**Report for:** Cabinet 18 June 2019

**Title: The new Haringey Safeguarding Children's Partnership Arrangements**

**Report authorised by:** Ann Graham, Director of Children's Services

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**Ward(s) affected:** All

**Report for Key/ Non Key Decision:** Key Decision

## 1. Describe the issue under consideration

1.1 The Council, Haringey Clinical Commissioning Group (CCG) and the Police are required to make new local arrangements for safeguarding and promoting the welfare of children in their area replacing the current LSCB arrangements. The purpose of this report is to seek Cabinet's approval on the proposed new local multi-agency safeguarding arrangements to promote the welfare of children in the borough and to be referred to as "Haringey Safeguarding Children's Partnership"

1.2 The Council and Haringey CCG are also required to make new arrangements for the review of each child death in its area. This report also seeks approval for the proposed combined arrangement for child death reviews that includes the geographical areas of Barnet, Camden, Enfield, Haringey and Islington.

## 2. Cabinet Member Introduction

2.1 Following the Wood Review, the Children and Social Care Act 2017, and publication of Working Together to Safeguard Children 2018 there is a requirement to replace LSCBs with new local multi-agency safeguarding arrangements to be determined by the local authority, CCG and the police. The Council and its statutory safeguarding partners have developed detailed proposals for a new local safeguarding arrangement for children in Haringey, as set out in attached paper. The approach taken by the three statutory partners has been to build on the strengths of the current LSCB and local partnerships, while seeking to further improve practice, partnerships, and outcomes for children and young people.

2.2 The attached proposal has benefited from the involvement of and consultation with the wider safeguarding partnership and has already been endorsed by the CCG and the police. Following Cabinet approval, it will be forwarded to DfE by the deadline of 29 June 2019 and become operational by 29 September 2019.

2.3 There is also a requirement to transform the child death review process. The new approach aims to support better learning from child deaths in order to improve care and outcomes, recognising that while the current process has its origin in safeguarding guidance, most preventable child deaths are not connected to safeguarding but largely medical in nature.

## 3. Recommendations

3.1 To approve for publication and implementation the proposed local arrangement for safeguarding and promoting the welfare of children in the borough to be referred to as "Haringey Safeguarding Children's Partnership" and which is attached as Appendix 1.

3.2 Subject to any further amendments to be made, to approve for publication and implementation the proposed combined arrangement for child death reviews to be referred to as 'North Central London Child Death Overview Partners and this is attached at appendix 2. The combined agreement consists of the geographical areas of Barnet, Camden, Enfield, Haringey and Islington.

3.3 To give delegated authority to the Director of Children Services to agree the final details of the proposed combined arrangement for child death reviews.

## 4. Reasons for decision

4.1 Under the Children and Social Work Act 2017, Haringey LSCB is due to be abolished and replaced. The Council, Haringey CCG and Police are required to make new local arrangements for safeguarding and promoting the welfare of children in their area. They have equal and joint responsibility and have greater flexibility and autonomy to determine the local approach to safeguarding children.

4.2 The Council and Haringey CCG must also make arrangements for the review of each child death in its area and for the analysis of information about deaths reviewed.

4.3 The new safeguarding and child death review arrangements must be published by 29 June 2019 and implemented by 29 September 2019.

## 5. Alternative options considered

5.1 In respect of the new safeguarding arrangement, the Council and its safeguarding partners considered the option of a joint arrangement with another area and including Haringey Adult Safeguarding Board and the Community Safety Partnership Board within the new multi-agency partnership arrangements. However, at this stage, it was felt beneficial to retain a strong focus on safeguarding children and minimise the risks inherent in a further change.

## 6. Background information

6.1 The Government commissioned Alan Wood in December 2015 to undertake a review of the role and functions of LSCBs. The review concluded that LSCBs were not sufficiently effective, confidence in LSCBs was not strong and the effectiveness was dependent on the ability of the Independent Chair. Many LSCBs were identified as lacking the willingness and ability to hold partners to account when there were shortfalls and failures in services to children. Alan Wood recommended the abolition of LSCBs and their replacement by a stronger partnership consisting of key statutory agencies (Police, Clinical Commissioning Groups and Local Authorities) who would, in turn, determine local safeguarding arrangements.

6.2 In its May 2016 response, the Government said that it agreed with Alan Wood's analysis and proposed a stronger, but more flexible, statutory framework to support local partners to work together more effectively to protect and safeguard children and young people, embedding improved multi-agency behaviours and practices. In April 2017, the Children and Social Work Act 2017 (The Act) was enacted. The Act abolished the LSCB. In its place, the Act requires the local authority, Clinical Commissioning Groups and police (referred to as the "safeguarding partners") to make local arrangements for safeguarding and promoting the welfare of children in their area. There will be greater flexibility and autonomy for the safeguarding partners to determine the local approach to safeguarding children.

6.3 The safeguarding arrangements must be agreed by the safeguarding partners and published by 29 June 2019 and implemented by 29 September 2019. The published arrangement must include provision for scrutiny by an independent person of the effectiveness of the arrangements.

6.4 The Act includes provision for child death reviews for the local area. The local authority and CCG are the statutory partners responsible for child death reviews. They must make arrangements for the review of each death of a child normally resident in their area and, if they consider it appropriate, for any non-resident child who has died in their area. They must also make arrangements for the analysis of information about deaths reviewed. The purpose of the review or analysis is: a) to identify any matters relating to the death or deaths generally, that are relevant to the welfare of children in the area or to public health and safety; and b) to consider whether it would be appropriate for anyone to take action in relation to any matters identified. Where it would be appropriate for a person to take action, they must inform that person. The transition from current LSCB Child Death Overview Panel (CDOP) to the new child death review arrangements must be completed by 29 September 2019. The current CDOP will continue until the child death review partner arrangements is in place.

**The proposed safeguarding arrangement - Haringey Safeguarding Children's Partnership**

6.5 The Council and its safeguarding partners are responsible for: a) the coordination of safeguarding services including how to work together and with other relevant agencies; b) the strategic leadership in supporting and engaging others; and c) implementing local and national learning including from serious child safeguarding incidents.

6.6 An Executive Group comprising of representatives from the Council, CCG and Police and chaired by the Independent Chair and supported by the Strategic Safeguarding Partnership Manager was formed to oversee the transition and proposals for the new arrangement. The Executive Group drew up proposals for the new arrangements based on:

- parameters set out by the Children and Social Work Act 2017;
- analysis of the effectiveness of national best practice around safeguarding arrangements
- analysis of Haringey Joint Targeted Area Inspection 2017; and
- commentary from existing LSCB partner agencies about the effectiveness of local arrangements.

6.7 The new arrangements have been presented in draft on three occasions to the three statutory partners for comments and feedback. In addition to regular meetings, and as part of preparing and consulting stakeholders for the new arrangements, the three

statutory partners held an Away Day in January 2019 and two task and finish groups meetings in February 2019 with other senior leaders across the partnership.

6.8 The safeguarding partners have agreed there is a need to strengthen the multi-agency response to safeguarding children including Early Help, Contextual Safeguarding and Transitional Safeguarding.

6.9 The new partnership arrangement, along with the strong political support it receives, will be a driving force in developing and maintaining safeguarding partnerships, challenging the safeguarding system and ensuring that the safety and welfare of Haringey children remains a priority. The new arrangement is to be referred to as 'Haringey Safeguarding Children's Partnership' (HSCP) and details are set out in Appendix 1. It includes the following:

a) The current Haringey LSCB arrangement;

b) The proposed HSCP changes;

c) The vision, values and priorities;

d) Leadership and governance;

e) Children and young people's voice/community involvement;

f) Functional responsibilities: Executive Group, Leadership Group and Delivery Sub-Groups;

g) Practice Learning Events and Multi-Agency Practice Week;

h) Responding to serious incidents where a child dies or is seriously harmed and abuse or neglect is suspected;

i) Relevant agencies involved in the new arrangement;

j) Independent scrutiny; and

k) Geographical area.

6.10 The key proposed changes under the new arrangement include:

a) To maintain the role of the independent chair for chairing and providing leadership and challenge;

b) To use various mechanisms of independent scrutiny that include the independent chair, commissioning an independent person to audit the new arrangement, conducting annual Section 11 Children Act 2004 audits and the local authority Overview and Scrutiny Committee and the Children and Young People's Scrutiny Panel. These scrutiny processes will contribute to the HSCP annual report;

c) Streamlining current LSCB subgroups (Performance Practice and Outcomes, Serious Case Review, Priorities and Training, Learning and Development) to two subgroups (Quality, Performance & Outcomes and Practice, Learning & Workforce development);

d) The Business Unit supports the work of the HSCP. The Independent Chair direct and prioritises the Business Unit's work;

e) There will be monthly partnership meetings between the Detective Chief Inspector, CCG designated professionals and a social care lead. This will ensure that children and young people are central to partnership strategic thinking, decision making and operational practice;

f) There will be stronger links to practice, through multi-agency practice week, audits, and training and development events;

g) There will be greater emphasis on Joint Targeted Area Inspections (JTAI) themes and contribution to all other Ofsted inspections including Care Quality Inspections and Youth Offending Inspections where the partnership responsibility is scrutinised. The partnership will continue to focus on practice in preparation for Ofsted led JTAI and as appropriate support all agencies in their inspections.

6.11 All organisations that were previously members of Haringey LSCB at the point of the new safeguarding arrangements being implemented have been named as relevant agencies. All schools (including independent schools, academies and free schools), colleges, early years and other educational providers in Haringey are designated as relevant agencies.

**Transition timeline**

6.12 As indicated above, the new safeguarding arrangements must be agreed by the safeguarding partners, published by 29 June 2019, and implemented by 29 September 2019.

6.13 The transition from current LSCB Child Death Overview Panel (CDOP) to the new child death review arrangements began on 29 June 2018 and must be completed by 29 September 2019. The current CDOP will continue until the child death review partner arrangements is in place.

6.14 The new arrangements need to be published on each partner agency website and be sent to the Secretary of State for compliance checks. Thereafter the arrangements need to be implemented within three months of publication. There will be a 12-month period for LSCBs after new arrangements are in place to complete and publish any outstanding Serious Case Reviews. There will be a four-month grace period for Child Death Overview Panels (CDOP) (under the LSCB) to complete child death reviews. Once the arrangements have been published and implemented, the LSCB will no longer exist.

**Current position**

6.15 The representatives of the statutory partner agencies involved in the new arrangements have fully reviewed the current and proposed future arrangements for working together to safeguard children and are recommending for approval by their respective executive decision-making body.

6.16 Once approved, the new arrangement will be submitted to the Department of Education on 21 June 2019 for their compliance check. The document will go live on the current LSCB website on 29 June 2019.

### Consultation

6.17 The LSCB members have been widely consulted on the new multiagency safeguarding arrangements and the workings of the proposed HSCP. The final draft arrangement was presented and ratified by the representatives of the statutory partners at their meeting on 16 April 2019.

6.18 Through the implementation of the new arrangement, the partners will further develop their engagement mechanisms with children and young people through the establishment of a Shadow Children's Board by September 2020. Children and young people will be consulted on the establishment of this Board to ensure that they are the driving force in this process.

## The proposed child death review arrangement - North Central London Child Death Overview Partners (NCL CDOP)

### Current Child Death Review Arrangement

6.19 The current Haringey Child Death Overview Panel (CDOP) is a multi-agency sub-committee of the LSCB chaired by the Assistant Director of Public Health. Members include the police, the CCG, the Council's children's services, the LSCB, North Middlesex University NHS Trust and Whittington Health NHS Trust. The group meets four times a year and reports to the LSCB.

The current CDOP borough process is:

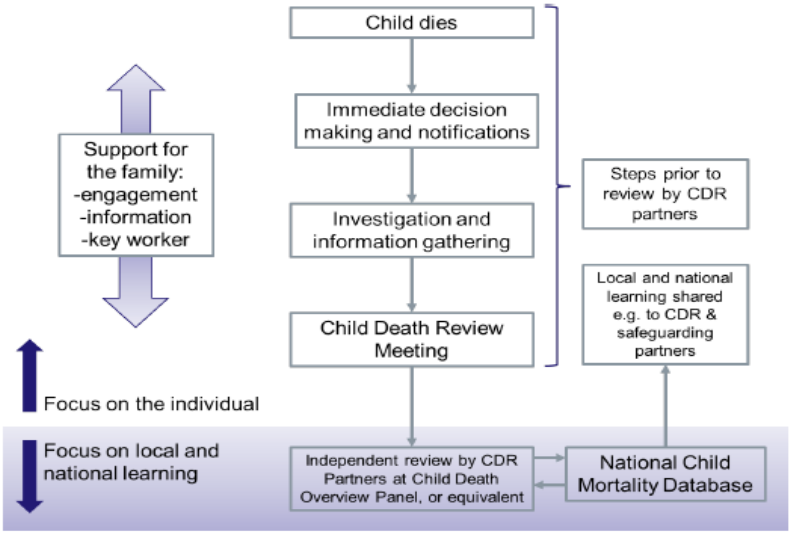
- A child dies, there is immediate decision making and notifications, if the death is from natural causes (expected death) information is collected and the death is reviewed at the CDOP.
- If the death is un-natural (unexpected) a Rapid Response meeting is held, decision making and notifications, information collected followed by the CDOP.

