Enfield Safeguarding Children Board

Annual Report

2017-18



www.enfield.gov.uk/enfieldlscb





Contents

| Foreword by Independent Chair | 3 |
|---|----------|
| 1. Introduction | 4 |
| 2. Enfield Context | 5 |
| 3. About us: Governance and Structure | 7 |
| 4. Changes and Achievements | 11 |
| 5. Safeguarding in different contexts | 12 |
| 6. Learning and improvement | 18 |
| 7. Training, Learning and Development | 21 |
| 8. Priorities and challenges for next year and beyond | 23 |
| Appendix 1: Membership list 2018-19 | 25 |
| ESCB Annual Summary 2017-18 – At a glance | 26 |
| Enfield Safeguarding Children Board | 28 |

Foreword by Independent Chair

As the Independent Chair of the 2017-18 Enfield Safeguarding Children Board I am pleased to write some introductory notes to what will be the final Annual Report of the current Safeguarding Children arrangements. The formal requirement placed on each Local Authority to coordinate and host a statutory Safeguarding Children Board began in 2006 (Children's Act 2004) and this has now been removed in new legislation approved in 2017 (Children and Social Work Act 2017). We are all now focusing on planning for the new arrangements when the Metropolitan Police. Enfield Clinical Commissioning Health Group and Enfield Local Authority all jointly share the responsibility for protecting children and young people across the Borough.

I encourage the reader to let the report speak for itself, and I wish to conclude this current phase of the existing ESCB by thanking all the various staff right across the existing partnership for their dedication, commitment, energy and focus on reducing harm to the children and young people of Enfield.

Several changes over this recent year are worth noting, we waved goodbye to Grant Landon who had been an effective and energetic Business Manager over his three year stay in Enfield. Our very effective lay members Irene Ridley and Rick Jewell, who represented the local community in Enfield have both moved on to other activities

and the Local Authority Administrative Unit was reduced in numbers when a colleague Aileen Ingram retired during Autumn 2017. Judy Dennis and Lisa Tait have between them continued to coordinate the ESCBs activities during 2017-18 and I want to thank them for all the activities undertaken on behalf of the partnership.

Finally a sincere thank you to all current and previous colleagues who have contributed to the formal full ESCB meetings, the active sub-groups, the various learning events and training courses. as well as other Children's Safeguarding focused activity. We have had ongoing contact with various children and young people's networks across the Borough and I thank them for their helpful and often challenging comments, suggestions and ideas. We also extend our thanks to Cllr Ayfer Orhan and Cllr Glynis Vince, who were supportive and regularly contributed to the ESCB in 2017-18.

The new Multi-Agency Safeguarding Arrangements are being worked on and shaped over the next few months. Do keep an eye on the ESCB website and Twitter pages to contribute to a newly invigorated and effective children's partnership network. Safeguarding the children and young people of Enfield is a serious responsibility undertaken with pride and commitment, we need to make sure this continues and improves in the new Multi-Agency Safeguarding Arrangements.



Geraldine Gavin Independent Chair Enfield Safeguarding Children Board

1. Introduction

- Enfield Safeguarding Children Board has a statutory duty to prepare and publish an Annual Report which describes how our partners safeguard vulnerable children and young people.
- Our primary responsibility is to provide a way
 for the local agencies that have a responsibility
 in respect of child welfare, to agree how they
 will work together to safeguard and promote
 the welfare of children and to ensure that they
 do so effectively.
- The ESCB supports partners as system leaders, challenges and holds them to account.
 We want to create conditions to develop a learning culture driving best collaborative practice for good outcomes. Our principles are: partnership working, family focus, a commitment to early help, and operating a learning culture.
- Section 2 of the report sets the context for safeguarding children and young people, by highlighting statistical information about Enfield.
- Section 3 sets out the local governance and accountability arrangements for the ESCB and structures in place to support the ESCB to do its work effectively. It also provides information on the new Safeguarding Arrangements that will be introduced in 2018-19 through the Children and Social Work Act 2017.

 Section 4 highlights some of the changes and achievements and the progress that has been made in the last year as well as reporting on the work undertaken across the partnership.

 Section 5, provides an overview of specific responses to safeguarding concerns, focusing on vulnerable young people and Early Help.

 Section 6 highlights the lessons the ESCB has identified through its Learning and Improvement Framework and provides an overview of the multi-agency audits undertaken, Serious Case Reviews and child death.

 Section 7 describes the range and impact of the multi-agency learning and development training provision and describes the communication activity undertaken by the LSCB.

 Lastly, Section 8 sets out the priorities and business plan the ESCB will take forward into 2018-19.

The Annual Report 2017-18 demonstrates the extent to which the functions of the Enfield Safeguarding Children Board, as set out in the national statutory guidance 'Working Together to Safeguard Children' (March 2015) are being effectively fulfilled.



2. Enfield Context

Local context

- The London Borough of Enfield is London's most northerly and fifth most populous borough. The overall population is currently approximately 333,00 and this is projected to rise over the coming years.
- There are currently approximately 84,200 (aged under 18) living in Enfield, making up 25% 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 20.5%).
- Enfield is the 13th most deprived borough nationally and the 5th most deprived in London.1
- Enfield continues to experience significant changes to its 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 and Africa.
- 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

Signs of safety - Social Work Model

- There is increased interest nationally into 'What Works?' when working in a child and family context. Signs of Safety (SoS) is one of several practice frameworks being used in the UK by local authorities and being evaluated through the English Innovation Project (DoE).
- The SoS implementation journey started 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.
- The Signs of Safety coordinator facilitates group learning and directly supports individual front-line staff with safety planning and multiagency case conference.
- The Board has continued to lead on and steer the direction of the Signs of Safety across the borough.



