

**MINUTES OF THE CHILDREN'S SAFEGUARDING POLICY AND PRACTICE ADVISORY COMMITTEE  
TUESDAY, 13 SEPTEMBER 2011**

Councillors Amin, Corrick, Davies, Hare, Rice and Stewart

Apologies None

Also Present: Marion Wheeler, Karen Baggaley, Sarah Peel

<b>MINUTE NO.</b>	<b>SUBJECT/DECISION</b>	<b>ACTON BY</b>
<b>CSPAP C12</b>	<b>APOLOGIES FOR ABSENCE</b>  Apologies for absence were noted from Sylvia Chew.	
<b>CSPAP C13</b>	<b>URGENT BUSINESS</b>  There were no items of urgent business put forward to the Committee.	
<b>CSPAP C14</b>	<b>DECLARATIONS OF INTEREST</b>  There were no declarations of interest put forward by Members of the Committee.	
<b>CSPAP C15</b>	<b>MINUTES</b>  The minutes of the meeting held on the 28 <sup>th</sup> July were agreed as a correct record of the meeting.	
<b>CSPAP C16</b>	<b>MATTERS ARISING</b>  There were no matters arising.	
<b>CSPAP C17</b>	<b>OVERVIEW AND UPDATE ON THE SAFEGUARDING PLAN</b>  The Committee considered the Safeguarding and Looked after Children Plan which picked up the issues arising from the January Ofsted inspection of the Safeguarding service. Ofsted had described the service as "adequate with good prospects for improvement". The enclosed plan being considered by Members had been updated in August with information on the progress of developments and responses to the inspection.  Members were asked to particularly note the attention being given by the	

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Safeguarding service to managing risk, domestic violence, quality assurance and workforce development.

In relation to action 1.7, Members queried the number of children with disabilities subject to child protection plans. There was concern that the action being undertaken did not match the recommendation. Members asked for comparisons between the numbers of disabled children subject to care plans in similar demographic boroughs. It was noted that in Hackney there were no children with a disability, subject to a protection plan. However, in the London Borough of Richmond, which had a dissimilar demographic to Haringey, there were higher numbers.

When considering action 1.2, the system for attendance at child protection review medicals reviewed and attendance monitored, the Committee noted there was an agreed protocol in place for paediatricians to check Framework 1 and communicate with the Social Worker to ensure that these appointments were kept to. There had previously been a significant number of children not attending appointments which had been dramatically reduced following the implementation of this protocol. These figures could be further shared with Members of the Committee to help understand the impact of this protocol if requested.

The Committee discussed the effectiveness of strategy meetings. There were best practice standards for attendance at strategy meetings which involved having a considered and planned response to these meetings. Currently Social Workers were ensuring that key agency and partner representation at these meetings. The Independent Member advised that it was also important to ensure that there was wide representation at the meeting involving, for the example, the immediate referrer and not contacting them after Strategy discussions. The service usually had 20 cases a week which required a strategy meeting and getting key people from the agencies together could sometimes cause delays. The service recognised that there was a need to look at how to get people together from the key agencies in contact with the child expediently and ensure that they were able to provide constructive contributions. This did not necessarily always mean that a meeting was the best vehicle to enable this. There were other ways of collating key information which could be through phone conferences and individual calls to collate a wide intelligence about the situation of the child. To further enable this could mean redefining strategy meetings as strategy discussions.

In relation to action 3, on establishing mechanisms to ensure that midwives, adult services and voluntary agencies were engaged with the CAF, there was interest by the Committee in looking at the areas not on track for this action. It would be useful to find out how many CAF's were being completed by Health agencies and if there was a potential training need. It would further be useful to find out the type of representatives from agencies and public bodies participating in CAF training to understand if there was a link to the current progress of this action.