There will be a four-month grace period for the CDOP (under the LSCB) to complete child death reviews before the new system starts.

### Proposed Arrangement

6.20 The Council and Haringey CCG are responsible for a) making arrangements for the review of each death of a child normally resident in the area and, if they consider it appropriate, for any non-resident child who has died in their area; b) making arrangements for the analysis of information about deaths reviewed. The new approach aims to support better learning from child deaths in order to improve care and outcomes, recognising that while the current process has its origin in safeguarding guidance, most preventable child deaths are not connected to safeguarding but largely medical in nature.

6.21 The diagram below shows the new child death overview process




6.22 In October 2018, guidance was published by the Department of Health and Social Care[1] on the development of child death review systems across England, in large part evolving out of the current Haringey CDOP process. A Steering Group (North Central London Child Death Overview Process Transformation (NCL CDOPT) comprising representatives from the Council, CCG, acute NHS Trusts across North Central London (NCL), LSCBs, Designated Doctors and chaired by the Assistant Director for Public Health in Camden and Islington and supported by the Assistant Directors/Consultants in Public Health from Barnet, Enfield and Haringey was formed to oversee the transition and proposals for the new arrangement. The emerging model for the new arrangement is a combined child death review arrangement covering the geographical areas of Barnet, Camden, Enfield, Haringey and Islington. The details of the proposed arrangement is still being developed and are set out in Appendix 2. It is to be referred to as 'North Central London Child Death Overview Partners'.

## 7. Contribution to strategic outcomes

7.1 The work of HSCP and new multi-agency safeguarding partnership are a statutory requirement of which Haringey is a statutory safeguarding partner. The work of the new partnership will help to deliver a priority from the Borough Plan Vision (2019-2030) ambitions namely: Priority two(People) – 'our vision is a Haringey where strong families, strong networks and strong communities nurture all residents to live well and achieve their potential'.

[1]Child Death Review Statutory and Operational Guidance (England), 2018, Department of Health and Social Care

## 8. Statutory Officers comments (Chief Finance Officer (including procurement), Assistant Director of Corporate Governance, Equalities)

### Finance

8.1 Currently there is a total of £30,102 partnership contribution and £165,000 Haringey Council contribution. Discussions have commenced with regard to the HSCP budget and resources in relation to funding and partner agency contributions going forward. Haringey Council will need to hold further discussions with the key statutory safeguarding partners (Police and CCG) to ensure that there is a full review and decisions made about the budget for the new partnership and funding formulae to determine the Partner contributions going forward.

8.2 The new CDOP arrangements will require administrative support. A 'case for change' has been written and will be considered by the NHS North Central London Accountable Officer and the Directors of Public Health across North Central London.

8.3 From April 2020 the eCDOP data and information system will need to be funded. It is estimated to be £10,000 per annum between the 5 local authorities and CCGs. This is part of the 'case for change'

### Procurement

There are no procurement implications arising from this report.

## 9. Legal comments

9.1 Under the Children Act 2004, as amended by the Children and Social Work Act 2017 (The Act), LSCBs, set up by local authorities, will be replaced. Under the Act, the three safeguarding partners (local authorities, chief officers of police, and clinical commissioning groups) must make arrangement locally to work together with relevant agencies (as they consider appropriate) to safeguard and protect the welfare of children in the area. The local arrangement must include arrangement for scrutiny by an independent person of the effectiveness of the arrangements to safeguard and promote the welfare of children. The independent person should be objective, acts as a constructive critical friend and promote reflection to drive continuous improvement. The safeguarding partners must publish their agreed local safeguarding arrangements by 29th June 2019. The Working Together to Safeguard Children 2018 Statutory Guidance provides that the following matters must be included in the published arrangements:

a) arrangements for the safeguarding partners to work together to identify and respond to the needs of children in the area;

b) arrangements for commissioning and publishing local child safeguarding practice reviews; and

c) arrangements for independent scrutiny of the effectiveness of the arrangements.

Further, that the following should be included:

d) who the three local safeguarding partners are;

e) geographical boundaries;

f) the relevant agencies the safeguarding partners will work with; why these organisations and agencies have been chosen and how they will collaborate and work together to improve outcomes for children and families;

g) how all early years settings, schools (including independent schools, academies and free schools) and other educational establishments will be included in the safeguarding arrangements;

h) how any youth custody and residential homes for children will be included in the safeguarding arrangements;

i) how the safeguarding partners will use data and intelligence to assess the effectiveness of the help being provided to children and families, including early help;

j) how inter-agency training will be commissioned, delivered and monitored for impact and how they will undertake any multiagency and interagency audits;

k) how the arrangements will be funded;

l) the process for undertaking local child safeguarding practice reviews, setting out the arrangements for embedding learning across organisations and agencies;

m) how the arrangements will include the voice of children and families; and

n) how the threshold document setting out the local criteria for action aligns with the arrangements.

9.2 The Act also requires the child death review partners for a local authority area (i.e. the local authority and the CCG) to make arrangements for the review of each death of a child normally resident in the area and, if they consider it appropriate, for any non-resident child who has died in their area. They must also make arrangements for the analysis of information about deaths reviewed. The Act enables child death review partners for two or more local authority areas to agree that their areas are treated as a single area and for one of them to carry out functions on behalf of the other.

9.3 The recommendations and the decisions sought are intended to give effect to these statutory requirements.

## 10. Equality

10.1 The MASA document has been screened using Haringey's Equality Impact Assessment Screening Tool. It is not anticipated that these changes will have any direct or indirect negative effect on service users, residents or staff. It is therefore not foreseeable for any direct or indirect discrimination against any individual or group protected by the Equality Act 2010 to occur as a result of the change.

10.2 Appendices

**Appendix 1**: THE NEW HARINGEY SAFEGUARDING CHILDREN PARTNERSHIP ARRANGEMENT
**Appendix 2. The new child death review arrangements**
**Appendix 3 List of Relevant agencies**
**Appendix 4 GLOSSARY**

**Appendix 1**: THE NEW HARINGEY SAFEGUARDING CHILDREN PARTNERSHIP ARRANGEMENT

## 1. Introduction

1.1 The purpose of this document is to outline the way in which Haringey Council, Haringey Clinical Commissioning Group (CCG) and the Metropolitan Police ('the safeguarding partners') will work together with other partners to deliver the new multi-agency safeguarding arrangements in order to safeguard and promote the welfare of children and young people in Haringey and in accordance with the Working Together to Safeguard Children Guidance July 2018 (WT 2018). The new arrangement is to be referred to as 'Haringey Safeguarding Children's Partnership'. Although there are clear expectations in WT 2018 about what must be included in the new arrangement, the safeguarding partners recognise that 2019 will be a year of transition, involving a programme of work to bring in new arrangements in a planned and managed way, designed to achieve maximum impact. There is likely to be considerable local and national learning and further development into 2020 and beyond as new arrangements prove their effectiveness. The partners strongly support continuing improvement of its multi-agency safeguarding arrangements (MASA).

1.2 As required by the WT 2018, the new arrangement includes the following:

a) How the safeguarding partners will work together to identify and respond to the needs of children in the area;
b) How the arrangements will include the voice of children and families;
c) Arrangements for commissioning and publishing local child safeguarding practice reviews;
d) How effectiveness of the arrangements will be scrutinised including how the arrangements will be reviewed and how any recommendations will be taken forward.
e) Who the three local safeguarding partners are;
f) The geographical boundaries and which relevant agencies safeguarding partners will work with, why they have been chosen and how they will work together;
g) How the arrangements will be funded;
h) How early years settings, schools (including independent schools, academies and free schools) and other educational establishments will be included in the safeguarding arrangements;
i) How any youth custody and residential homes will be included in the safeguarding arrangements;
j) How safeguarding partners will use data and intelligence to assess the effectiveness of the help (including early help) being provided to children and families;
k) How inter-agency training will be commissioned, delivered and monitored for impact, and how multi-agency audits will be undertaken;
l) How the learning from child safeguarding practice reviews will be embedded across local organisations and agencies;
m) How the threshold document setting out local criteria for action aligns with the arrangements; and
n) How the partnership will be led and supported to deliver the new MASA arrangements.

1.3 The safeguarding partners (through their lead representatives i.e. Director of Children's Services, Borough Commander and the CCG Chief Operating Officer) met regularly

between October 2018 and April 2019 as a new shadow Executive Group, to drive partnership improvement and to shape the new arrangements. They decided to:

a) use the new arrangements as an opportunity to improve the partnership focus on safeguarding priorities and the effectiveness of multi-agency working;
b) identify opportunities to strengthen the governance arrangements and improve effectiveness through joint working with other partnerships e.g. Safeguarding Adults Board and Community Safety Partnership;
c) reduce unnecessary bureaucracy and simplify the structure, and
d) develop a new, sustainable model which focuses on improved relationship-based practice

1.4 The new arrangements have given the partners the opportunity for a 'cultural shift' review to change some of their ways of working, focusing on how they can make a real difference to multi-agency frontline practice to improve outcomes for children, young people and their families in Haringey.

**2. Legislative context**

2.1 In response to several disappointing outcomes of Local Safeguarding Children Board (LSCB) Inspections, the Government commissioned Alan Wood in December 2015 to undertake a review of the role and functions of LSCBs. The review concluded that LSCBs were not sufficiently effective, confidence in LSCBs was not strong and the effectiveness was dependent on the ability of the Independent Chair. Many LSCBs were identified as lacking the willingness and ability to hold partners to account when there were shortfalls and failures in services to children.

2.2 Alan Wood recommended the abolition of LSCBs and their replacement by a stronger partnership consisting of key statutory agencies (Police, Clinical Commissioning Groups and Local Authorities) who would, in turn, determine local safeguarding arrangements.

2.3 In its May 2016 response, the Government said that it agreed with Alan Wood's analysis and proposed a stronger, but more flexible, statutory framework to support local partners to work together more effectively to protect and safeguard children and young people, embedding improved multi-agency behaviours and practices. In April 2017, the Children and Social Work Act 2017 (The Act) was enacted. The Act abolished the LSCB. In its place, the Act requires the local authority, Clinical Commissioning Groups and police (referred to as the "safeguarding partners") to make local arrangements for safeguarding and promoting the welfare of children in their area. There will be greater flexibility and autonomy for the safeguarding partners to determine the local approach to safeguarding children.

2.4 The WT 2018 guidance sets out the changes needed to support the new system of multi-agency safeguarding arrangements established by the Act. The safeguarding partners have equal and joint responsibility for the local safeguarding arrangements. They must co-ordinate their safeguarding services, provide strategic leadership and implement local and national learning including from serious child safeguarding incidents. The lead representatives for the safeguarding partners are the local authority chief executive, the CCG accountable officer and the police chief officer. The lead representatives, or those they delegate authority to, should be able to:

a. Speak with authority for the safeguarding partner they represent;
b. Take decisions on behalf of their organisation or agency and commit them on policy, resourcing and practice matters;
c. Hold their own organisation or agency and any services they commission to account on how effectively they participate and implement the local arrangements.

2.5 In Haringey, the safeguarding statutory partners are the following senior officers:

| Statutory responsibility | Delegated responsibility |
|---|---|
| Zina Etheridge (CEO for Haringey Council) | Ann Graham (Director of Children Services) |
| Helen Pettersen (Accountable Officer for Haringey Clinical Commissioning Group) | Tony Hoolaghan, (Chief Operating Officer for Haringey Clinical Commissioning Group) |
| Treena Fleming (Chief Superintendent Enfield & Haringey) | Tony Kelly (Detective Superintendent Enfield & Haringey) |

2.6 The new safeguarding arrangements must be agreed by the safeguarding partners, published by June 2019, and implemented by September 2019. The published arrangement must include provision for scrutiny by an independent person of the effectiveness of the arrangements.