Safeguarding – Enfield in numbers in 2017-18

1,673

was the average number of contacts to Children Services per month (4.3% reduction)

As of the 31st March 2018 Cheviots (part of the Joint Service for Disabled Children) social workers had

177 open cases

There were a further 370

children with disabilities receiving a service







242

children were subject to a child protection plan at the end of the year, significantly lower than the 2016-17 figures

347

children were looked after (LAC) at the end of year (a lower rate than the national average and our statistical neighbours)

Of the 347 LAC, 63 are UASCs,

rates in Enfield remain higher than the national threshold



early help assessments completed in 2017-18

136

children and young people identified as affected by children sexual exploitation (CSE), this is an increase on previous years and an indicator of increased awareness

SCRs commissioned

ESCB website

and 1 published on the

726

places were taken up from the ESCB targeted training programme

Out of Borough SCRs

were contributed to by

local Enfield agencies

26

child deaths were reviewed in 2017-18





3. About us: Governance and Structure

Partners considered what the future local multi-agency safeguarding arrangements could be following the legislative changes introduced through the Children and Social Work Act 2017.

- Each local area is required by Law to have a Local Safeguarding Children Board. The LSCB is a statutory body established in legislation (Children Act 2004) and works according to national guidance 'Working Together to Safeguard Children 2015'.
- ESCB 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, who meet four times a year.
- 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.

LSCB functions

- Developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:
 - The action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;
 - Training of persons who work with children or in services affecting the safety and welfare of children:
 - Recruitment and supervision of persons who work with children:
 - Investigation of allegations concerning persons who work with children;
 - Safety and welfare of children who are privately fostered;
 - Cooperation with neighbouring children's services authorities and their Board partners.

- Communicating and raising awareness.
- Monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve.
- Participating in the planning of services for children in the area of the authority.
- Undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.
- Undertake functions related to child death.
- The functions of the ESCB are progressed by the Boards five Sub Committees. More information can be found here.



Structure chart

Executive Director of People Director of Children Services

Responsible within the local authority for improving outcomes for children, local authority children's social care functions and local cooperation arrangements for children services

LBE Chief Executive

Accountable for the effectiveness of the ESCB

Responsible for appointing or removing the ESCB Chair

Holds the ESCB to account for the effectiveness of the ESCB

Lead Members

Hold Children Services to account

Strategic links to

Health and Wellbeing Board

Safer Strong Community Board

Enfield Safeguarding Adults Board

Enfield Targeted Youth Engagement Board

Scrutiny and Challenge

- Geraldine Gavin has been the Independent Chair of the ESCB since 2010, she is tasked with leading the Board and ensuring it fulfils its statutory objectives.
- The Board demonstrates a culture of positive challenge and scrutiny which is evidenced in the Board and Subcommittee minutes. The Chair is accountable to the Chief Executive of Enfield Council and meets regularly. The Chair also regularly meets the Executive Director of People and the Director of Children Services.
- It is important to remember that the ESCB does not commission or deliver direct frontline services. Whilst the board does not have the power to direct other organisations it does have the power to influence and hold agencies to account for their role in safeguarding.



Enfield Safeguarding Children Board

Chair: Geraldine Gavin

Business Group

Chair: Geraldine Gavin

Serious Case Review

Chair: Geraldine Gavin

Vulnerable Young People

Chair: Andrea Clemons

Quality Assurance

Chair: Christina Keating

Learning and Development (joint with SAB)

Chair: Bharat Ayer

Child Death Overview Panel

> Chair: Stuart Lines

Measuring Success

- The FSCB is committed to ensure that it can demonstrate it has an impact on services to ultimately improve the safety and wellbeing of children in Enfield.
- The effectiveness of the Board is dependent on our ability to build strong relationships with each other, our young people and our communities. We also need to have joined up objectives and priorities. Measuring the success of the work of the Board is considered in the context of each safeguarding activity. For example: The Board wanted all school attending children from Year 7+ to have an opportunity to learn about exploitation. Success was achieved as Chelsea choice was delivered in all local schools.
- It is important that we note success can take many forms, as well as analysing existing data, we are looking to devise more extensive multiagency impact measures, using police and health data as well as children social care.

ESCB financial arrangements

• 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, cochairing the subgroups which support the work of the Board, and contributing to Serious Case Reviews.
- In 2017-18 the Board had a budget of £173,375.00, which was made up of contributions from our partners. Approximately 53% of the total budget was contributed by the London Borough of Enfield with the CCG as the next highest contributor.

Staffing costs were lower than originally projected. This was due to a reduction in ESCB support team following the departures of the CDOP coordinator post and the Service Manager for Practice and Partnership.



The Children and Social Work Act 2017

- Following the Wood Review and the Children and Social Work Bill in 2016, new safeguarding arrangements were passed into law through the Children and Social Work Act 2017.
- Provisions within the Children and Social Work Act 2017 will replace Local Safeguarding Children Boards (LSCBs) with new local safeguarding arrangements, led by three Safeguarding Partners and supported by relevant agencies. It also places a duty on new Child Death Review partners to review the deaths of children normally resident in the local area.
- In October 2017 the Department of Education (DfE) consulted on the draft 'Working Together to Safeguard Children 2018' guidance which lays down in much more detail the new safeguarding arrangements. The final version was published on 4th July 2018.
- Alongside the 'Working Together' the DfE has released statutory guidance on transitional arrangements.
- This document for Local Authorities, Police, Health and LSCBs provides guidance on the arrangements that should operate as part of the transition from LSCB's to Safeguarding Partners and Child Death Review Partners.

- Safeguarding Partners are identified as:
 - Local Authorities
 - Chief Officers of Police
 - Clinical Commissioning Groups
- Child Death Review Partners are identified as:
 - Local Authorities
 - Clinical Commissions Groups
- Safeguarding Partners will identify the relevant agencies required to support local safeguarding arrangements and will include agencies that are currently members of the LSCB.
- The guidance also describes the transitional arrangements which should be followed during the transition from the system of Serious Case Reviews to the new national and local review arrangements.
- Following publication Safeguarding Partners have up to twelve months to agree safeguarding arrangements. These arrangements must be subject to independent scrutiny. Enfield Safeguarding Children Board 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. We will continue to carry out all of our statutory functions, until the point at which safeguarding partner arrangements begin to operate.

Relationship with other boards

The ESCB works has a relationship with other strategic boards. Each board has a specific focus:

- 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 Chair, Christabel Shawcross to ensure there is dialogue and mutual understanding of priorities and initiatives. Last year the Learning & Development subcommittees of the two boards merged to improve and enhance the training programmes of both boards and to co-commission and co-deliver training where relevant.