MW

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	<p>The Safeguarding Champion scheme was explained to the Committee. This involved high level managers in the Council gaining more understanding of how frontline Children's services worked through the offer of various participation exercises. The attention given by managers to this scheme had been good but there was a need to review how the scheme had worked with consideration to how engagement by senior managers could be sustained. Officers were currently considering whether the scheme should continue.</p> <p>The intentions behind child champion scheme were described to the Committee. This scheme was aimed at getting an understanding of the child's sense of family life and this could be achieved through speaking to the child with their youth worker, mentor or teacher. Social Workers felt that they should have the skills to gain this information first hand from the child and asked to be assisted in this through a toolkit .Group Practitioners were now looking at how they could compile this . Proposals were due at the Best Practice Committee, a sub body of the LSCB, and this information could also be shared with this Committee if wanted.</p> <p>Members noted that, following questions at the last meeting on the current practices being followed in the supervision policy, there was an update to be sent by Rachel Oakley, Head of Safeguarding, Quality Assurance &amp; Practice Development, to Members of the Committee. Members were assured that there was constant attention being given to supervision and support. Members asked about alternatives ways of analysing the quality of supervision, other than completing standard audits. The Committee were advised that this could be done through checking case recordings to understand the quality of the discussion around the case between the Social Worker and their manager. The Safeguarding service was already encouraging Social Workers to add narratives to the case work files to enable this analysis.</p> <p>Regarding Action 36, developing and monitoring outcomes for children who have experienced Early Years services but are not subject to a child protection plan, it was not clear to the Committee how the action would be completed .The Committee suggested that it would be useful to find out if children, that were from defined vulnerable groups and accessing early years service, were seeing an improvement in their development . It would be useful to find out if there was a tracking system that could provide information on children's development.</p>	MW
CSPAP C18	<p><b>OVERVIEW OF THE SAFEGUARDING PLANNING AND MONITORING FRAMEWORK</b></p> <p>Sarah Peel, LSCB Business Manager, attended the Committee on behalf of the LSCB board to discuss the work and role of the Local Children's Safeguarding Board (LSCB). The annual report of the LSCB was due to be considered at their meeting in October and following</p>	

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<p>ratification it would be published on their website. Sarah Peel agreed to circulate this to Members of the Children's Safeguarding Policy and Practice Committee for reading when published.</p> <p>Sarah Peel, LSCB Business Manager, continued to set out the role of the LSCB and explain that it provides policies, guidance and protocols which underpin partnership work on safeguarding. The LSCB are signed up to Pan London safeguarding arrangements. The LSCB ensure that these agreed safeguarding practices are understood through guidance which is issued. The Committee further learned what is crucial in LSCB partnership relationship is that each agency understand their safeguarding role in relation to others. An example of a protocol currently being worked was enabling Mental Health services to record on case files whether a user had any children. Then also enabling this information to be passed to Children's services. This action where necessary would help build a profile of a child's family life.</p> <p>The strategic role of the of the LSCB was monitoring, along with training and evaluation of monitoring of LSCB member roles. This would be further elucidated upon in the LCSB's annual report. The structure and sub groups of the LSCB were visually set out for Member consideration. Each of the sub groups role and purpose was explained to Committee Members. The Chair remarked on the number of different partner representatives on the LSCB Board which made the meetings quite large. The LSCB Business Manager explained that attending the meeting was a key part of a partner's accountability in relation to safeguarding. When considering the number of sub groups the LSCB had, that teachers had welcomed the establishment of the Health and Education forums as they allowed them to communicate more directly with health colleagues.</p> <p>Information was provided to Committee Members about when a Serious Case Review was completed, by whom and how the findings were then reviewed by Ofsted. The Munro report was advocating unpicking the organisational context for each individual agency or body connected to the case to understand the actions taken by their representatives. Haringey LSCB was part of a pilot project considering this and information on this could be provided to the members of the Committee. The Committee and attendees discussed their experiences of Serious Case Review and usually how their findings were similar. They discussed: whether there was a systemic method to incorporating the findings of a review into everyday practices, finding ways to assist Social Workers with managing and dealing with the bombardment of information that needs to be acted upon on a daily basis, further focussing on the certain stages of a child's development that will make them more vulnerable.</p> <p>The Committee thanked Sarah Peel, LSCB Business Manager for the helpful information provided which had assisted with the Committee's understanding around the safeguarding context in Haringey.</p>	SP
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<b>CSPAP C19</b>	<p><b>DISCUSSION ON THE SAFEGUARDING CONTEXT IN HARINGEY</b></p> <p>Agenda compilation error – Please see information above which was part of this item.</p>	
<b>CSPAP C20</b>	<p><b>EXCLUSION OF THE PRESS AND PUBLIC</b></p> <p>The press and public were excluded from the meeting for consideration the items below as they contained exempt information as defined in Section 100a of the Local Government Act 1972 (as amended by Section 12A of the Local Government Act 1985): paras 1 &amp; 2: namely information relating to any individual, and information likely to reveal the identity of an individual.</p>	
<b>CSPAP C21</b>	<p><b>AUDIT OF REFERRALS TO THE SAFEGUARDING TEAM</b></p> <p>A programme of audits had been established by the Committee in order to monitor practice and performance in Children's Social Care, and identify areas of good practice and areas for improvement. An audit of new referrals between July the 12<sup>th</sup> and 19<sup>th</sup> 2011 had been examined by the Independent Member with involvement from Cllr Amin, a Member of the Children's Safeguarding Policy and Practice Committee.</p> <p>There were 37 families reviewed with the work of more than one team included in the range of cases looked at. The Committee noted that, of this sample, the highest number of referrals came from the Police with Schools also providing a higher than anticipated number of referrals. The case notes reflected the work done by the service to put the child's wellbeing at the forefront of all decisions. The highest category and reason for referral was abuse and according to the circumstances this required timely intervention by Children's services.</p> <p>The Independent Member reported that in the past there had been criticism of Children's services for holding onto cases for too long but in this audit there was appropriate closures of cases seen. The positive aspect of the audit were that there were circumstances of outstanding individual work completed by a Social Worker in very complex cases which required follow up work with a number of agencies and constant attention being given to a family. There were also comments on cases records from health services representatives, in contact with the family,</p>	