2.7 The Act includes provision for child death reviews for the local area. The local authority and CCG are the statutory partners responsible for child death reviews. They must make arrangements for the review of each death of a child normally resident in their area and, if they consider it appropriate, for any non-resident child who has died in their area. They must also make arrangements for the analysis of information about deaths reviewed. The purpose of the review or analysis is: a) to identify any matters relating to the death or deaths generally, that are relevant to the welfare of children in the area or to public health and safety; and b) to consider whether it would be appropriate for anyone to take action in relation to any matters identified. Where it would be appropriate for a person to take action, they must inform that person. The transition from current LSCB Child Death Overview Panel (CDOP) to the new child death review arrangements began on 29th June 2018 and must be completed by 29th September 2019. The current CDOP will continue until the child death review partner arrangements is in place. Haringey's Public Health Team and the CCG are setting out the direction of travel for the new child death review arrangement and how this may be operationalised across North Central London.

2.8 The key differences between the LSCB and new arrangements are set out in the table below:

| Local Safeguarding Children's Board | Haringey Safeguarding Children's Partnership |
|---|---|
| Accountability - LSCB Independent Chair to the Local Authority | Three Equal Partners – Local Authority, CCG, and Police |
| LSCB Independent Chair role | Independent Person and Scrutineer |
| Serious Case reviews | Two-tier National and Local Child Safeguarding Practice Review |
| Standardised process – WT (2015) national and regional | "Innovation" – Working Together to Safeguard Children (2018) |
| Local Child Death Reviews | Sub regional Child Death Reviews |
| Large scale partnership | Desire to move to a more agile structure |

**3. The current LSCB arrangements**

3.1 Under the current legislation, regulations and statutory guidance, the LSCB is required to co-ordinate work to safeguard and promote the welfare of children and to ensure that it is effective.

3.2 The LSCB carries out the following functions:

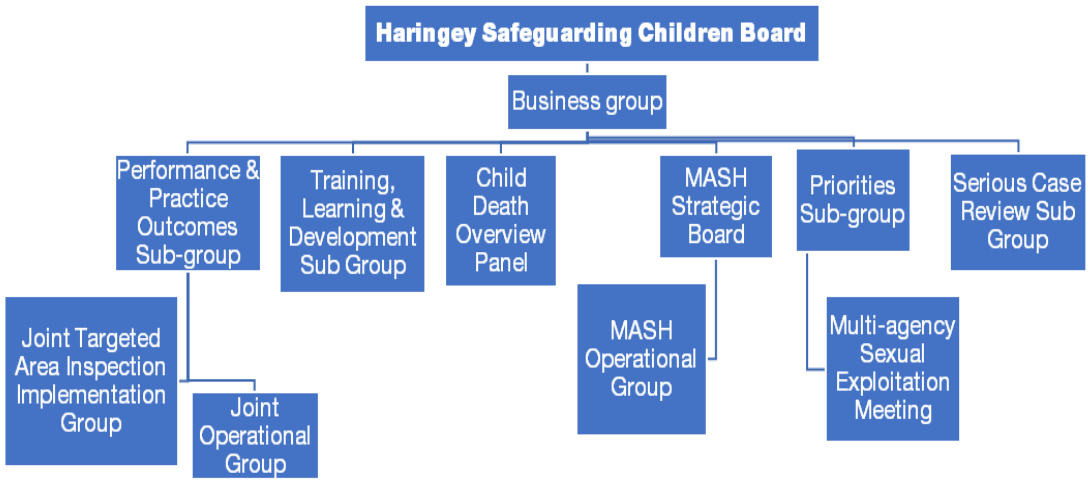
a) the provision of policies and procedures covering a range of issues and approval of the Thresholds Guidance (Pathway to Provision);

b) communicating with persons and bodies in the area about the need to safeguard children and raise awareness;
c) monitoring and evaluating the effectiveness of safeguarding work by partner agencies and advising on ways to improve;
d) participating in the planning of services for children;
e) undertaking serious case reviews.

3.3 The LSCB structure has an Independent Chair and a number of subgroups chaired by a senior member from across the partner agencies. The Independent Chair is accountable to the Chief Executive of the Local Authority for chairing the LSCB and overseeing its work programme. The role of the Vice-Chair is undertaken by the Director of Children's Services. Although there are some existing and successful Haringey arrangements relating to children's safeguarding, it is recognised that a small number of partners attend multiple subgroups leading to a sense of inefficiency and duplication. The revised arrangements provide a significant opportunity to impact effectiveness in the current ways of working, when a small number of people are drawn upon to work on the children's safeguarding agenda.

3.4 The partner agencies represented on the LSCB are drawn from a range of statutory and non-statutory organisations. They include Haringey Council representatives from relevant departments, Police, Clinical Commissioning Group (NHS), Health Providers, National Probation Service, Community Rehabilitation Company, CAFCASS, Homes for Haringey, Haringey Legal Services, London Ambulance Service, the voluntary sector (Bridge Renewal Trust) primary and secondary school head representatives and the Cabinet Member for Children's Services.

3.5 The chart below describes the current structure of the LSCB:




## 4. The proposed changes - Haringey Safeguarding Children Partnership (HSCP)

4.1 The new arrangements have been presented in draft on three occasions to the three statutory partners for comments and feedback. Helen Millichap (former Chief Superintendent for Enfield & Haringey) represented the Police in those statutory partners consultations meetings. In addition to regular meetings, and as part of preparing and consulting stakeholders for the new arrangements, the three statutory partners held an

Away Day in January 2019 and two task and finish groups meetings in February 2019 with other senior leaders across the partnership. As a result of this consultation process, it was agreed that the proposed safeguarding arrangements should only cover Haringey and that there should not be a proposed merger with another LSCB. Opportunities for the new MASA to align itself more with the Safeguarding Adults Board (SAB) and Community Safety Partnership (CSP) were also examined. However, the three statutory partners agreed to keep the new arrangement separate to other Boards, while seeking opportunities to work more closely together on shared areas of interest.

4.2 The three statutory partners considered a number of options and agreed that the partnership should be called: "Haringey Safeguarding Children's Partnership" (HSCP). The proposed functions of the HSCP are to:

a) Co-ordinate work undertaken by partners to safeguard and promote the welfare of children and young people;
b) Monitor, evaluate and challenge – listen to children and young people's feedback;
c) Have a dedicated focus on quality assurance as we recognise that good and effective services require robust quality assurance work to ensure children are safeguarded as well as they can be;
d) Develop relationships where creativity, challenge and innovation can flourish;
e) Develop our workforce through a vibrant Learning and Improvement framework;
f) Ensure a greater focus on practice and service user experience;
g) Ensure effective policy and procedures including thresholds, training, recruitment, supervision, allegations;
h) Communicate and promote safeguarding to raise awareness;
i) Use performance data, qualitative information and local strategic needs analysis to identify partnership priorities.

4.3 WT 2018 guidance states that, to achieve the best possible outcomes, children and families need to receive targeted services to meet their needs in a co-ordinated way and that there should be shared responsibility and effective joint planning between agencies to safeguard and promote the welfare of all children in a local area. Safeguarding children draws upon a wide range of expertise across the Borough and although the three statutory partners are tasked to take the lead and share responsibility for safeguarding arrangements, it is only with collaboration from education, youth services, health providers, the voluntary sector and hearing the voices of children and their families can progress be made.

## 5. The Vision

5.1 The partnership will provide the strategic leadership, vision and influence which ensures:

a) that at every opportunity the lived experience of children and young people (CYP) is integral to how we safeguard and protect;
b) there are improved outcomes through strengthening partnership workforce and community resilience; and
c) our relationship-based practice is strengthened, demonstrating continuous improvement.

5.2 The partnership will support the vision by:

a) Using digital technology and building workforce development;
b) Working to a Standard Operating Procedure (SOP) that makes us operate as three organisations in one partnership;
c) Reducing bureaucracy and doing what is best for children; and

d) Proactively and continually assessing the needs for safeguarding services in Haringey and ensuring that these needs are met within the resources we have available.

## 6. The Values

6.1 The safeguarding partners are committed to delivering their vision according to a set of agreed values and principles and these govern the work of the whole Partnership:

a) Listening to the voice of the child is paramount
b) We will put the best interest of children at the centre of what we do;
c) We will always strive to continually improve professional practice in the safeguarding and protection of children;
d) We commit to using evidence and best practice in our approach to safeguarding local children;
e) We commit to providing strong, visible leadership from our partnership to ensure the new children's safeguarding arrangements work optimally; and
f) We will do everything within our means to intervene early and keep children safe and away from harm.

## 7. The Focus

7.1 As they introduce the new arrangements, partners have agreed to focus on four key elements:

a) Measuring impact linked to practice;
b) A strong evidence base;
c) Workforce development; and
d) Sustainability.

## 8. Other Key Changes

8.1 The safeguarding partners have agreed there is a need to strengthen the multi-agency response to safeguarding children. This covers all safeguarding aspects, including the frontline practitioner (who identifies an 'at risk' child) making a referral to the local authority and leaders who determine local strategic and operational responses to safeguarding issues. There is a commitment by the HSCP to ensure this is right for any child who experiences abuse or neglect in Haringey.

8.2 Addressing contextual safeguarding, such as extra-familial threats, is a key objective across the partnership. Examples include exploitation by criminal gangs and organised crime, such as county lines; trafficking and modern slavery; online abuse; sexual exploitation; young people with other vulnerabilities and the influences of extremism leading to radicalisation.

8.3 The partnership recognises that a more fluid and 'transitional safeguarding' approach is needed for young people entering adulthood. Haringey has made efforts to improve the response to young people at risk of exploitation at the point of transition. However, we wish to create greater alignment between children's and adults' safeguarding, particularly in recognition of the contextual harm young people and young adults can face.

8.4 The safeguarding partners have agreed the following changes for the new arrangements:

a) To maintain the role of the independent chair for chairing and providing leadership and challenge.

b) To use various mechanisms of independent scrutiny that include the independent chair, commissioning an independent person to audit the new arrangement, conducting annual Section 11 Children Act 2004 audits and the local authority Overview and Scrutiny Committee and the Children and Young People's Scrutiny Panel. These scrutiny processes will contribute to the HSCP annual report.
c) Streamlining current LSCB subgroups (Performance Practice and Outcomes, Serious Case Review, Priorities and Training, Learning and Development) to two subgroups (Quality, Performance & Outcomes and Practice, Learning & Workforce development)
d) The Business Unit supports the work of the HSCP. The statutory partners have agreed that the Independent Chair direct and prioritises the Business Unit's work.
e) There will be monthly partnership meeting between the Detective Chief Inspector, the CCG designated professionals and a social care lead which will be facilitated by the Strategic Safeguarding Partnership Manager. This will ensure that children and young people are central to partnership strategic thinking, decision making and operational practice.
f) There will be stronger links to practice, through multi-agency practice week, audits, and training and development events
g) There will be greater emphasis on Joint Targeted Area Inspections (JTAI) themes and contribution to all other Ofsted inspections including Care Quality Inspections and Youth Offending Inspections where the partnership responsibility is scrutinised. The partnership will continue to focus on practice in preparation for Ofsted led JTAI and as appropriate support all agencies in their inspections.

## 9. The Key Drivers

9.1 The drivers for the new partnership include:

a) Maintaining a local Haringey focus, and strengthening the scrutiny and performance across the partnership leading to practice improvement;
b) Increasing partnership ownership of resources and delivery within Haringey;
c) Having the most appropriate level of leadership at meetings to make decisions;
d) Establishing fair and transparent funding arrangements;
e) Being responsive to the outcomes of previous or future inspections related to safeguarding; and
f) Using data to generate a more intelligence-led approach to identify needs, trends and issues.

9.2 The partners' delivery plan for the new arrangements will also reflect the local authority's ambition to provide early help under its Borough Plan to enable children and families to have positive outcomes and reach their full potential independent from additional services. The new partnership, along with the strong political support it receives, will be a driving force in developing and maintaining safeguarding partnerships, challenging the safeguarding system and ensuring that the safety and welfare of Haringey children remains a priority. The partners require:

a) A cultural shift towards a more integrated system, and understanding roles, responsibilities, collaboration, participation and representation;
b) To further develop multi- agency *'custom and practice';*
c) To ensure a transparent approach to the sharing of risks to operational multi-agency safeguarding practice;
d) Increasing clarity of what each agency can offer to families; and
e) Clear, defined pathways of intervention to enable the embedding of a shared understanding of thresholds and risk.