- There are also strong links with Enfield's Safer and Stronger Communities Board (SSCB) and Targeted Youth Engagement Board (ETYEB).
- There will be statutory changes with the abolishing of LSCBs and the introduction of new safeguarding arrangements, changes to the Serious Case Reviews and the introduction of Safeguarding Practice Reviews and the role of the National Safeguarding Practice Review Panel.
- There will also be changes around the Child Death reviews and there is an expectation that the number of death reviews increase. Therefore, indicating a need to consider cross border Child Death panels.
- The changes offer flexibility and provide opportunities to streamline strategic boards and reduce duplication. The ESCB will:
 - Continue to engage and challenge these partnerships where appropriate to safeguard and promote the welfare of children in Enfield.
 - Embed statutory changes outlined in Working Together 2018.
 - Over the next 12 months will see the partnership agreeing and publishing new local arrangements.

4. Changes and Achievements

CSE Awareness Campaign & 'Chelsea's Choice'. In June and July 2017, 40 performances of Chelsea's Choice a powerful and thought-provoking play, focusing on the challenges and dilemmas many young people face was commissioned. The play was performed in almost all of our secondary schools and also to a range of professionals including elected members. Also presented to CCG safeguarding conference to 150 health practitioners in July 2017. It was very well received with much positive feedback from schools where the play prompted a great deal of discussion and learning opportunities. Impact: Helps young people gain a better understanding of the devastating impact that sexual exploitation can have on a young person's life and to provide them with some skills and knowledge to be able to protect themselves from this form of abuse.



The Missing from Home, Care, Education and/or Health protocol was developed in August 2016 and updated in May 2017. All agencies working with children who are missing from home, care, education or health will implement this protocol and ensure their staff are aware of it. The protocol is designed to ensure accurate data recording and information sharing which supports local working arrangements between the relevant agencies involved in developing this. For the first time our Missing Protocol covers guidance on what to do when working with children who go missing from Education and Health as well as from Home and Care.

Impact: The purpose of the protocol is to assist practitioners across all agencies to develop a robust response to children and young people who are missing. This includes preventing the child suffering harm and if necessary, recovering them to a place of safety as soon as possible.

Domestic abuse – new Violence Against Women and Girls (VAWG) Strategy, published in July 2017, which has been produced for the multi-agency partnership (see attached). This sets out clear objectives to continue to develop practice and knowledge on domestic abuse for practitioners and people who live, work and study in Enfield.

Police

- Child Abuse Investigation Team (CAIT) referrals desk relocated to sit within the Single Point of Entry.
- The planned restructure of the 32 borough police services to 12, will see Haringey and Enfield being brought together.

North Middlesex Hospital

Safer Sleeping Week 13th-17th March - NMUH held a one-week event in line with the Lullaby Trust's campaign to raise awareness around safer sleeping. This included teaching for midwifery staff and others and a stall in the fover to involve the public.

Enfield CYPS

In 2017, as part of World Mental Health Day, ECYPS held a two day "Mind Kind" event with local schools, over 400 young people attended, and the event was oversubscribed with a further 500 wanting to attend. The workshop included giving teachers and young people the tools to look after their mental wellbeing.

5. Safeguarding in different contexts

Partners focused on understanding the issues that pose a risk to young people and how they impact on their lives – in a local context.

Preventing radicalisation and extremism

- Responsibility for the Prevent agenda in Enfield sits within the Community Safety Unit (CSU). There is a strong focus on safeguarding individuals from supporting or becoming involved in terrorism.
- There is a structured programme of support to schools and other organisations to offer support to those who are deemed to be at risk.
- A key element of Prevent is the Channel programme, which receives concerns about vulnerable individuals and the needs are assessed along with any risks that the police may highlight suggesting terrorism or radicalisation concerns.
- Recent Home Office figures showed that nationally around 63% of individuals discussed at a Channel panel were aged under 20 years, similarly in Enfield we find that a higher proportion of referrals are about young people.
- The past year has been a very active and innovative period for Prevent in Enfield. There were significant changes in the way the threat from terrorism to the nation has evolved over the year.

- At the beginning of the year, the focus was working to reduce the influence of radicalisers and mitigate the risk of vulnerable people travelling to areas of conflict. By the end of the year the focused moved away from stopping people travelling to conflict areas to working on a programme where the country is starting to receive returnees from these conflict areas and how do we support their needs.
- By the end of 2017 Prevent training had been successfully delivered to over 70% of secondary schools and nearly 65% of Primary schools. To strengthen the local, Prevent programme two extra staff were recruited funded by a grant from the Home Office.
- In 2017 an anti-radicalisation workshop was piloted for year 6 students at the age they will be preparing to move over to secondary school.

"A very engaging presentation that helped the children build on their knowledge of this subject. It also improved their understanding of influential peacemakers – Ghandi, King, Parkes etc."

Primary School Teacher

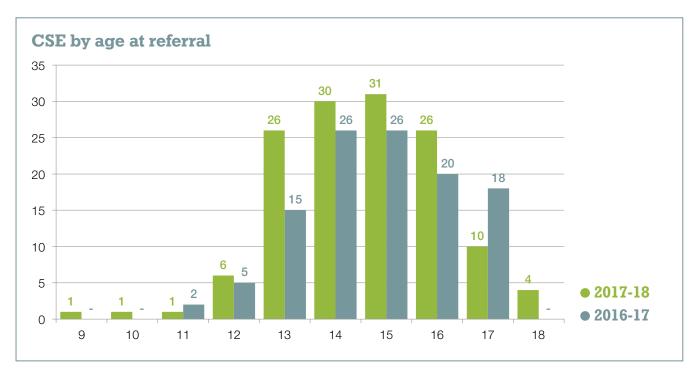
Child Sexual Exploitation

- Child Sexual Exploitation is a form of Child Abuse and causes children and young people serious harm. The Enfield CSE operating protocol has been developed by the Enfield Safeguarding Children Board (ESCB) to assist practitioners from all agencies to make decisions and to access timely support when working with children and young people who are at risk of, or known to be experiencing Child Sexual Exploitation (CSE). There are several key documents designed to support practitioners working with CSE which should be referred to. These documents along with a range of supporting tools and documents can be found on the ESCB website on the CSE webpage.
- A key aspect of Enfield's approach to tackling CSE is our multi-agency Child Sexual Exploitation Prevention (CSEP) Team which was established in July 2015. The multi-agency team was initially part of the Youth and Family Support Service (YFSS) and was moved into Children's Social Care 2017. The team is made up of Social Workers, Police officers, specialist workers from Safer London, youth workers and a CSE coordinator.

