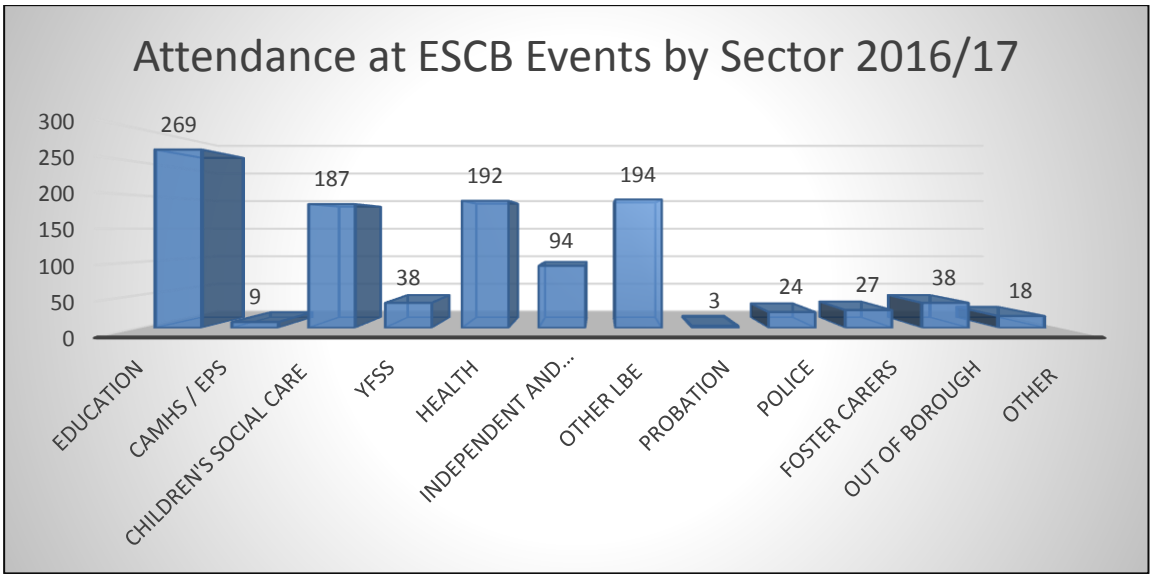
The ESCB Training programme is commissioned by the Board and monitored on the Board's behalf through the multi-agency Joint Adults & Children's Learning & Development sub-committee which meets at least quarterly.

ESCB Learning Events are broadly open to everyone in the Enfield children's workforce, with detailed guidance offered as to who should attend which courses according to role and responsibilities available on the website.

14 different topics were covered during this course of the year. These have all been generally very well attended. The topics are listed below.

- Child exploitation online protection (CEOP) – online safety
- Child protection – introduction
- Child protection – elected members
- Complex neglect
- Child sexual exploitation (CSE) training
- Direct work with children and young people
- Domestic abuse – working with families
- Learning from serious case reviews
- Managing allegations against staff
- Parental substance misuse
- Significant harm
- Signs of safety
- Single point of entry (SPEO) workshop
- Workshop to raise awareness of prevent (wrap)

A total of 1093 places have been filled at ESCB Learning events this year. This is a small decrease from the 1118 places that were filled last year Attendees have been from the following sectors:



- There has been very good engagement from the Education sector this year with 269 people attending events. This is, to some extent explained by the large number of Signs of Safety sessions that were delivered from schools during the year, but there have also been significant numbers of school staff on other courses.

- There has also been very strong attendance from Children's Social Care, which is a positive step. Consistently, feedback from courses is positive about the multi-agency nature of ESCB courses and the input and attendance of social care staff is particularly valued
- There has been a notable increase in the numbers of Police colleagues attending training sessions for the second successive year. There were some bespoke CSE courses specifically for Police colleagues, but they have also attended a number of other sessions in significant numbers, particularly the Modern Slavery Conference.
- Attendance from Probation colleagues has fallen, which is probably reflective of the various changes that have taken place in that sector this year.
- No courses had to be cancelled this year, which reflects an overall positive engagement with the programme

During the course of the year a total of £8,654 was spent on learning and development. This is inclusive of trainer costs and venue hire. As is previous years we have worked hard to ensure that costs are kept as low as possible, primarily by engaging staff from across the partnership to deliver the training at no additional cost and by utilising London Borough of Enfield venues wherever possible.