## 10. Priorities for 2019-2021

10.1 The partners have agreed that the next three years partnership priorities will be the following three Ofsted JTAI future themes:

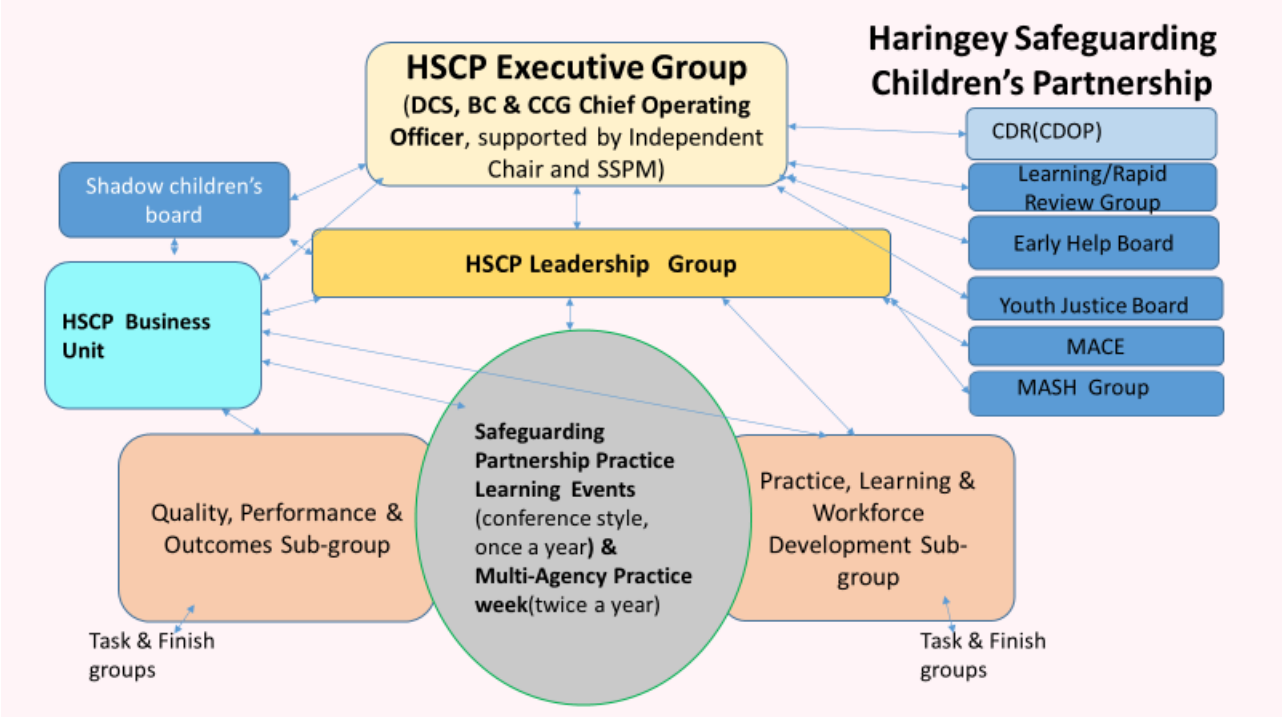
a) children living with mental health issues;
b) prevention and early intervention;
c) older children in need of help and protection, and contextual safeguarding, including exploitation.

10.2 The partnership will also revisit, on a six-monthly basis, the JTAI (2017) combined action plan to see how practice has moved forward since the closure of the JTAI implementation group and ensure that progress has been sustained. However, the partnership will be visiting multi-agency actions from all safeguarding inspections across the partnership to ensure effective implementation and improved outcomes for children and their families.

## 11. Leadership and Governance

### The Structure

11.1 The diagram below describes the new Haringey Safeguarding Children's Partnership structure.




11.2 The partners have agreed to appoint an Independent Chair for the first year who will undertake the chairing responsibility of the HSCP. The post of the Independent Chair and the Business Unit function for the HSCP will be hosted by the local authority. The Independent Chair is accountable to the three statutory partners. In order to ensure coordination with other partnership arrangements in Haringey, there will be at least an annual meeting between the Independent Chair and all other Haringey Boards with a safeguarding remit for vulnerable children and adults that operate across the council.

The Independent Chair will also develop and embed new multi-agency safeguarding arrangements that meet the requirements set out in WT 2018.

11.3 In an unlikely event where there is a performance or other issues with the Independent Chair, the local authority in consultation with the CCG and police will hold him/her to account and address the matter.

11.4 The three statutory partners will have equal and joint responsibility for safeguarding arrangements. They will also have responsibility to make safeguarding arrangements which allow all schools (including multi Academy Trusts), colleges and other educational providers in the local area to be fully engaged. The local authority also assumes responsibility for ensuring that Youth Offending Services and registered providers of residential provision for Looked After Children and Care Leavers are fully engaged in safeguarding. The CCG will have responsibility for overseeing the effectiveness of safeguarding arrangements across primary care, acute, mental health and community health services and health partners, secondary and NHS service providers.

11.5 The partners will report to their own internal management, quality and assurance processes to satisfy themselves of their own safeguarding responsibilities, evidence of which will be shared with the HSCP Executive group.

11.6 In supporting its working principles, Public Health exists as both a function to assist Haringey Safeguarding Children's Partnership and as a commissioning partner with relevant agencies to improve health and wellbeing outcomes for children. A public health approach will promote and encourage the partnership and its relevant agencies to maintain those working principles by remaining outcome focused, maximising prevention, promoting greater integration of services and utilising epidemiological and other forms of intelligence, research or evidence to support planning and decision-making.

## 12. Children and young people's voice and family/community involvement

12.1 HSCP is committed to engaging with children, young people and their families at an individual, service and strategic level. Our new approach will work with young people, developing into a more enduring model that focuses on understanding strengths and assets, as well as contextual safeguarding issues. The partnership's ambition is to engage with all children and young people who experience services, particularly those harder to engage.

12.2 Agencies and organisations will make sure that the information, help, protection and services are available at the right time and the right place leading to better outcomes where children and young people are resilient and safe. There will be a strengthened partnership approach to understanding the views and experiences of children, young people and families, particularly the most vulnerable. There will also be opportunities to further develop new and innovative ways of working collaboratively leading to co-production that builds on individuals' strengths and assets.

12.3 We will make use of the various systems, processes, groups and forums in place to gather the views of children, young people and families, either directly through services via independent voice representatives or via established groups and networks. There are forums where children and young people have their say, share their views and experiences, challenge and support local decision-makers and shape and influence strategic planning, commissioning and service provision at an individual, service and strategic level. These include:

- Youth Council
- Aspire group (LAC).

12.4 Through our MASA implementation we will further develop our engagement mechanisms with children and young people through the establishment of a Shadow Children's Board by September 2020. Children and young people will be consulted on the establishment of this Board to ensure that they are the driving force in this process.

12.5 Two lay members will be appointed as members of the HSCP Leadership Group to inform the work of the Partnership. They will support stronger public engagement in local child safety issues and contribute to an improved understanding of the partnership's Early Help and child protection work in the wider community and provide independent challenge to organisations on the effectiveness of their services in relation to safeguarding.

## 13. HSCP - Functional responsibilities

### The Executive group

13.1 **Role:** The HSCP Executive group is the high level, overarching local governance for the partnership that will primarily focus on safeguarding systems, performance and resourcing. This Group will have the statutory accountability for children's safeguarding arrangements in Haringey. It will:

a) Have strategic ownership of the safeguarding arrangements in Haringey, with stronger joint responsibility for the whole system;
b) Be responsible for financial, strategic and reputational risk;
c) Be responsible for ensuring cross-partnership collaboration and agency participation, convening and supporting participation in the HSCP Leadership group
d) Have responsibility for ensuring that independent scrutiny of the partnership's effectiveness is regular and has impact; and
e) Review progress of priorities work.

13.2 Part of this group's agenda will include assurance and challenge sessions where senior officers from partner agencies are invited to provide evidence regarding the effectiveness of their safeguarding arrangements for children and young people within their agency.

13.3 **Membership**: The membership of this group will be the strategic leads: Director of Children Services (DCS); Borough Commander, and Chief Operating Officer of the CCG. The group will be chaired by the Independent Chair and supported by the Strategic Safeguarding Partnership Manager. In an event where a statutory partner lacks specific expertise in child protection, arrangements for accessing this (for example through designated professionals) could be required via pre-meetings. However, where necessary, CCG designated professionals, Detective Superintendent and the Assistant Director of Social Care will be invited to attend this group, as and when required, for specific agenda items.

13.4 **Chair**: To be chaired by the Independent Chair for the first year with a review in September 2020.

13.5 **Frequency of meetings**: Quarterly with additional meetings to be convened if required.

13.6 **The Leadership group**

13.7 **Role**: This group will act as the 'engine room' of the partnership where senior officers from the statutory partners and the relevant agencies, including lay members, authorise the policy, process, strategy and guidance required to support partnership priorities and effective safeguarding. Meetings will be themed around agreed local and national safeguarding priorities, and areas identified through data and performance, focusing on outcomes. The group will be accountable to the HSCP Executive group and responsible for the progress of the two subgroups. The main focus for the HSCP Leadership group will be the management of risk to operational safeguarding and to the delivery of the work of the subgroups via a risk log. The HSCP Leadership group will:

a) Drive the work of the partnership, delivering on priorities and ensuring learning from practice and development opportunities have an impact;
b) Challenge evidence of agency contribution and impact against HSCP priorities
c) Be driven by the management and mitigation of safeguarding risks in the community and understand the risks to operational delivery;
d) Direct audit activity;
e) Arrange Safeguarding Practice Learning events to learn lessons and develop increasingly effective frontline practice;
f) Analyse relevant performance data to draw out themes and hold partners to account;
g) Analyse relevant partner annual reports to measure the outcomes for children against set objectives;
h) Analyse inspection reports to learn lessons, agree and monitor multiagency actions;
i) Analyse audit information to learn lessons, agree and monitor actions; and
j) Analyse MASH performance and interagency collaboration at the front door, including the effectiveness of Strategy Meetings, Child Protection Investigations, Child Protection Conferences and, most importantly, the voice of the child.

13.8 **Membership:** This Group will have a wide strategic membership of stakeholders and 'relevant agencies': Local Authority Assistant Directors (Social Care, Early Help, Community Safety); CCG designated leads (doctor, nurse); Assistant Director Public Health; Assistant Chief Officer (Probation); Detective Superintendent; Primary School Head representative; Secondary School Head rep; and Directors of health providers. Amongst this group will be the Cabinet Member for Children's services and two lay members.

13.9 **Chair**: To be Co-chaired by the Independent Chair and Director of Children Services for the first year with a review in September 2020.

13.10 **Frequency of Meeting**: quarterly

13.11 **The Delivery Subgroups**

13.12 The new arrangements are designed to reduce duplication and improve integration with other local partnerships. The number of subgroups forming the Partnership is significantly reduced and the new subgroups will focus strongly on improving practice and ensuring an emphasis on learning, enabling a feedback loop across partner agencies and the front line.

13.13 It has been decided that the HSCP will have two Delivery subgroups: Quality, Performance and Outcomes Subgroup; Practice, Learning and Workforce Development

subgroup. The previous subgroups, chaired by statutory leaders, were often cancelled (due to the burden of day jobs), seen as too time consuming and perceived as dominated by social care. In order to remain independent, both subgroups will be Chaired by the Strategic Safeguarding Partnership Manager with representation from a wider group of agencies including the private, voluntary and independent sectors. The HSCP Business Unit will support and co-ordinate the work of the subgroups, providing a mechanism for the members to meet regularly outside of normal scheduled meetings, undertake analysis, monitor plans and approve work completed by their task and finish groups. This will ensure that there is co-ordination and information-sharing between subgroups. Both subgroups will report to the HSCP Leadership group. These delivery subgroups will be assisted by smaller task and finish groups to develop and deliver specific outcomes. It is anticipated that the new subgroups will operate from 29th June 2019.

13.14 **Quality, Performance & Outcomes Subgroup**

13.15 **Role**: This Delivery Subgroup is central to changing and improving quality and effectiveness of multi-agency frontline practice. It will define operational impact of priorities work and new risks as well as identify the key areas of learning for dissemination. There is a need to ask key questions around how we know we are making a difference and to challenge agencies to gather feedback and evidence.

13.16 The subgroup will produce an annual work plan outlining the multi-agency audit and review activities scheduled for the next 12 months. This group will:

a) Include analysis of early help data as well as data from safeguarding and specialist services;
b) Conduct a series of multi-agency audits per year, informed by data intelligence, partnership priorities and findings from case reviews. It is expected that at least four major 'deep dive' audits will be conducted per year, in addition to smaller 'deep dive' audits which may be multi- or single-agency, depending on the identified need;
c) Develop and monitor action plans, resulting from multi-agency audits or identified performance risks, and ensure that actions are completed in a timely manner (within six months);
d) Identify whether practice has changed as a result of completed audits and action plans, through performance data review and re-auditing where necessary;
e) Ensure that all relevant safeguarding partners are included in multi-agency performance data analysis and audits, including schools;
f) Receive, analyse and challenge relevant single agency audit reports and performance reviews, and identify any significant issues that need to be monitored and/or raised to the partnership;
g) Ensure clarity, high quality and consistency in practice in carrying out Safeguarding practice reviews and ensure that the partnership learn lessons can improve the response to children and families;
h) Report findings and recommendations from audit and performance reviews to the HSCP Leadership group on a quarterly basis;
i) Identify and analyse relevant trends and risk to performance.
j) Be responsible for maintaining an up-to-date threshold document.