- The team have recently commissioned an organisation to support young women to exit gang culture.
- The MASE and CSEP team cross reference data regularly. Annually the CSEP team collate an annual profile to build up the picture to aide understanding and as far as possible the scope and nature of Child Sexual Exploitation (CSE) in Enfield, with a view to informing the strategic and multi-agency efforts to tackle CSE and other associated vulnerabilities affecting the young people in the Borough.
- During the year 136 young people were identified as either experiencing or being at significant risk of CSE. This figure is higher than the last full year analysis where 112 young people were identified in 2016-17.
- There is a larger span of referrals by age in comparison with 2016-17. All children on the list were aged between 9 and 18 years at point of referral. The most common ages for referral are 14 and 15, with 83% of children being aged between 13 and 16 years at the time they were referred which is a slight increase to 78% in 2016-17, although there has been a decline in referrals for 17 and 18-year olds.
- Of the 136, the majority are female, there was a decrease in the number and percentage of boys identified. There were 99 girls (88%) and

- 13 boys (12%). We know that nationally there is an under reporting of boys who are victims of CSF.
- As in 2016-17 the largest identified ethnic group is White (48% similar to 45% in 2016-17). This includes those identified as "All other White". Further significant cohorts are identified Black (31% of cohort in total).
- 108 of the 136 children (79%) are reported as living at home with parents or relatives.

- Very few are missing education (11 are NEET).
- The majority live in four postcodes where there is known gang activity however very few are known to the gang partnership as affiliated with gangs.
- Since March 2018, the names of the young people known to the CSEP team are checked with those who are believed to be involved in County Lines this will be reported on next year.



Multi-Agency Sexual Exploitation (MASE) group

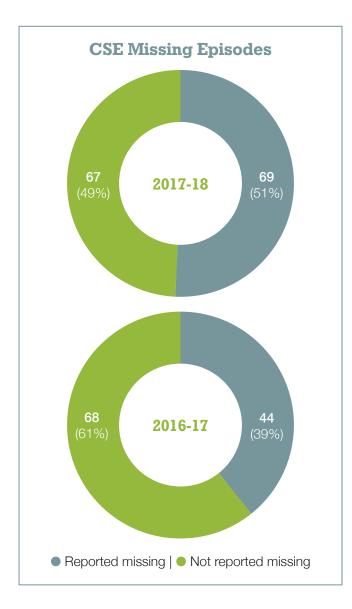
- The MASE is a strategic multi-agency meeting comprising of a variety of senior staff from across the LSCB partnership and has been in operation since 2013. The meetings are police led and are co-chaired by the Detective Inspector responsible for Public Protection and service manager for Practice and Partnerships.
- The MASE meets monthly, recent developments in MASE include a stronger shift in focus toward a more strategic approach in line with London-wide policy. The meeting considers children who are identified as "high risk" and shares information to identify themes, locations, trends, cross border issues with discussion about high risk individual cases and perpetrators in order to inform disruption activity. As of April 2018, this group will include those young people involved in County Lines.²
- 49 young people were discussed at the MASE meeting. In comparison, 36 young people were discussed at MASE meetings in 2016-17. This is a slight increase in the number of cases being presented to MASE from 32% to 36%.



² **County Lines** is the term used to describe the approach taken by gangs originating from large urban areas, who travel to locations elsewhere such as county or coastal towns to sell class A drugs. Gangs typically recruit and exploit children and vulnerable young people to courier drugs and cash through deception, intimidation, violence, debt bondage and/or grooming. Typically, users ask for drugs via a mobile phone line used by the gang. Couriers travel between the gang's urban base and the county or coastal locations on a regular basis to collect cash and deliver drugs. Young men and women may be at risk of sexual exploitation in these groups.

Missing

- The correlation between missing from home and care and CSE remains significant (over 50% of the cohort). There will be new arrangements for debriefing young people who return home from 1st October 2018 which will strengthen the quality of the debriefing interviews and ensure the push/pull factors are understood and risks addressed within care planning.
- The graphs demonstrate the proportion of children on the CSE list who are known to have been reported missing on at least one occasion.
- The Missing Children Risk Management Group (MCRMG) was established in July 2015. 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.
- Whilst not an ESCB subcommittee the work of this multi-agency group There are strong links between related groups including the Multi-Agency Sexual Exploitation (MASE) group, the Gangs Partnership Group and a newly established County Lines group which sits within the Youth Offending Unit (YOU).





- This group has been instrumental in facilitating a positive partnership with other agencies; mainly due to the capacity for open forum discussions with multiple agencies with safeguarding responsibilities.
- One of the most successful outcomes had been the improved partnership with colleagues from the Police and the ability to have police checks conducted on CME and missing cases discussed as part of MCRMG.
- **ECPAT** in 2017-18, work began with the national charity ECPAT on their innovative Partnership Against Child Trafficking (PACT project). The project offered a thorough case file audit of cases where there have been concerns primarily around child trafficking. The audit identified good practice particularly

- in relation to CSE and missing and areas for development in relation to understanding risks and links between trafficking and County Lines.
- Enfield was the 4th London borough for victims of Serious Youth Violence, Gang, Serious Youth Violence and exploitation is a complex multi-faceted problem and there are no simple answers, professionals and the community need to work together to deliver a holistic response that deals with the issue and its causes and this is why partnership and community involvement is a key aspect to respond to these issues.
- The Local Children's Safeguarding Board, The Safer Strong Communities Board, the Health and Well Being Board and the Enfield Targeted Youth Engagement Board all work together and ensure that Serious Youth Violence and our response are all a key area of focus.
- established in June 2015 focussing on CSE, in December 2017 the Council agreed to changing the scope to closely reflect the VYP sub-committee of the ESCB. The members task group meets four times a year offering strong leadership, oversight and scrutiny for the work undertaken to tackle exploitation and other associated vulnerabilities across the borough. The Cabinet member for Children's Services is invited to all meetings.