Evaluation and Impact

Attendees at all learning events are sent a link to an online course evaluation which they are asked to complete as soon as possible. Certificates of attendance are only issued on completion of the evaluation. Completion rates are improving but further work is still required to maximise the value of the evaluations.

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.
The effectiveness of ESCB training is also monitored through the quality assurance and audit programme and other activities such as a recent Signs of Safety audit. Findings are incorporated into an ongoing Training Needs Analysis and are used to inform ongoing training and development.

Basic Child Protection Course

'The course, contents and delivery were very well organised, the trainer was very knowledgeable and shared her expertise and skills with the participants'

– Secondary School Teacher

Online Safety Course

'this was great training, very interesting and relevant to my role and generally in life'

– Change & Challenge Worker

All courses delivered this year have been evaluated positively.

All evaluation reports are sent to Training providers and all are analysed by the Training and Development Group. This analysis has resulted in amendments to course content over the course of the year and will inform the Training Needs analysis for 2017/18. Some providers, for example, will not be commissioned again, whilst others will be considered for further training based on their feedback

A breakdown of attendance and evaluation of all courses can be found in the ESCB Learning and Development Annual report 2016/17

In the coming year the key priority of the Training and Development subgroup, in addition to ensuring the training programme is robust and flexible to meet the needs of the workforce, will be to improve our understanding and ability to evidence the impact of training primarily through a structured programme of 'follow-up' which will target both training attendees and their mangers.

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 2016/167 the Board had a budget of £184,910 which was made up 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 **9%** 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. 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

Complex Neglect Course

'Fantastic course that could really have done with being over 2 days to cover all areas more thoroughly. The course leader had a great style of teaching that helped to visual scenarios. It is a shame that this could not be explored further to gain an increased insight in tackling the rising problem of neglect'

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 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

What have we done?

The Integrated safeguarding team is well established, motivated, enthusiastic and working well to deliver a think family approach to safeguarding. This means that where concerns about children are identified the care response provided by the Trust may call upon the expertise of the safeguarding professionals, adult and child, as well as the midwifery safeguarding specialist, the learning disability liaison nurses and the independent domestic & sexual violence advisors.

There is a robust governance structure in place which is led at executive level by the group chief nurse and overseen by the clinical commissioning group representatives for safeguarding via the quarterly integrated safeguarding committee.

Safeguarding children work undertaken and key achievements in 2016 – 2017

- Annual audit plan in place agreed by and monitored by the integrated safeguarding committee quarterly.
- Implementing the national child protection information sharing system (CP-IS) in unscheduled care settings at Chase Farm hospital, the Royal Free hospital and Barnet hospital to enable staff to identify all children who attend who are subject to a child protection plan or who are a looked after child.
- Robust process to ensuring attendance and contribution at child protection conferences from appropriate staff.
- Consistently high training figures for all levels of training
- Prevent level 2 or WRAP training is now part of the mandatory training requirements (MAST) and training rates will be monitored by the integrated safeguarding committee
- Consolidated the role of the independent domestic and sexual violence advisors at both the Royal Free hospital and Barnet hospital through increased training which has led to an increase in referral.
- Joint working between maternity service and the liaison nurses for patients with learning disability to increase the midwives understanding of and confidence in working with parents who have a learning disability or parents who have a child with a learning disability.
- Successful and highly evaluated annual safeguarding conference "tackling domestic violence- what can health services do?" in June 2016 attended by over 100 staff.
- Contribution to serious case reviews and implementation of recommendations and learning where required, actions and learning are monitored by the safeguarding committee.
- Positive engagement and working relationships with external partners and safeguarding boards that allow challenge
- Revision and implementation of relevant safeguarding policies overseen by the safeguarding committee
- Strengthening of the child death reporting pathway to ensure internal and external processes are followed
- The first RFL integrated safeguarding team newsletter was published in early 2017. Subsequent editions will be published twice a year and feature relevant practice updates and local and national priorities.
- Successful recruitment into vacant posts

How well did we do it?