13.17 **Membership:** Membership of the group will include representatives from the safeguarding partners and relevant agencies that have responsibility for safeguarding performance and quality assurance within their organisation (Head of Services; Service managers; named leads; specialist Service managers from the local authority; health, NHS representatives and police). The local authority Assistant Director with portfolio for Children's Social Care and, the Detective Superintendent and the CCG designated professionals will be invited to participate when relevant.

13.18 **Frequency of Meeting:** quarterly

13.29 **Practice, Learning & Workforce Development Subgroup**

13.20 This subgroup will produce an annual work plan, outlining practice, learning and workforce activities scheduled for the next 12 months.

13.21 It will focus on developing a safeguarding development framework around effective working together, dissemination of learning from practice and innovative opportunities including practice learning events. Evaluation of the training delivered will test out how the early help and statutory systems are responding to needs across the continuum and the impact on lives of children and young people in Haringey. The subgroup will:

a) Be responsible for planning and organising appropriate multi-agency safeguarding learning and development activities, as well as challenging or influencing the activities delivered by individual agencies;
b) Ensure identified multi-agency safeguarding learning needs are addressed for the children's workforces;
c) Deliver consistently high-quality multi-agency safeguarding learning and development activities that incorporate relevant research, national good practice and learning from case reviews and safeguarding adult reviews;
d) Take ownership for maintaining and further developing the partnership training pool;
e) Evaluate multi-agency learning and development activities to seek assurance that delivery is of high quality and has met requirements and to inform future planning;
f) Report annually to the HSCP Leadership group on multi-agency training delivered through the training pool and monitored for impact, including how learning will be embedded across different agencies;
g) Review learning and development for individuals, teams and organisations involved in safeguarding;
h) Respond to specific training needs around the partnership priorities, identification of training needs across the partnership, ensuring the best practice standards, professional curiosity and creativity; and
i) Manage partnership communications and the website.

13.22 **Membership:** Membership of this Subgroup will include representatives from the safeguarding partners and relevant agencies with responsibility for workforce development, learning and practice improvement (Head of Services; Service managers; NHS representatives, CCG named leads; specialist practitioners from the local authority; health; and police).

13.23 **Frequency of Meeting:** quarterly

13.24 **Quorum for the Executive Group, Leadership group and subgroups:**

13.25 The quorum for any multi-agency meeting is 100% attendance of three safeguarding partner at the time of the meeting. Relevant agencies must send representation and non-attendees (without valid reason) will be reported to their agency's line manager.

13.26 **Safeguarding Partnership Practice Learning Events & Multi-Agency Practice Week**

13.27 The aim of the Safeguarding Practice learning events will be to analyse lessons from practice locally and nationally, to improve practice and to achieve ambitious outcomes for all children. The events will develop and mature collaborative and authentic partnership relationships and find creative and innovative solutions to achieving better outcomes for children. Practitioners will take part in a series of talks and workshops

aimed at improving the outcomes for children and their families. The workshops will be led by a mixture of local experts, leading academics and national policy leads giving practitioners the chance to reflect on current thinking and practice to support their knowledge and skills.

13.28 The events will use service-user feedback, practice week feedback and the voice of the child in practice, to challenge and promote practice growth and continuous development. The HSCP Business Unit will gather information from a variety of sources and present this to the HSCP Leadership group in order to inform the first set of discussions about the practice issues/themes being considered. This will include analysis of current data and performance, evidence from self-assessments, multi-agency audits and peer challenge, S11 findings, success and impact measures and relevant statutory and other guidance. The HSCP Executive group will make the final decision on themes.

13.29 Findings from the local reviews undertaken in Haringey will be shared with relevant parties locally through large Partnership Practice Learning Events and there will be regular auditing to ascertain progress on the implementation of recommended improvements. The sustainability of these improvements will be monitored regularly and followed-up by the HSCP Business Unit to ensure that there is a real impact on improving outcomes for children. The events are aimed at providing interactive learning opportunities, building relationships and problem-solving.

13.30 Partners have agreed to use learning from the recent JTAI as the first theme and have tasked the current Independent Chair and the SSPM to lead this event. The Safeguarding Partnership Practice Learning events and the Multi-Agency Practice week will:

a) Brief frontline staff across the partnership on emerging themes affecting our children and develop practitioner led interventions to reduce the impact.
b) Consult on, and contribute to, changes to policy and procedure.
c) Brief frontline practitioners on national policy, procedure and legal changes and develop local strategies to incorporate changes to practice.
d) Analyse collaborative working through multi-agency audit and service-user feedback, learn lessons, increase interagency review and assessment and agree creative and innovative ways of working to reduce the number of touch points for families.
e) Identify and celebrate good practice.
f) Identify barriers to good practice and develop innovative and creative solutions to break barriers down.
g) Learn from children, young people and their families to strengthen practice.
h) Own the learning of Child Safeguarding Practice Reviews and Domestic Homicide Reviews to change and strengthen authentic partnerships and further improve practice.
i) Evaluate the multi-agency 'front door' for child protection, when children at risk of harm first become known to local services.
j) Conduct 'deep dive' investigations in order to provide an opportunity to explore joint responses to children and young people.
k) Evaluate multi-agency arrangements for the response to all forms of child abuse, neglect and exploitation at the point of identification.
l) Evaluate multi-agency arrangements for the quality and impact of assessment, planning and decision-making in response to notifications and referrals.

13.31 Terms of reference for the Multi-Agency practice week will be developed by the current JTAI implementation group led by the DCS and the Independent Chair, supported by the SSPM.

13.32 **Accountability and Reporting Arrangements**

13.33 The Safeguarding Partnership Practice Learning event & the Multi-Agency Practice week are accountable to the HSCP Leadership group. The HSCP, alongside the Quality, Performance and Outcomes subgroup, will complete a child and family impact analysis following each learning event/practice week outlining key learning and actions to strengthen authentic safeguarding practices to address priorities and need. The Safeguarding Partnership Practice Learning Events will be led by the Independent Chair supported by the HSCP Business Unit. The multi-agency practice week will be led by the three statutory partners taking turns jointly with the Independent Chair. The next multi-agency practice week theme (Neglect, September 19) will be led by the local authority DCS.

13.34 **Frequency:**

13.35 One Safeguarding Partnership Practice Learning event and two Multi-Agency Practice week will take place every year.

## 14. The HSCP Business Unit

14.1 The Business Unit's primary focus will be to support the operation and ongoing development of the multi-agency safeguarding arrangements.

14.2 In consultation with the HSCP Leadership group and its subgroups, the Business Unit will prepare for approval an annual Business Plan in April of each year. This document will clearly set out the priorities for the HSCP on an annual basis, plan for multi-agency audit, scrutiny and workforce development, and specific actions to deliver on the priorities. Progress against delivery will be reviewed on a quarterly basis.

14.3 In addition, the HSCP Business Unit will prepare for approval an Annual Report in June/July of each year to be published on the HSCP website. This will clearly set out evidence of the impact of the work of the safeguarding partners and relevant agencies, including training, on outcomes for children and families from early help to looked-after children and care leavers. It will confirm delivery against agreed actions, findings from audits, scrutiny activity, child safety practice reviews and learning from local case reviews and engagement events. The annual report will also include an analysis of any areas where there has been little or no evidence of progress on agreed priorities. Based on local and national evidence it will also highlight the priorities which should feed into the next annual Business Plan.

14.4 The staff of the Business Unit will continue to be 'hosted' within an agency with regards to employment, leave, pension and so forth. For continuity and simplicity, it remains appropriate for that to be the local authority. It is important that the HSCP Business Unit serves the three statutory partners equally and is seen to be independent. This will be facilitated by retaining the Independent Chair, who will direct its work on behalf of the three statutory partners. However, in an unlikely event where there are staffing issues, the local authority will address the matter according to their internal procedures.

14.5 There may be a need for a review of the staffing structure when the new partnership arrangements are in place and have bedded in. Consideration will be given to opportunities for key officers in other agencies to be co-located in the HSCP Business Unit as an in-kind contribution resource.

## **15**. **Haringey threshold document**

15.1 A new Threshold Document has been produced and published on our current LSCB website which aligns with the requirements of WT (2018) and is used in multi-agency training. This guide is aimed at all practitioners, and volunteers, supporting, or working with, children and / or their families within statutory, voluntary, private or independent organisations in Haringey. It aims to help professionals when wanting to access services or making a referral for services to ensure children and families get the right level of support at the right time. It should be read alongside the London Child Protection Procedures and the London Threshold: Continuum of Help and Support. As well as preventative measures, such as having a range of safeguarding policies, safe practice also involves safer recruitment and consistent procedures for dealing with abuse allegations against staff. Therefore, we support all areas of professional practice with a detailed resource of relevant documents, including:

a. local and national guidance
b. guidance on specific areas and contexts of child protection work
c. Safeguarding and Child Protection practice is supported by the legal framework and both statutory and non-statutory guidance.
d. The London Safeguarding Children Board issues guidance and London-wide child protection procedures to ensure consistency in the practice across the 32 London boroughs.

## **16**. **Inter-agency training and multi-agency audits**

16.1 The HSCP will develop a partnership learning and development framework based identified needs to enable the partnership to deliver and reflect on priorities, assess partnership performance against the priorities, change and review practice accordingly. Given the current limited resources, the HSCP aims to deliver the core programme of activity with partners through a training pool identified by the partnership. All multi-agency training will be co-delivered by two trainers from partner agencies.

16.2 The HSCP will have oversight of the quality and provision of single and inter-agency safeguarding. In order to meet this responsibility, a practitioner Section 11 audit of single agency will be undertaken. In addition, the HSCP will set minimum standards which have to be met by all providers of single and interagency training.

16.3 Our evaluation method will be based on the London Training Evaluation and Impact Analysis Framework, which was developed by the Safeguarding Training Subgroup and endorsed by the London Board as good practice with the following:

a. relevance, currency and accuracy of course content;
b. quality of training delivery;
c. short and longer term outcomes; and
d. impact of working together and inter-professional relationships.

16.4 The HSCP will also develop a partnership performance management framework which will be aligned with Haringey's Children's Social Care quality assurance framework. It will consist of six levels:

1. Section 11 self-audits - undertaken by all statutory agencies within Haringey in compliance with the Children Act 2004
2. Safeguarding Practice Reviews (SPR) – undertaken where appropriate

3. Performance Reporting and Performance Indicators - on a range of safeguarding areas such as child protection conferencing data and a regular review of the comprehensive data set
4. Single agency audits – both individual and themed.
5. Multi-agency practice audits - looking together at individual cases and assessing the effectiveness and multi-agency practice (the current theme is neglect as per JTAI recommendation)
6. Themed reviews - Providing detailed analysis of a broad area of safeguarding practice or process as identified by the HSCP such as neglect, core groups and thresholds. These reviews should consider evidence from a range of sources.

16.5 Reports will go to the Quality, Performance & Outcomes Subgroup before being taken to the Leadership group and a judgment made about which reports need to be tabled and which circulated for information only. The Leadership group will retain the right to request specific audit reports as and when it sees appropriate or in response to specific issues that may arise. Each of the above should be undertaken with a view to ensure that there is a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and to promote good practice.

**17. Responding to Serious Incidents of child health/serious harm**

17.1 There is to be a two-tier system - local and national - for safeguarding practice review (SPR) (currently known as serious case reviews (SCR)). The responsibility for how the system learns lessons from SPR at a national level lies with the Child Safeguarding Practice Review Panel (the Panel) and at a local level with the safeguarding partners.

17.2 The safeguarding partners are required to make arrangements to identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area. They must commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken.

17.3 Where a case meets the criteria for a SPR - where, (a) the child dies or is seriously harmed in the local authority's area, or (b) while normally resident in the LA's area, the child dies or is seriously harmed outside England and the local authority knows or suspects that the child has been abused or neglected) - the local authority must notify the Panel within 5 working days of becoming aware of the incident. The authority should also notify its safeguarding partners. The Assistant Director of Children's Social Care will undertake this responsibility on behalf of the local authority.

17.4 The safeguarding partners are required to undertake a rapid review of serious safeguarding cases. The aim is to: a) gather the facts about the case; b) determine whether there is any immediate action needed to ensure children's safety and share any learning; c) consider the improvements to safeguard and promote the welfare of children; and d) decide the steps that should be taken next, including whether or not to undertake a child safeguarding practice review.