- Given the progress made on tackling CSE 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 and agreed in 2017 that the good work is built upon and expanded as part of a new Vulnerable Young People group. The new group includes a focus on:
 - CSF
 - Criminal exploitation and County Lines
 - Gang activity in relation to young people
 - A sharpened focus on Trafficking and Modern Slavery
 - Radicalisation and the Prevent agenda
 - Children and young people involved in or at risk of Harmful Practices (including Female Genital Mutilation, Forced Marriage and Honour Based Abuse)
 - Young people who are in abusive relationships, at risk of or experiencing domestic abuse.
- There is already significant work addressing these issues being undertaken in the borough.
 The new Vulnerable Young People (VYP) subcommittee does not attempt to replace

- or replicate the work of these groups but links closely with them to ensure that there is robust communication and closely allied work programmes.
- To support the partnership in understanding how these issues intersect and how we should locally respond, there will be a focus on developing an overarching Vulnerable Young Peoples Strategy: "Protecting Young People from Exploitation and Abuse".

Female Genital Mutilation

- Female Genital Mutilation (FGM) is a form of child abuse and violence against women and girls (VAWG).
- Enfield VAWG strategy focuses on safeguarding and states that FGM is a crime under the Anti-Social Behaviour, Crime and Policing Act 2014.
- A needs assessment in 2014 estimated that more than 2,800 women and girls were at risk in Enfield. This is likely to have been an overestimate. The Iris clinic opened in August 2015 at North Middlesex University Hospital. Only one case of an Enfield girl has been reported to Ofsted. There has been no prosecution.
- The Enfield Safeguarding Children Board established a multidisciplinary group in 2014

in response to an increasing understanding of FGM and the need for a more coordinated approach to tackling it and providing support. The key actions from this were to continue working with local communities to raise awareness of the issue and of the local services available. There is also an ongoing programme of training for social workers and health professionals that includes advice on the types of FGM, data on countries that practice FGM and local implications, health issues related to FGM, cultural and religious reasons behind the practice, legislation on FGM and support services. In recognition of the mental and physical impact FGM has on health Enfield Health and Wellbeing Board now oversees work in this area.

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. The new model will be based on a Hub system. There will be one Children's Centre Hub, with a number of satellite sites across the borough. The three agencies forming the Family hub at inception will be children's centres, Change & Challenge (developed as Enfield's response to the Government's Troubled Families programme) and Parent Support Unit.

- In 2017-18 there were 977 early help assessments completed the outcome of which was:
 - 470 families supported with a range of interventions.
 - **164** families were stepped down from early help targeted services and received ongoing support from universal or community services.
 - 278 families continue to receive low level early help support.
 - 46 cases stepped up to social care.
 - 8 families moved out of the borough.
 - 11 families did not want to engage with early help support services.
- 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.



6. Learning and improvement

Published one Serious Case Review which started in the previous year. Commissioned one local learning case review.

Performance data headlines

- The ESCB continually monitors the quality, timeliness and effectiveness of multi-agency practice through the multi-agency dataset.
 Where gaps are identified, implications for the LSCB are considered and any agreed actions are monitored.
- Referrals to Children Social Care have fallen 4,110, from 4,154 (2016-17).



- In April 2017, the SPOE was restructured, social workers were replaced with managers. This has directly contributed to the reduction in SPOE contacts, partners contacting the SPOE for case discussions are speaking directly to managers helping them to decide the appropriate pathway for cases.
- In 2017-18 there was a drop in the timeliness of assessments (just over 61% of Child and Family Assessments had been authorised within 45 days). During this time there was increased staff turnover and caseloads were high.
- The number of Social Care referrals to CAMHS is up. Self-harm referrals (0-13yrs) are recorded differently. SAFE get the 13+ year-old referrals. Significant changes have taken place in CAMHS, which is now divided into generic CAMHS, SAFE (Service for Adolescents and Families in Enfield) and SCAN (learning difficulties).

Multi-agency audits

 Monitored partners compliance to section 11 audit. The Section 11 audit process included responses from a range of agencies and challenge interviews have taken place with most agencies. A Section 11 action plan is monitored through the QA subcommittee. A strategy meetings audit identified the nonattendance of some partners to meetings. Partners were written to by the Independent Chair with a reminder of their statutory role. There has been significant improvement in the partner contribution to meetings since communication from the Independent Chair.

Single agency audits

Single agency audits were monitored by the Quality Assurance group including:

- North Middlesex University Hospital domestic abuse audit (maternity). Audit findings: All women are screened at booking and again during pregnancy for domestic abuse. Challenge: There is sometimes difficulty in getting immediate support for a woman who presents at the hospital and discloses domestic abuse. Findings were shared with the Domestic Violence Strategy Group.
- Children Centres case file audit. Audit findings:
 Children's centres currently use paper-based files, which can hinder sharing of information. The plan is to move to shared access of the Early Help module; the same system used by Education. There will be quarterly monitoring, with an ability to readily track children's history and progress.

Serious Case Reviews

- Serious Case Reviews are published on the ESCB website. This year the Board published one Serious Case Reviews in October 2017. Outcomes and findings feed into all structures to promote a culture of continuous learning and improvement across the partner agencies of the LSCB.
- Child YT: A tragic case of a 17-year-old who took his own life just hours after arriving in this country in the summer of 2016. The report can be found here. Key themes: Vulnerability of young asylum seekers, Availability of interpretation services for foster carers. Information sharing with foster carers out of hours.
- One local learning review was started in 2017-18 focusing on a baby who sustained injuries whilst in care of parent and concerns around domestic abuse and disquised compliance.
- The LSCB continues to implement the recommendations from Serious Case Reviews. Action plans are monitored by the SCR sub committee and reviewed by the LSCB Board. Learning is shared following serious Case Reviews publication to contribute to the professional development of staff and improve their understanding of local safeguarding concerns and themes.

For more information on Serious Case Reviews click here.