- Consistently high training figures for all levels of training
- Highly evaluated level 3 training which is delivered by a full range of internal and external colleagues from across the partner agencies
- strengthened reporting and governance structure to the integrated safeguarding committee
- CQC inspection in February 2016 which rated all three hospitals in the Trust as good identified that staff were aware of their safeguarding responsibility and could give examples of when they would need to raise concerns

- In February, the community midwifery team at RFH was visited by the executive director, supporting people as part of the Camden SCB governance visits. He identified good links with the children centres and health visitor, good understanding of FGM, the work of the IDSVA's and training both single agency and multi-agency is appropriate, accessible and well supported by the Trust.

How did we make a difference?

- The integrated team approach means that the team work closely together to support all members of the family when concerns are identified are more
- During 2016/17 we delivered thirty three safeguarding children Level 3 update seminars in house covering a full range of topics.
- Participants who attended training on child sexual exploitation, domestic violence and Harm Online where asked to assess their confidence to recognise and respond to concerns. The responses ranged from the lowest 4.72 to the highest 5.66 (out of 1 – 6) demonstrating improved confidence and ability to recognising and responding to the safeguarding concerns discussed in the seminar.
- Evaluation demonstrates that midwives report feeling more confident talking to women about concerns around domestic abuse and FGM after training from the IDSVA's.

- Where the audit programme identified gaps in processes these have been addressed
- Due to the implementation of CP-IS we can identify a greater number of vulnerable children who access unscheduled care at Barnet hospital, Chase farm hospital and the Royal free hospital
- Better support for women with learning disabilities who are pregnant

What are we going to next year?

- A revised annual audit plan will be presented to the integrated safeguarding committee for approval in October 2017.
- As an integrated safeguarding team we will set out our three year aims and work plan in to be presented to the integrated safeguarding committee in January 2018
- Develop an activity dashboard that will provide the assurance on a monthly basis via the patient safety and clinical outcomes meeting to each hospital that is part of the group model.
- Ensure that actions identified in the section 11 audit are achieved prior to the next section 11 submissions and challenge event.
- Host safeguarding conference in March 2018 with a focus on early help and think family
- Implement CP-IS into the maternity areas

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 Prevention
  - 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 their 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

What did we do?

Identified the need for problem solving approach regarding frequent missing children, understanding why they go missing and what interventions are possible; encourage curiosity about why they go missing and where they go? Who they associate with and what do they do when missing? Listened to the voice of the child ensuring the child has been spoken to at the earliest opportunity. Ensured proportionate action is taken to identify offenders, and assess what risk they pose to the victim and others. Learning disseminated through borough commander updates and Detective Inspector public protection briefings to emergency response teams. Operation Beat now live all dedicated ward officers now briefed on those registered sex offenders living on their wards.

How well did we do it?

Officers from across the borough received specific training relation to Missing, CSE and Sexual offences. There were also a number of training days lead by the local authority with officers from public protection in attendance. Vulnerable victims are now discussed at the daily management meeting to ensure risk, harm or threat is identified and gripped at the earliest opportunity. CSE reporting is up on last year as well as those children missing which is down to a greater understanding by police of the issues posed. Signs and symptoms are now spotted earlier by officers allowing swifter support and risk management to the victims. MPS Intelligence sharing both internal and external has been reviewed with improved protocols to remove blockages.

How did we make a difference?

Enhanced partnership working including a new approach to MASE is in place, young people who are or at risk of being sexually exploited have varying levels of needs. They have multiple vulnerabilities and therefore an appropriate multi agency response and effective coordination and communication is essential. By treating sexually exploited children as victims of abuse and not offenders is making the difference. Police must direct resources against the coercers and sex abusers to remove the trigger and protect our most vulnerable.

What are we going to do next year?

MPS media department will be working with design agency on internal and external communication campaign to ensure safeguarding messages have the right look and feel. Jigsaw teams will be briefed on new visitation and reactive management protocol. Enfield is anticipated to move towards a safeguarding command early next year. This will bring child abuse, sexual offences and CSE under one governance.

This arrangement will see a more joined up approach to improving victim care and reducing red tape for partners.