17.5 On being informed of a notifiable incident, the HSCP will undertake a Rapid Review in line with published guidance in Working Together 2018. The 'Rapid Review' will be undertaken within 15 days when a child dies or is seriously harmed and abuse or neglect is suspected. Any immediate action needed to ensure children's safety or share learning will be identified and the safeguarding partners will decide, in conjunction with other organisations that have been involved, if a more in-depth review is needed. The report on the rapid review will be shared with the national Panel including the decision on whether a local or national SPR is appropriate.

17.6 The responsibility for undertaking these tasks rests with the Learning Review/Rapid Review Group which will make a recommendation to the Executive Group. The Executive Group with support from the HSCP business unit will be responsible for commissioning a Safeguarding Practice review using regional and national information on known reviewers and their expertise. Reviews will be published as outlined in Chapter 4 of WT (2018) on the HSCP website.

17.7 The Learning Review/Rapid Review Group will work with the Practice, Learning & Workforce Development Subgroup to ensure that the lessons learned from the Learning Reviews/Rapid Reviews are well understood by the partnership workforce and embedded in practice. Actions may include:

a) Revision of existing single or multi-agency training
b) Creation of a learning summary and arrange accompanying events to disseminate the learning from the review
c) Adding any completed / amended policies / protocols to the practitioner's toolkit and promoting their use
d) Commissioning / developing specialist training or e-learning
e) Focused evaluation of practitioner knowledge on a particular area of practice.

17.8 The Practice, Learning & Workforce Development Subgroup will take responsibility for the provision of training events and resources to support the dissemination of the lessons and changes to practice and the Leadership group will focus on assurance that the lessons have been embedded across the partnership and that these changes to practice are having an impact on outcomes for children and families in Haringey.

**18. Relevant agencies**

18.1 According to WT 2018, relevant agencies are those organisations and agencies whose involvement is considered by the safeguarding partners as a requirement to safeguard and promote the welfare of children with regard to local need. The list of relevant agencies is set out in the Child Safeguarding Practice Review and Relevant Agency (England) Regulations (2018). The safeguarding partners have agreed which relevant agencies can bring the targeted help and support that children and families need in Haringey (Appendix 3). However, it should be noted that the safeguarding partners may include any local or national organisation or agency in their arrangements, regardless of whether they are named within the regulations. Those organisations that are listed in the regulations have a statutory duty to act in accordance with the arrangements.

18.2 Acting in accordance with the safeguarding arrangements requires safeguarding partners and relevant agencies to work together and:

a) Fully engage with Haringey's Safeguarding Children Partnership functions as set out within this document;
b) Provide information which enables and assists the safeguarding partners to perform their functions to safeguard and promote the welfare of children in their area, including as related to local and national child safeguarding practice reviews;
c) Ensure that their organisation works in accordance with the inter-agency safeguarding procedures approved by the partnership;
d) Have appropriate robust safeguarding policies and procedures in place specifically relevant to their organisation;
e) Provide evidence of the above to the Safeguarding Partnership Leadership Group.

18.3 All organisations that were previously members of Haringey LSCB at the point of the new safeguarding arrangements being implemented have been named as relevant agencies. Each relevant agency has been provided with details of their ongoing responsibilities and

the expectations placed on them by the new arrangements in Haringey. The local arrangements in Haringey have been developed in consultation with as wide a breadth of partner agencies as possible and the arrangements now adopted reflect their commitment to improving outcomes for children and young people. The safeguarding partners expect relevant agencies to co-operate with them in the same way as agencies have been co-operating with Haringey Safeguarding Children Board since its inception.

18.4 However, membership of the HSCP leadership group and its subgroups will be reviewed. This ensures that the valuable contribution of those organisations to safeguarding work will continue to be taken forward collaboratively. In addition to the three main statutory safeguarding partners, various other relevant agencies will work as part of the Partnership. These agencies will be members of the Partnership Leadership Group and participate in the Partnership Learning events and some will also be members of subgroups who have the decision-making authority for the safeguarding partner they represent. Anyone entrusted with attending in their place will need to have similar delegated authority.

18.5 As recommended by WT (2018), all schools (including independent schools, academies and free schools), colleges, early years and other educational providers in Haringey are designated as relevant agencies. The list of relevant agencies will be reviewed by the safeguarding partners at least annually. The intention will be to use the opportunity of introducing new arrangements to broaden the reach of the safeguarding arrangements and, in time, consider how sports clubs, religious institutions, armed forces, the voluntary sector, private providers of health services and children's homes, for example, can be further engaged.

18.6 Whilst the legislation and statutory guidance draws a distinction between safeguarding partners and relevant agencies to ensure clarity around accountability, it is clear that all members of Haringey's Safeguarding Children Partnership have a shared responsibility to work collaboratively to provide targeted support to children and families. Schools will be engaged as part of the partnership Leadership group and subgroups to ensure joint working to safeguard children within a multi-agency shared approach.

18.7 The Partnership will aim to build on established relationships with schools and education providers to ensure they remain a key partner agency when the landscape of school organisation is changing. There will also be a focus on exploring how schools can contribute to ensuring the voices of children and young people contribute to safeguarding developments and priorities. The termly Designated Safeguarding Leads forum led by Haringey Education Partnership will act as a mechanism for schools to learn and promote our safeguarding arrangements. The SSPM delivers regular presentations to this forum with safeguarding local and national updates and this will continue.

**19. The role of Youth Offending and custody services, Children living away from home**

19.1 The Youth Offending Service reports to the Youth Justice Partnership Board chaired by the DCS. Our new safeguarding arrangements will continue to actively support effective delivery of their services though the HSCP Leadership group and its subgroups. The Youth Offending service will continue to submit annual overview reports to the HSCP for scrutiny and promotion of their local offer across the partnership. The Youth Offending Service is directly represented on the HSCP Leadership Group and on other sub-groups.

19.2 The HSCP will also ensure that those responsible for looking after children in settings away from home, including residential homes for children, foster carers and youth custody settings, have effective safeguarding arrangements. Where there are incidents identified, use of HSCP escalation policy is triggered.

19.3 The Multi Agency Criminal Exploitation group (MACE) identifies the Child Sexual Exploitation profile of Haringey and oversees Haringey's CSE Strategy and Action Plan. It aims to reduce incidents of sexual exploitation through the delivery of an integrated strategy, sharing information and intelligence and producing data on current trends and threats. The MACE group will continue to produce an annual report to the HSCP for overview and scrutiny.

**20. Use of data and intelligence**

20.1 We will develop a new Performance Management Framework for the partnership setting out the way performance information is provided to the Leadership Group to inform its assessment of the effectiveness of the help being provided to children and families (including early help). Data relating to key safeguarding processes and particularly vulnerable groups of children will be provided each quarter with an analysis that provides an explanation of any trends and issues for attention of the group. This will be supplemented by specific reports on topics that have been identified by the Executive Group as requiring assurance monitoring.

20.2 The framework will be subject to regular review by the Leadership Group and therefore the issues covered may vary according to the needs of children in Haringey and risks identified.

**21. Partnership Integration**

21.1 The Independent Chair will take a strategic lead in developing partnership working with the three statutory partners, wider partners and stakeholders including across the voluntary and community sector to improve outcomes for children and young people in Haringey. The Strategic Safeguarding Partnership Manager will work closely with the designated health leads, directors of providers, social care leads and the DCI/Detective Superintendent to address barriers, problem solve and escalate as required to ensure that risks are managed and mitigated to remain on track. Their monthly meetings will support the development of key strategic relationships between the three organisations and wider senior partners in relation to the delivery of the new arrangement and the partnership priorities.

**22. Independent Scrutiny**

22.1 WT 2018 states that the new arrangements should include scrutiny of its effectiveness to safeguard and promote the welfare of children by an independent person.The scrutiny is intended to provide the necessary assurance in judging how effective the multi-agency arrangement is to safeguard children including arrangements to identify and review serious child safeguarding cases. The independent person will be objective, act as a constructive critical friend and promote reflection to drive continuous improvement.

22.2 Part of the role of the independent chair is to provide challenge and a level of scrutiny. In addition, the partnership will commission a scrutineer to provide independent evaluation of the effectiveness of local multi-agency arrangements to safeguard and promote the welfare of all children. The scrutineer will provide an assessment of the safeguarding partners' leadership of the arrangements for inclusion in the partnership's yearly report. He/she will focus on the impact of the partnership arrangements and working rather than processes. In effect, his/her role would be to find evidence that the partnership is making a positive difference to children and young people. The scrutineer will provide assurance to the Safeguarding Partners that organisations have strategies in place for addressing priorities, gaps and risks and how effective they are. The scrutineer will also

scrutinise the findings and outcomes of any safeguarding reviews and how agencies are held to account for the effective implementation of recommendations identified. He/she will report to the safeguarding partners any recommendations from their scrutiny and/or assurance activities. The scrutineer will be independent from the statutory partners and will have expertise in child safeguarding, an understanding of local need and effective partnerships.

22.3 The independent scrutiny arrangements will also include a wider system of scrutiny; peer reviews, the CYPS overview scrutiny panel, LA Departmental Management Team, independent inspectorates' single assessment of the individual safeguarding partners (for example, Ofsted, HM Inspectorate of Constabulary, Care Quality Commission inspection reports) and Joint Targeted Area Inspections.

## 23. Dispute Resolution

23.1 Haringey safeguarding partners and relevant agencies will proactively work together to resolve any disputes locally. In the event that dispute arises all staff, from partners and relevant agencies, will proactively work together to resolve any disputes locally through timely dialogue, discussion and where necessary escalation (see HSCP/LSCB escalation policy on the LSCB website). Any public bodies failing to comply with their obligations under law will be held to account through a variety of regulatory and inspection activity.

## 24. Geographical area

24.1 It is acknowledged that two statutory partners (Police and CCG) to these arrangements have responsibility for services outside Haringey due to their organisational boundaries overlapping other local authority areas. The new HSCP/ LSCB Escalation policy makes a reference to cross-borough boundaries, interagency safeguarding children procedures and includes operational guidance for circumstances where a child and or their family is living in another area or moving between areas. It may also be necessary for some partners to these arrangements to work with another area's arrangements, for example during a child safeguarding practice review commissioned by another area, and the HSCP Business Unit will help facilitate communication with other areas and engagement by partners.

## 25. Financial Consideration

25.1 The WT 2018 guidance makes it clear that safeguarding partners should agree the level of funding secured from each partner and relevant agency to support the new safeguarding arrangements. Decisions on funding are for local determination but contributions should be equitable and proportionate to meet local needs. In the absence of a nationally prescribed funding formula, local negotiations will need to reach agreement as to what is proportionate and equitable.

25.2 There is a concern about the cost of paying for independent authors and the inconsistent quality of the reports. There is also some concern about the restrictions regarding the methodology that can be used to carry out the reviews – the methodological approach is overseen nationally. Going forward, in the event of a child safeguarding practice review, funding will be met by the three safeguarding partners and, where necessary, each partner will contribute equitable and proportionate funding over and above the normal allocation in order to fulfil the full costs of any child safeguarding practice review arrangements.

25.3 The new safeguarding arrangements will commence with the continuation of the current levels of funding. Currently there is a total of £30,102 partnership contribution and £165,000 local authority contribution. Clearly the local authority makes the largest contribution to these arrangements, followed by health services, with the police/MOPAC making a small contribution. Currently, the local authority is the de-facto lead for these partnerships, and this is reflected in the local authority's commitment to the management and resourcing of this partnership. The Independent Chair will support the SSPM to manage the pooled budget for the HSCP ensuring its most effective deployment, adhere to Best Value principles, control cost and enhance value, within the context of the council's budget monitoring process and financial controls. The Independent Chair will also ensure that partner agencies contribute towards the running costs of the HSCP. The safeguarding partners have agreed that the current arrangement for funding will be kept under review.

## 26. Risk Assessment

26.1 There is a risk that the quality of scrutiny and quality assurance could be compromised if arrangements are changed in light of the Act. However, all partners have agreed that clear principles must be adhered to when considering any future changes. Any changes need to enhance and further strengthen partnership working and safeguarding practice and the priority will be on safety and protection at all times.

26.2 A second risk is the financial implication of setting up and operating a new model which is key to the effectiveness of the new arrangements. This will be mitigated by the three statutory partners addressing all financial matters so it is clear what the expectations would be on all partners who have safeguarding responsibility

## 27. Implications for Haringey Council's priorities

27.1 Ensuring that children and young people are safe from harm is a core statutory duty for the Council. It is essential that that elected members are informed and able to be assured of how effectively this duty is discharged via a robust performance and quality assurance framework.

## 28. Equalities

28.1 The Council, the Police, and the Clinical Commissioning Group have a Public Sector Equality Duty under the Equality Act (2010) to have due regard for the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act
- Advance equality of opportunity between people who share those protected characteristics and people who do not
- Foster good relations between people who share those characteristics and people who do not.