Domestic Homicide Reviews

- A domestic homicide Review learning event was held in January 2018 for adults and children services.
- Continuous reporting of safeguarding performance data has provided reassurance that practice standards are being met. There is recognition more data is needed from some partners to enable a fuller understanding on how the partnership are safeguarding.
- A range of multi and single agency audits were conducted over the year, of the audits completed they provided an understanding of strengths and areas for improvement.
- Local and serious case reviews have been completed in a timely manner and action plans monitored.
- Partners will strengthen the learning and improvement framework by:
 - Update the dataset to capture multi-agency intelligence.
 - Review multi-agency early help and early intervention arrangements.
 - Renew focus on increasing the number of

- multi-agency case audits.
- Focusing on developing further models to disseminate and embed lessons learned.
- Monitor action plans with the view of providing an analysis of the impact of the learning on multi-agency practice.

Child Death

- The Child Death Overview Panel share their key learning from child deaths. They monitor and challenge agencies for the completion of recommended identified actions and publish a separate annual report.
- Between April 2017 and March 2018 CDOP received notifications 22 child deaths (death of a person under 18 years of age).
- 26 children were reviewed in 2017-18, of the 26 cases, 14 cases were from previous year 2016-17.
- Modifiable factors were found in 4 cases. Recommendations were made in 4 cases.
- The number of deaths reported over the last 3 years has been fairly stable.
- Of the 26 cases reviewed 14 were of males. 12 of females. 14 deaths were unexpected, 11 cases were referred to the coroner, 7 postmortems were undertaken, 3 inquests held.

- 13 cases were of 'white' ethnicity' (50%), 6 'Black African, Caribbean or Black British' (24%), 2 of 'Asian' (8%) and 3 'not known' (12%).³
- Only seven children were living in the parental home at the time of death.
- Learning Disabilities Mortality Review
 Programme (LeDeR) is a 3-year project led by
 NHS Improvement and the University of Bristol.
 All deaths of people with learning disabilities
 from age 4+ should be reviewed. Two deaths
 have been reported to LeDer in 2017-18.
- eCDOP came into use with one-year funding from NHS England.
- There will also be changes around the Child Death reviews next year. There is an expectation that child death need to be reviews over a population size that gives sufficient number of deaths to be analysed for patterns, themes and trends of death. This suggests there will be a need to consider cross border Child Death panels.

Find out more information about Child Death Reviews click <u>here</u>.

Inspections

- In April 2017 Enfield Children Services
 volunteered to take part in a pilot inspection
 for Ofsted's new Inspection of Local Authority
 Children's Services (ILACS) framework. The
 overall effectiveness was rated Good. The
 inspection findings in relation to early help
 found that services are not yet as developed
 and joined up as they might be which has had
 the effect of increasing demand on children's
 social care. The full report can be found here.
- During the year BEHMHT CQC Review of Mental Health services for children and young people – General findings were that there was strong partnership working, and any gaps were already identified by the service. How Early Help can be managed is a national concern; there are also national issues around limited bed spaces for specialist inpatient care.

Allegations against staff or volunteers

 The role of the Local Authority Designated Officer (LADO) is set out in the "Working Together to Safeguard Children" guidance. In Enfield, the role of the LADO is undertaken by the Head of Safeguarding and Quality Service (SQS) who has responsibility for overseeing investigations, alerting senior council officers to allegations of a serious nature and making referrals to the Disclosure and Baring Service.

- In addition to leading on investigations, the service offer advice and guidance when there may be concerns about a person's conduct and when the threshold for a formal investigation has not been met.
- During the year there was a total of 62 allegations which met the threshold for formal LADO involvement was 62.
- 22 (approximately 35%) of the allegations were substantiated.
- In addition to the 62 allegations, there have been approximately 80 consultations with the LADO, where the threshold for formal LADO intervention had not been met.
- The number of allegations has increased by just under 25% this year and the number of substantiated ones has also increased significantly. These figures would suggest that the LADO intervention has been appropriate and measured.

You can read more information about the work of the LADO and related data in the Annual LADO report on the ESCB website.

³ Population data between censuses are always projections and therefore subject to error but this compares to the general population in which approximately 40% of the population is 'white' and 17% Black African, Black Caribbean or Black other. Again, caution should be used in the interpretation of this data as numbers are small.

7. Training, Learning and Development

The ESCB and the ESAB progressed the merger of their respective Learning and Development subcommittees.

- ESCB offered 10 different topics in 2017-18. The training programme this year has had a strong focus on training and awarenessraising in relation to Child Sexual Exploitation (CSE). A grant of £15,570 from The Enfield Strategic Partnership Fund was used to offer all Enfield secondary schools a hard-hitting theatre production Chelsea's choice. This was successful in raising awareness of CSE amongst 11 to 16-year olds.
- **Continued** to work with Safer London Foundation to provide training and awareness raising in relation to CSE. The ESCB has continued to deliver targeted training sessions for specific professionals. Professionals benefiting from this training include, Social Workers, Police officers, and Community Safety unit staff, Pupil Referral Unit staff and Health Visitors and School Nurses.
- There was a continued focus on embedding Signs of Safety via workshops for all Enfield and multi-agency staff.
- A County Lines workshop was held in August 2017 where 135 professionals across Enfield attended. The session was delivered by Police colleagues from Met Police as well as officers here in Enfield. The focus was to raising awareness and a better understanding of the issue of County Lines.

- Modern Slavery and Human Trafficking. **Every Child protected against Trafficking** (ECPAT) provided three days of training at Enfield to explore in depth the subject of modern slavery, child trafficking and exploitation and how children missing is inter linked.
- A total of **726 places** were taken up from the ESCB targeted training programme, which included a full training programme for designated leads in school.
- This year's course was targeted to focus on areas of practice prioritised by the Board with learning from local and national case reviews being fully integrated into the training material.
- There has been very good engagement from the Education sector this year with 105 people attending events. This is, to some extent explained by the large number of Signs of Safety and a new course Single Point of Entry which aimed to increase practitioners understanding on what happens when they make their referrals.
- 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.