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	<p>which Social Workers could view. This was a good result of the MASH (Multi Agency, Safeguarding Hub) working together and sharing information. The audit further reflected that there were a lot of strategy discussions taking place which would aid timely decisions being made.</p> <p>Committee Members asked the Independent Member about any unsatisfactory elements of her findings. It was noted that a small number of cases had been prematurely closed when the case recordings indicated that the issues would reoccur. These findings had been referred to management and appropriate action was being taken. There were delays in a family being seen needing immediate re - housing where if earlier intervention from relevant agencies had occurred they may have been able to stay in the family home . Learning points from this case was the need to look at the decision making process being embarked upon when a family is assessed as being in need and evaluating the risks involved .Then as a Social Worker deciding whether you can gather the required information in a timely way to assist a family .</p> <p>There was a further separate case where a referral from a GP could have been quicker. In another case where a sibling had reported abuse and the actions undertaken may not have been as prompt in comparison to a father being the perpetrator of abuse.</p> <p>An Action Plan dealing with the areas identified for improvement from the audit was tabled from the Head of Safeguarding and First Response. This included information about what a Social Worker will have to contend with such as insufficient data at the point of contact with family, collecting information from other boroughs , and how this will be dealt with such as enhanced working of the MASH(Multi agency safeguarding hub) which will see additional services and agencies joining the First Response Multi agency screening team to increase intelligence about a family or child . Additional actions included increased monitoring pf particular social workers work and identifying training support.</p> <p>The Committee thanked the Independent Member and Cllr Amin for their work which provided a key insight into the current work in Safeguarding team.</p>	
<p><b>CSPAP C22</b></p>	<p><b>NEW ITEMS OF URGENT BUSINESS</b></p> <p>None</p>	
<p><b>CSPAP C 23</b></p>	<p><b>DISCUSSION ABOUT THE NEXT JOINT MEETING WITH THE CORPORATE PARENTING COMMITTEE</b></p> <p>The Committee noted that the Chair of the Corporate Parenting Committee had suggested that a report on children missing from home and from care could be considered. The Chair recommended that items</p>	<p>All to</p>

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	6 and 10 could be considered at the joint meeting . It was agreed that any further suggestions for items to be considered at this joint meeting could be put forward to the clerk.	note
<b>CSPAP C24</b>	<b>ANY OTHER BUSINESS</b>  The Committee noted that the next meeting was to be held on the 03 November 2011, the Independent Member was due to carry out a domestic violence related audit that would focus around under two year olds living in households where domestic violence was a feature.	HC

Cllr Reg Rice

Chair