28.2 The three parts of the duty applies to the following protected characteristics: age, disability, gender reassignment, pregnancy/maternity, race, religion/faith, sex and sexual orientation. Marriage and civil partnership status apply to the first part of the duty.

28.3 It is not anticipated that these changes will have any direct or indirect negative effect on service users, residents or staff. It is therefore not foreseeable for any direct or indirect discrimination against any individual or group protected by the Equality Act 2010 to occur as a result of the change.

28.4 The strategic objective of the changes is to improve the effectiveness and sustainability of multi-agency frontline practice in order to improve outcomes for children, young people and their families in Haringey. It is therefore reasonable to anticipate that the changes will make the partnership more able to meet the specific needs of children, young people, and parents of young children, and to minimise or remove disadvantages they experience that are inherent to these characteristics and so the changes are also likely to help address known inequalities in Haringey.

## 29. Looking beyond Wood review and next Steps

29.1 The arrangements will enhance the scrutiny and monitoring role of the partnership and further enforce effective joint working arrangements within a context of trust and commitment to safeguarding. The overall effectiveness of the new arrangements will be reviewed in the summer 2020. Following this review, partners will agree the frequency, however, the intention is to review the governance arrangements at least every two years.

## Appendix 2. The new child death review arrangements

1.1 The Act names as statutory child death review partners Local Authorities and CCGs. The Act enables child death review partners for two or more local authority areas to agree that their areas are treated as a single area and for one of them to carry out functions on behalf of the other.

The Council and Haringey CCG are responsible for a) making arrangements for the review of each death of a child normally resident in the area and, if they consider it appropriate, for any non-resident child who has died in their area; b) making arrangements for the analysis of information about deaths reviewed.

The new approach aims to support better learning from child deaths in order to improve care and outcomes, recognising that while the current process has its origin in safeguarding guidance, most preventable child deaths are not connected to safeguarding but largely medical in nature.

In October 2018, guidance was published by the Department of Health and Social Care[2] on the development of child death review systems across England, in large part evolving out of the current CDOP process.

1.2 A steering group (the North Central London Child Death Overview Process Transformation steering group (NCL CDOPT steering group)) comprising representatives from the Council, CCG, acute NHS Trusts across North Central London (NCL), LSCBs, Designated Doctors and chaired by the Assistant Director for Public Health in Camden and Islington and supported by the Assistant Directors/Consultants in Public Health from Barnet, Enfield and Haringey was formed to oversee the transition and proposals for the new arrangement.

The NCL CDOPT steering group has focussed on four areas:

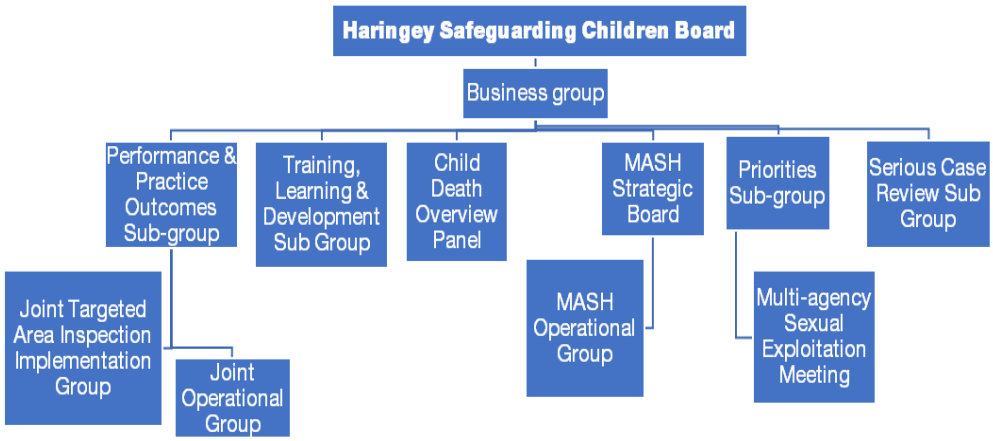
- Completed a review of existing system structures, staffing and resources within the local system.
- Mapped existing assets and their fit with the new statutory requirements
- Completed a 'case for change' for the new arrangements based on the key differences between the current and future systems.
- Supporting the acute NHS Trusts to establish the new system structures and staffing requirements.

1.3 The NCL CDOPT steering group members have agreed there is a need to a) strengthen administrative capacity to support the NCL CDOP, the joint agency response (JAR), the child death review meeting (CDRM) for deaths in settings such as hospice/ home, and support acute NHS Trusts with their CDRM; b) ensure excellent quality key worker and bereavement support for families; c) establish a single point of information regarding NCL CDOP; d) identify funding for the eCDOP system[3] from April 2020 onwards and e) consider having an Independent Chair of NCL CDOP.

[2] Child Death Review Statutory and Operational Guidance (England), 2018, Department of Health and Social Care

[3] The electronic data and information system introduced across London in April 2018 funded for one year by the Healthy London Partnership. In April 2019 the system was funded by NHS England (London Region) for one year.

1.4 The current Haringey Child Death Overview Panel (CDOP) arrangement;



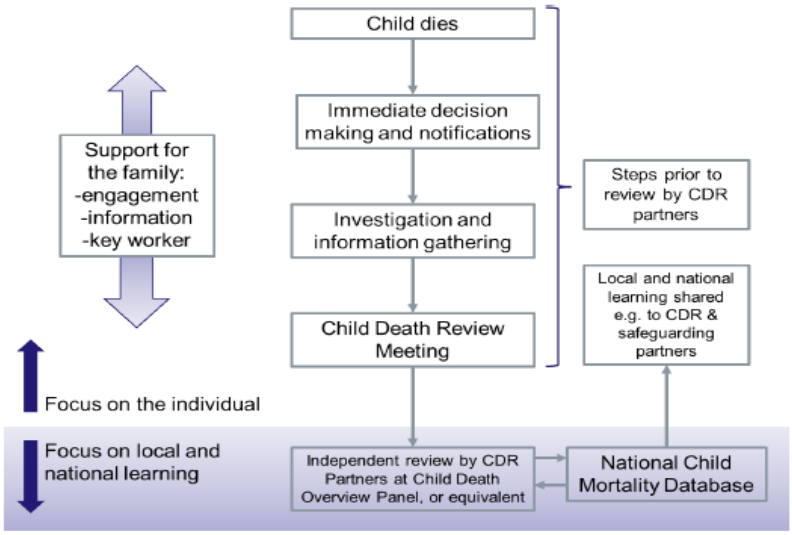

Haringey CDOP is a multi-agency sub-committee of the LSCB chaired by the Assistant Director of Public Health. Members include the police, the CCG, the Council's children's services, the LSCB, North Middlesex University NHS Trust and Whittington Health NHS Trust. The group meets four times a year and reports to the LSCB.

The current CDOP borough process is;

- A child dies, there is immediate decision making and notifications, if the death is from natural causes (expected death) information is collected and the death is reviewed at the CDOP.
- If the death is un-natural (unexpected) a Rapid Response meeting is held, decision making and notifications, information collected followed by the CDOP.

There will be a 4-month grace period for the CDOP (under the LSCB) to complete child death reviews before the new system starts.

1.5 The new child death overview process



### 1.5.1 Geographical Footprint

One of the significant changes is that the geographical and population 'footprint' of child death review partners should cover a child population, such that they typically review at least 60 child deaths per year. This footprint should consider networks of NHS care, and agency and organisational boundaries, in order to reflect the integrated care and social networks of the local area. It must extend to at least one Local Authority area or may overlap with more than one Local Authority area or CCG. Child death review partners should come together to develop clear plans outlining the administrative and logistical processes for these new review arrangements. The NCL CDOPT steering has recommended combining Barnet, Camden, Enfield, Haringey and Islington child death overview panels.

This geographical footprint meets the statutory requirements. Based on the last three years' data the average number of deaths across the five boroughs is 80 (Barnet, 20, Camden 11, Enfield 20, Haringey 20 and Islington 13).

The five areas are increasingly working together. It reflects integrated care and social networks as well and they already use eCDOP so could merge to one electronic system.

### 1.5.2 Immediate decision making and notifications

Several decisions need to be made by professionals in the hours immediately following the death of a child. This provides a focus on providing good clinical care. It aims to provide the family with compassionate care and support, signposting them to appropriate bereavement support, and ensuring that their voice is heard throughout.

This part of the process includes:

- how best to support the family;
- whether the death meets the criteria for a JAR;
- whether a Medical Certificate of Cause of Death (MCCD) can be issued, or whether a referral to the coroner is required;
- whether the death meets the criteria for a serious incident investigation by any agency.
- A number of notifications must also be made, via the 'Child death notification form' (formally Form A) to the child's GP and other professionals, to the Child Health Information System, the relevant CDOP, and (once operational) the National Child Mortality Database (this will be done automatically by eCDOP).
- Identification of a Key Worker. Supporting and engaging the family who have lost a child is of prime importance throughout the whole child death review process. Recognising the complexity of the process, and the state of total shock that bereavement can bring, families should be given a single, named point of contact (Key Worker) who they can turn to for information on the processes following their child's death, and who can signpost them to sources of support. In addition, they should be provided with a leaflet for parents, families and carers to help understand and navigate the child death review process.

The NCL CDOPT Steering Group has identified that this function can be supported by existing workers across the system, but they recommend that further training be offered for them to meet the responsibilities and competencies required.

1.5.3 Investigating and information gathering

There are no changes to this stage.

Information gathering will be through formal investigations and via a 'child death review form' (formally Form B)

The Key worker will provide overarching coordination alongside any investigation to facilitate the family voice and to keep them informed at all stages.

1.5.4 Child Death Review Meeting (CDRM)

This is a new stage

Although investigations following the death of a child will vary, every child's death should be discussed at a child death review meeting. This is the final multi-professional meeting involving the individuals *who were directly involved* in the case. The nature of this meeting will vary according to the circumstances of the child's death and the practitioners involved but has common aims and principles in all cases. The results of the meeting should be captured on a draft 'child death analysis form' (formally Form C) and uploaded to the eCDOP system. This will involve an increase in time commitment from all agencies.

The NCL CDOPT steering group has identified this could be balanced by using existing meetings within the acute NHS Trusts.

1.5.5 Child Death Overview Panel (CDOP**)**

It is required that all areas hold a multi-agency panel made up of senior professionals *who have had no involvement* in the cases under discussion (this will provide independent scrutiny of each child's death from a multi-agency perspective) and who can identify thematic system changes, in order to learn lessons for the prevention of future child deaths. At this meeting the draft 'child death analysis form' (formally Form C) received from the acute NHS Trusts will be considered, finalised and signed off. The CDOP will review the death of all children normally resident in the area, and where appropriate, the deaths of non-resident children. Local actions to modifiable factors identified will be taken. The frequency of the CDOP is to be confirmed but it is likely to be 3 or 4 times a year. It is recommended that these meetings will be chaired by Public Health or an independent chair. Core membership will be Designated Doctors, local authority Public Health and children's social care, the CCGs, acute NHS Trusts, Designated Doctors for Child Death, and the Coroner's Office. Depending on the theme of the meeting additional experts in that area will be invited.

The new multiagency panel will be the NCL CDOP (covering Barnet, Camden, Enfield, Haringey and Islington).

1.6 The proposed new arrangements have been presented in draft to the Council's Corporate Board, the CCG, the 4 Directors of Public Health (covering the 5 boroughs) and the Accountable Officer for NHS NCL CCGs.

In addition to monthly NCL CDOPT steering group meetings, and as part of preparing and consulting stakeholders for the new arrangements, two workshops were held in January 2019 and April 2019 with other leaders across the partnership.

1.7 The new arrangement is to be referred to as the 'North Central London Child Death Overview Partners (NCL CDOP). It includes the following:

1.7.1 Leadership and governance

The new arrangement will be led by the NCL CDOP. It is yet to be agreed where in NCL governance will be provided.

The NCL CDOPT steering group wants to see strong links between the new safeguarding partnerships, the CCG Quality and Safety Committees as well as an appropriate NCL group.

Information Governance - Under the data protection legislation, all data sharing and processing requires agreements between those sharing and processing data. Whilst by its nature the key subject of a child death review is not subject to the data protection law as it only applies to the living, the Common Law Duty of Confidentiality will still apply, and where others (e.g. parents, professionals) have their data recorded their information will be subject to the data protection law. There are certain exemptions for safeguarding. There is a North London Information Governance Working Group which was set up to deal with these issues. The NCL CDOPT steering group will request assistance with these information governance issues and arrange for a representative of the group to attend the steering group meetings.