- Attendance from Probation colleagues and Police has fallen, which is probably reflective of the various changes that have taken place in that sector this year.
- An important focus has been strengthening the ESCB Learning & Development sub-committee which is now joint with the Safeguarding Adults Board (SAB) equivalent committee. This was in response to recognition by both boards that there is overlap in the training needs of both workforces and the importance of thinking of the family as whole.

"The course was concise, effective and delivered the updated training that we needed to keep abreast of changes to online safety."

Youth offending worker, Child Exploitation Online Protection (CEOP) - Online Safety

"The course was well presented with lots of useful information. The trainer was very knowledgeable and offered good advice."

Primary School Teacher, Child to Parent Abuse

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 committee. Findings are used to inform ongoing training and development.
- 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.
- A breakdown of attendance and evaluation of all courses can be found in the ESCB Learning and Development Annual Report 2017-18.

For more information of training click here.

- There have been some challenges in the engagement of adults safeguarding, which has improved now the group is chaired by the adults safeguarding board manager.
- The financial resourcing and delivery of training are different and this year, there has been an acknowledgement of the differences, but a recognition that there are many areas of opportunity to join up learning and embed a Think Family approach.
- The agency percentage breakdown attending training attendance has remained consistent, with Education, Children Social Care, health and VCS.

The partners will:

- Strengthen the joint multi-agency learning and development offer and ensure despite who commissions training it will be available to all areas regardless if their primary focus is children or adults.
- Recognising the different learning models there will be a focus on embedding more online and bite size learning opportunities.
- Next year there will be a focus on increasing the attendance of partners whose attendance was lower than expected.

Communication

- 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.
- 923 ESCB twitter followers, 173 tweets viewed 60,622 times and retweeted 173 times.
- 5,459 users visited the ESCB website in 2017-18 with over 21,000 pages views. Most popular pages excluding home page: a) SPOE, Contact Us and Learning and Development.

8. Priorities and challenges for next year and beyond

| What the ESCB want to achieve | What we will do | How will we know | |
|--|--|--|--|
| Priority 1: The Local Safeguarding | Context | | |
| Children and Young people are safe from harm, inside the home, outside the home and online. | Work with partners to identify and respond to Enfield's local safeguarding priorities: | We will know our local profile of the children and young people who are at risk of harm or exploitation, and will use this information to inform strategies, commissioning and | |
| | Vulnerable Children and Young People: those affected or at risk of CSE, Radicalisation, Neglect, violence and gang activity, mental health, Trafficking and Modern Slavery, Harmful Practices (including Female Genital Mutilation, Forced Marriage and Honour Based Abuse, Domestic abuse and violence. | practice. | |
| | Create a multi-agency dataset that reflects activity across the partners, focused on continuous improvement of child protection and identifying themes for further activity. | We will know the local responses across the partnerships in response to the identification of risk of harm or exploitation of children and young people. | |
| | Capture the voices of children and young people so they exert ongoing influence on the partnership's effectiveness. | We will be able to demonstrate the voice of children and young people has been sought and captured and evidence where their voices have influenced the partnership. | |
| Priority 2: Early Help & Early Interv | ention | | |
| Children and young people have access to the right help, the right service at the right time and in the right place. | We will agree and publish a revised Threshold of Needs document which sets out the local criteria for action in a way that is transparent, accessible and easily understood. | We will be able to evidence that staff report they have an increased awareness and understanding and are confident to apply locally agreed thresholds. | |
| | Monitor the effectiveness of the Front door arrangements and ensure the partnership have an agreed understanding and approach to MASH. | Early, targeted support is available for children, adults and families who need it. | |
| | Monitor the accessibility and impact of the early help offer being provided to children and families. | We will have evidence that Children, young people and parents/carers views were sought and that they were made aware of where to go to access support and when that support has made a difference. | |

| What the ESCB want to achieve | What we will do | How will we know | |
|--|--|---|--|
| Priority 3: Strong Leadership & Strong Partnership | | | |
| Effective partnership working and accountability to improve safeguarding outcomes for children, young people and their families. | Continue to strengthen the link and governance arrangements between the ESCB and other key strategic forums and work happening locally to support children and families. | We will have a governance protocol setting out the unique identities, roles, focus areas and interrelationship of the strategic partnerships. | |
| | Ensure the ESCB continues to carry out all its statutory functions until such time the new arrangements begin to operate in Enfield ⁴ . Maintaining the strengths and ownership of safeguarding across the partnership during the transition to the new arrangements. | We will publish the local arrangements and notify the Secretary of State for Education. | |
| | Maintaining and, if necessary, recruiting additional lay members from the community into the partnership to continue the excellent dialogue, scrutiny and involvement from recent years. | | |
| Priority 4: A healthy workforce | | | |
| Reassurance that agencies have in place effective arrangements to support their staff to continue delivering high quality and safe practice considering current public funding reductions. | Seek reassurance that management oversight is robust and front-line staff have access to reflective supervision. | We will understand agencies capacity to maintain safeguarding arrangements. | |

⁴ Safeguarding partners have **up to 12 months**, from 29 June 2018, to agree their local arrangements and which relevant agencies they consider appropriate should work with them to safeguard and promote the welfare of children in their area.

Appendix 1: Membership list 2018-19

| Independent Chair | |
|--------------------------|--|
| Geraldine Gavin | |
| ESCB Team | |
| Bharat Ayer | Safeguarding Adults & Children Team Manager |
| Lisa Tait | ESCB Coordinator |
| Vacant | ESCB Coordinator |
| Participant Observer | s |
| Cllr Achilleas Georgiou | Lead Member for Children, London Borough of Enfield |
| Board Members | |
| People Directorate | |
| Tony Theodoulou | Executive Director of Children's Services |
| Anne Stoker | Director of Children & Family Services |
| Clara Seery | Assistant Director Education |
| Sharon Burgess | Head of Safeguarding Adults, QA & Complaints |
| Andrea Clemons | Head of Service, Community Safety Unit |
| Public Health | |
| Stuart Lines | Public Health Director |
| Third Sector | |
| Claire Whetstone | Director, ECYPS |

| Schools | |
|----------------------|---|
| Antoinette Goldwater | Headteacher, Fleecefield Primary School |
| Yeliz Sabri | Vice Principal, Aylward Academy, Secondary School |
| Gail Weir | Headteacher, Waverley School, Special School |
| Police | |
| Helen Millichap | Borough Commander |
| Tony Kelly | Detective Superintendent, Enfield Borough Police |
| CCG | |
| Carole Bruce-Gordon | Director of Quality & Governance (Acting), Enfield CCG |
| Hetul Shah | GP, Enfield CCG |
| Christina Keating | Designated Nurse, Enfield Clinical Commissioning Group |
| Vacant | Designated Doctor for Safeguarding in Enfield |
| NMUH | |
| Deborah Wheeler | Director of Nursing & Midwifery |
| Betty Wynne | Deputy Director of Nursing |
| BEHMHT | |
| Linda McQuaid | Interim Director of Nursing, BEHMHT |

| Royal Free Lond | on NHS Trust | |
|-----------------|--|--|
| Helen Swarbrick | Acting Head of Safeguarding/ Named Nurse, Royal Free London NHS Foundation Trust | |
| Mary Sexton | Executive Director of Nursing, Quality and Governance | |
| London Ambula | nce Service | |
| Sophie Hill | Quality, Governance & Assurance Manager, London Ambulance Service | |
| CAFCASS | | |
| Paula Kelly | Service Manager | |
| Probation | | |
| Clare Ansdell | Assistant Chief Officer, National Probation Service – Barnet, Brent & Enfield | |
| CRC | | |
| Katie Morgan | Area Manager, North London | |
| Lay Members | | |
| Vacant | Lay Member | |
| Vacant | Lay Member | |

ESCB Annual Summary 2017-18 – At a glance

| What did we do? | What did it tell us? | Next Steps |
|--|---|---|
| Considered what the future local multi-agency safeguarding arrangements could be following the legislative changes introduced through the Children and Social Work Act 2017. | There will be statutory changes with the abolishing of LSCBs and the introduction of new safeguarding arrangements, changes to the Serious Case Reviews and the introduction of Safeguarding Practice Reviews and the role of the National Safeguarding Practice Review Panel. There will also be changes around the Child Death reviews. There is an expectation that child deaths need to be reviewed over a population size that gives a sufficient number of deaths to be analysed for patterns, themes and trends of death. The changes offer flexibility and provide opportunities to streamline strategic boards and reduce duplication. | Embed statutory changes outlined in Working Together 2018. Over the next 12 months will see the partnership agreeing and publishing new local arrangements. To have a sufficient number of deaths to analyse consideration will need to be given to having cross borough Child Death Overview Panels. |
| No new Serious Case Reviews were commissioned. Published one Serious Case Review which started in the previous year. Commissioned one local learning case review, the learning from this review will be disseminated across the partnership and included in next year's report. | The SCR was completed in a timely manner. Learning: Practitioner involvement could be better in the review process We should build on understanding the vulnerabilities of young asylum seekers The importance of information sharing out of hours Domestic abuse and disguised compliance | The group will focus on developing further models to disseminate and embed lessons learned. Monitor action plans – with the view of providing an analysis of the impact of the learning on multiagency practice. |
| The Quality Assurance Sub Committee continued to lead on and scrutinise the ESCB learning and improvement framework. A range of multi and single agency audits were conducted over the year. Including a strategy meetings audit which identified the non-attendance of some partners to meetings. Partners were written to by the Independent Chair with a reminder of their statutory role. | Continuous reporting of safeguarding performance data has provided reassurance that practice standards are being met. There is recognition more data is needed from some partners to enable a fuller understanding on how the partnership are safeguarding. There has been a significant improvement in partner contributions to strategy meetings since communication from the Independent Chair. Of the audits completed they provided an understanding of strengths and areas for improvement. | Update the dataset to capture multi-agency intelligence. Review multi-agency early help and early intervention arrangements. Renew focus on increasing the number of multi-agency case audits. |

| What did we do? | What did it tell us? | Next Steps |
|---|--|---|
| The ESCB expanded its CSE group and established a new Vulnerable Young People Group, chaired by the Head of Community Safety. Partners focused on understanding the issues that pose a risk to young people and how they impact on their lives – in a local context. The group has looked at a range of issues from Radicalisation to County Lines and continued a specific focus on CSE. | It was identified that the complex vulnerabilities of young people frequently intersect and overlap. It was agreed that approaching these as separate needs is less effective than considering the complexity of a young person's needs. | To support the partnership in understanding how these issues intersect and how we should locally respond, there will be a focus on developing an overarching Vulnerable Young Peoples Strategy: "Safeguading Adolescents from Exploitation and Abuse". |
| The ESCB and the ESAB progressed the merger of their respective Learning and Development subcommittees. Delivered a targeted multi-agency training safeguarding programme appropriate to the needs of staff across all agencies and sectors; enabling them to effectively promote the safeguarding of children. | There has been improved engagement from across all agencies, and the group is now chaired by the adults safeguarding board manager. The financial resourcing and delivery of training are different and this year, there has been a recognition that there are many areas of opportunity to join up learning and embed a strengths-based Think Family approach. The agency percentage breakdown attending training has remained consistent, with participants from Education, Children Social Care, health and VCS as the highest attendees. | The partners will strengthen the joint multi-agency learning and development offer and ensure despite who commissions training it will be available to all areas regardless if their primary focus is children or adults. Recognising the different learning models there will be a focus on embedding more online and bite size learning opportunities. Next year there will be a focus on increasing the attendance of partners whose attendance was lower than expected. |

2017-18 has been a busy year for the Safeguarding Board, despite changes and challenges that have at times impacted on the Board's ability to progress work, agencies across the partnership have continued to demonstrate strong commitment to the Board and its activities. The Board remains committed to a programme of scrutiny, monitoring and, quality assuring the quality of safeguarding activity across Enfield. This programme of robust analysis and challenge will continue to ensure that children and young people who are at risk of exploitation or abuse are identified and responded to speedily and effectively, as we move forward and embrace the opportunities the new statutory guidance offers.

Enfield Safeguarding Children Board















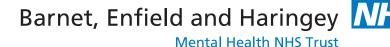


...because safeguarding children is everybody's business













Notes



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



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