1.7.2 Relevant agencies involved in the new arrangement;

- Local authorities: Barnet, Camden, Enfield, Haringey and Islington
- CCGs: Barnet: Camden, Enfield, Haringey and Islington
- NHS Trusts: North Middlesex University NHS Trust, Whittington Health NHS Trust, Royal Free Group NHS Trust, University College London NHS Trust and Great Ormond Street Hospital.

1.7.3 Geographical area;

- Barnet, Camden, Enfield, Haringey and Islington

1.7.4 Support for bereaved families

The new role of a 'key worker' will give bereaved families a single point of contact for information and support. The need for this role has been identified through national feedback from bereaved families who have requested further support. The NCL CDOPT steering group propose developing an NCL Bereavement Offer, this could be done through goodwill by the acute NHS Trusts. Steering group members from the acute NHS Trusts are addressing this task and are currently updating and sharing their bereavement support contacts.

1.7.5 Functional responsibilities:

**Acute NHS Trusts**

- Stage one - Immediate decision making and information gathering

At death a discussion and strategy planning session on the appropriate review with notification to relevant multi agency partners. Includes initial case strategy, rapid response and initiation of bereavement support

- Stage two: Investigation and information gathering

Depending on the specific process required. If the death is a sudden unexpected death in infancy or childhood related a joint visit or other process initiation

- Stage Three: Child death review meetings

Multi agency CDRM conducted by the NHS Trust (acute, community or mental health) with care responsibility for the deceased. This aims to establish chronology and causation, submitting local recommendations/actions to CDOP.

The NHS Trusts will need to ensure effective approaches are in place following child deaths, including a) procedures for timely notification of SPOC for child death; b) a process for determining whether to oversee a CDRM or refer for a JAR; c) processes to ensure child death review meetings engage those who have been involved with the care of the child whether they are from other NHS trusts or the community

Trusts will need to ensure they are adequately resourced, that they have confidence in appropriate challenge and that processes are well aligned with other process such as the perinatal mortality review tool, and LeDeR process.

**NCL CDOP**

- Stage Four: child death overview panel

  Considers the CDRM input and identify local or regional learning. Submission to the Department of Health and National Child Mortality Database to inform national identification of trends to enable population-based interventions for the prevention of child deaths.

1.8 The key changes under the new arrangement include:

- In the new system each child's death will be reviewed at a multi-agency CDRM which is to be held by the agency which declares the death (many now will fall into the remit of the acute NHS trusts) as well as the NCL CDOP.
- In the case of unexpected deaths, a JAR is required. This will be similar but within shorter timescale than the current Rapid Response.
- Each family is allocated a Key Worker to act as a single point of contact.
- Across NCL all deaths will be reviewed thematically by independent review by Child Death Review Partners at the CDOP. Currently all deaths are reviewed within each borough at CDOP.
- Submission of data to the National Child Mortality Database (established 1st April 2019). Previously data was submitted to Department of Education.

1.9 Transition timeline

1.9.1 As indicated earlier in the report, the new CDOP arrangements must be agreed by the statutory partners, published by 29th June 2019, and implemented by 29th September 2019.

1.9.2 The transition from current LSCB Child Death Overview Panel (CDOP) to the new child death review arrangements began summer 2018 and must be completed by 29th September 2019. The current CDOP will continue until the child death review partner arrangements is in place.

1.9.3 There will be a 4-month grace period for borough based CDOPs (under the LSCB) to complete child death reviews.

1.10 Current position

The NCL CDOPT steering group continues to meet to finalise the requirements in the Act and to support acute NHS Trusts with setting up their new systems and responsibilities.

## Glossary of new terminology for the new system

**Child Death Review Meeting**
The stage of the review process that precedes the independent multi-agency panel arranged by child death review (CDR) partners. This meeting should be a multi-professional meeting where all matters relating to an individual child's death are discussed. The Child Death Review Meeting (CDRM) should be attended by professionals who were directly involved in the care of the child during his or her life, *and* any professionals involved in the investigation into his or her death. The nature of this meeting will vary according to the circumstances of the child's death and the practitioners involved and should *not* be limited to medical staff.

For example, the CDRM could take the form of a final case discussion following a Joint Agency Response (JAR), a perinatal mortality review group meeting in the case of a baby who dies in a neonatal unit, or a hospital-based mortality meeting following the death of a child on a paediatric intensive care unit. These meetings could, as a way of standardising practice nationally, be known as a Child Death Review Meeting.

Outputs from CDRMs (draft Analysis Forms) should be shared with the group set up by CDR partners to conduct reviews, i.e. Child Death Overview Panel (CDOP).

**Child Death Overview Panel, or equivalent**
A multi-agency panel set up by CDR partners to review the deaths of all children normally resident in their area, and, if appropriate and agreed between CDR partners, the deaths in their area of non-resident children, in order to learn lessons and share any findings for the prevention of future deaths.

In all cases, legal responsibility for ensuring that arrangements are made to review the death of a child lies with the CDR Partners where the child is normally resident.

The CDOP should be informed by a standardised report from the CDRM, and ensures independent, multi-agency scrutiny by senior professionals with *no named responsibility* for the child's care during life. In practice, CDOPs will conduct the independent multi-agency scrutiny on behalf of the local CDR partners responsible for ensuring that the review of deaths of all children normally resident in that area takes place.

**Designated doctor for child deaths**
A senior paediatrician, appointed by the CDR partners, who will take a lead in co-ordinating responses and health input to the child death review process, across a specified locality or region.

**Forms: Notification, Reporting, Analysis**
Three standard forms should be used in the child death review process:
• Notification Form (previously "Form A") for initial notification of a death to CDR partners;

• Reporting Form (previously "Form B") for gathering information from agencies or professionals who have information relevant to the case. Reporting forms should be completed

by the relevant responsible officer and shared with the relevant CDOP. For certain child deaths, a supplementary Reporting Form should also be completed as required; and

• Analysis Form (previously "Form C") initially drafted at the CDRM and completed at CDOP for evaluating information and identifying lessons to be learned. The Analysis Form is the final output of the child death review process. From 2020 this information should be shared with the National Child Mortality Database, when operational. Specified data to NHS Digital for the transitional period will be notified to Child Death Review Partners separately. The mechanism for collecting, and the content of, this data will evolve as the National Child Mortality Database becomes operational.

All forms and templates to be used for reporting child deaths can be found on GOV.UK. These forms should continue to be used until the introduction of the National Child Mortality Database, in 2019.

**Joint Agency Response**

A coordinated multi-agency response (on-call health professional, police investigator, duty social worker), should be triggered if a child's death:

• is or could be due to external causes;

• is sudden and there is no immediately apparent cause (including SUDI/C);

• occurs in custody, or where the child was detained under the Mental Health Act;

• where the initial circumstances raise any suspicions that the death may not have been natural; or

• in the case of a stillbirth where no healthcare professional was in attendance.

The full process for a Joint Agency Response is set out in the SUDI/C Guidelines.

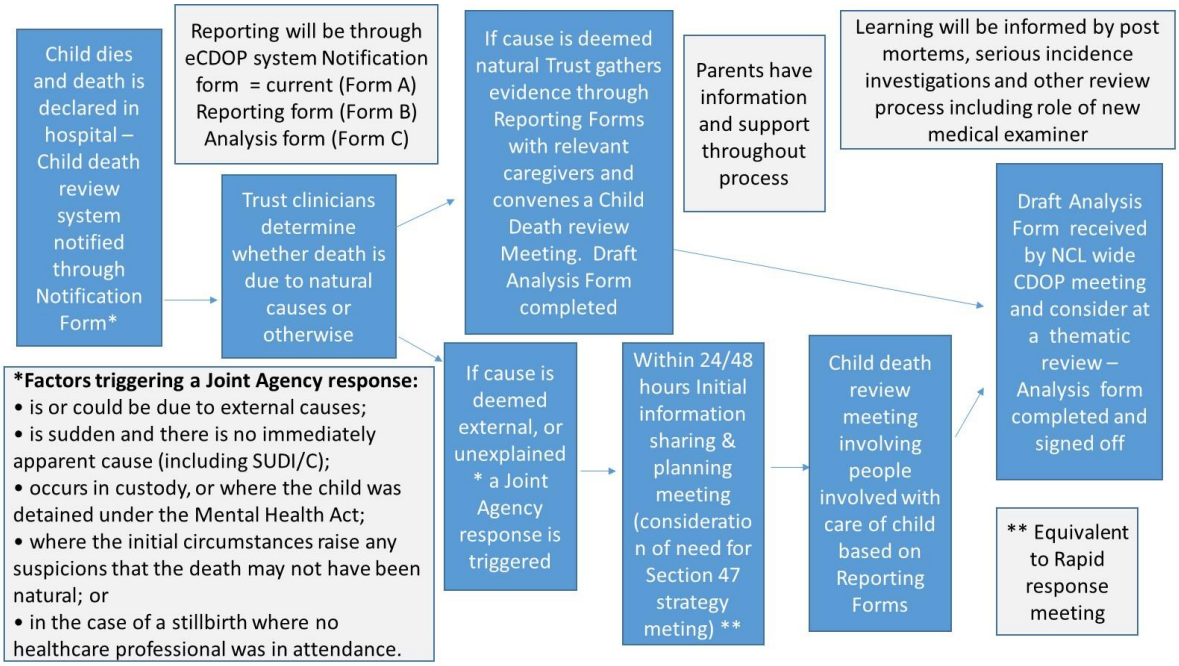
**Key Worker**

A person who acts as a single point of contact for the bereaved family, who they can turn to for information on the child death review process, and who can signpost them to sources of support. This person will usually be a healthcare professional.

**Lead health professional**

When a JAR is triggered, a lead health professional should be appointed, to coordinate the health response to that death. This person may be a doctor or senior nurse, with appropriate training and expertise. This person will ensure that all health responses are implemented and be responsible for ongoing liaison with the police and other agencies. Where no out-of-hours health rota for a JAR exists in a locality, the role of lead health professional should be taken by the senior attending paediatrician.

## Summary of the new Child Death Review Process



**Appendix 3**

**List of Relevant agencies**

| AGENCY |
|---|
| **CAFCASS** |
| **HARINGEY COUNCIL (CYPS)** |
| **Haringey Education Partnership** |
| **Health Services:**<br><br>**Clinical Commissioning Group**<br><br>**North Middlesex University Hospital**<br><br>**Whittington Health**<br><br>**Barnet, Enfield & Haringey Mental Health Service** |
| **LA Housing Department** |
| **Public Health** |
| **LBH Legal Services** |
| **Police** |
| **National Probation Service (NPS)** |
| **London Community Rehabilitation Company (London CRC)** |
| **Lead Member CYPS** |
| **Primary School Head rep** |
| **Secondary School Head rep** |
| **London Ambulance Service (LAS)** |
| **Adult Social Services** |
| **General Practitioners** |
| **Haringey** Association of Voluntary and Community Organisations (**HAVCO) (Vol Sector)** |
| **The Bridge Renewal Trust (Vol Sector)** |

**Appendix 4**

**GLOSSARY**

**AD – Assistant Director**

**BC – Borough Commander**

**CAFCASS – The Children and Family Court Advisory and Support Service**

**CCG – Clinical Commissioning Group**

**CCO - CCG Chief Operating Officer**

**CDOP – Child Death Overview Panel**

**CDR – Child Death Review arrangements**

**CRC – Community Rehabilitation Company**

**CSC – Children's Social Care**

**CSP – Community Safety Partnership**

**CYP – Children and Young People**

**DCI – Detective Chief Inspector**

**DCS – Director of Children's Services**

**HoS – Head of Service**

**HSCP – Haringey Safeguarding Children Partnership**

**ILAC – Inspecting Local Authority Children's Services**

**JTAI – Joint Targeted Area Inspection**

**LA – Local Authority**

**LAC - Looked After Children**

**LBH - London Borough of Haringey**

**LSCB – Local Safeguarding Children's Board**

**HSCP – Haringey Safeguarding Children's Partnership**

**MACE – Multi Agency (meeting for) Criminal Exploitation**

**MASA – Multi Agency Safeguarding Arrangements**

**MASH – Multi Agency Safeguarding Hub**

**MOPAC – Mayor's Office for Policing and Community**

**MPS – Metropolitan Police Service**

**NCL – North Central London (Haringey/Enfield/Barnet/Camden/Islington)**

**NHS – National Health Service**

**Ofsted – Office for Standards in Education, Children's Services and Skills**

**SAB – Safeguarding Adults Board**

**SCR – Serious Case Review**

**SEND – Special Educational Needs and Disability**

**SOP – Standard Operating Procedure**

**SPR – Serious Practice Review**

**SSPM – Strategic Safeguarding Partnership Manager**

**WT 2015 – Working Together To Safeguard Children 2015**

**WT 2018 – Working Together To Safeguard Children 2018**

**YJB – Youth Justice Board**

**YOT – Youth Offending Team**