HSCP
Haringey Safeguarding Children Partnership

# Haringey Safeguarding Children Partnership Annual Report 2021-22

METROPOLITAN POLICE

NHS North Central London Clinical Commissioning Group

Haringey LONDON

# Contents

# Foreword

Welcome to the Annual Report produced on behalf of the Haringey Safeguarding Children Partnership (HSCP). The report covers the period from April 2021 to March 2022.In line with the Multi-Agency Safeguarding Arrangements outlined within the statutory guidance, Working Together to Safeguard Children 2018, the HSCP operates within these requirements.

The HSCP provides the safeguarding arrangements under which the statutory partners and relevant agencies work together. We coordinate the safeguarding services, identify and respond to the needs of children and young people in Haringey, commission and publish Local Safeguarding Practice Reviews, implement local and national learning, listen to the views of service users and staff and provide scrutiny to ensure the effectiveness of our safeguarding arrangements.

At the core of these arrangements is a commitment from us, as safeguarding partners, to work together effectively, encourage constructive challenge where needed, identify what is working well and foster a culture of continual learning to drive improvement.

Helping and protecting children through a coordinated approach to safeguarding children is everyone's responsibility. Through collaborative action across organisations and agencies that work with children, young people and their families, our aim is that everyone can recognise the significant role they play and respond and fulfil their responsibilities to ensure that children, young people and families are effectively safeguarded and supported.

Helping and protecting children through a coordinated approach to safeguarding children is everyone's responsibility.

This report recognises the continued progress made by the HSCP amidst the unprecedented challenges and impact of COVID-19 and exemplifies not only the Haringey community spirit but highlights the benefits we can draw on from proactive, collaborative partnership working.

As we now move forward, we recognise the vital role the HSCP will play in coordinating a robust safeguarding response through efficient multi-agency working, ensuring the best outcomes for all our children, young people and families in Haringey are achieved.

During the forthcoming year we will be focusing on how we can involve children, young people, and staff to provide scrutiny and feedback in the work that partners undertake.  In addition, it is our intention to set up a Young People's Board: this specific piece of work was unfortunately put on hold owing to the pandemic. Along with other local authorities, we will consider how to introduce additional independent scrutiny and challenge to further evidence the impact of our partnership's collective decisions and actions.

We continue to be extremely grateful for the work of our Independent Chair and Scrutineer, David Archibald, and value the challenge, accountability, and expertise he continues to bring to the partnership.

**The Haringey Safeguarding Children Partnership Executive**

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# Welcome

I am delighted to introduce the Annual Report for 2021-22 of Haringey Safeguarding Children Partnership, which covers the second full year of the new Multi-Agency Safeguarding Arrangements, which were implemented on 29 September 2019. In preparation for these new arrangements, the three Statutory Safeguarding Partners (Clinical Commissioning Group, Metropolitan Police Service and Haringey Children's Services) worked extremely closely together to plan the detail of the new arrangements and express their joint commitment to further develop and improve multi-agency safeguarding.

One important aspect of the new national arrangements was to give the three Statutory Safeguarding Partners joint and equal accountability for safeguarding children and young people in Haringey. This change was implemented rigorously and effectively and there is clear joint and equal accountability embraced and displayed by the three agencies. This joint and equal accountability has been maintained and further developed, and is a crucial foundation of the partnership.

Over the last year, these strong partnerships have continued to respond effectively to the challenge of dealing with the COVID-19 pandemic. They responded rapidly and effectively, increasing the frequency of the Executive Group and Leadership Group meetings in order to work even more effectively together, sharing the details of responses to the pandemic, pressures on the system and temporary service models in order to ensure that the safeguarding of children and young people continues to be as effective as it could be under complex and challenging circumstances for organisations, front-line staff, families and children and young people themselves. This strong joint response has in turn further strengthened the partnership, laying strong foundations for future joint working.

The partnership has continued to develop its alliance with Haringey's Safeguarding Adults Board and has agreed several areas for joint work, with good progress being made on Transitional Safeguarding and Think Family, where there is good scope for further improvements in services and outcomes.

I write this section of the Annual Report as Independent Chair and Scrutineer. In common with many MASAs, Haringey is developing its approach to independent scrutiny over time and intends to take account of current national work on this over the next year. As Independent Chair and Scrutineer, I continue to work closely with the three Statutory Partners in the decisions they make concerning Rapid Reviews and Safeguarding Practice Reviews, providing both independent challenge and scrutiny.

The HSCP and the safeguarding system across Haringey have performed well during this period and are in a strong position to continue to do so.

**David Archibald**
**Independent Chair And Scrutineer**

# Introduction

The Haringey Safeguarding Partnership (HSCP) publishes an Annual Report as part of its statutory responsibilities under Working Together to Safeguard Children 2018.

The report outlines the effectiveness of multi-agency safeguarding arrangements, focusing on the impact and the difference made to children, young people and families. Evidence is from the activity of the sub-groups, training evaluations and the voice of children and families. Learning is from Local Safeguarding Practice Reviews, multi-agency and single-agency audits, local data, scrutiny, assurance and monitoring activities. Additionally, the report brings transparency for children, young people, families and practitioners and will set out how effective our safeguarding arrangements have been in practice. The report will also include:

- Evidence of the impact of safeguarding partners and relevant agencies' work, including training, on outcomes for children and families ranging from Early Help to looked after children and care leavers.
- An overview of any areas yet to demonstrate progress on agreed priorities.
- Decisions and actions by partner agencies to implement the recommendations of any local or national Child Safeguarding Practice Reviews
- Ways in which partners have obtained and used feedback from children, young people and families to inform their work and improve service provision.

The Annual Report reaffirms the HSCP's work and commitment to focus on continuous learning and development as well as fulfilling its strategic leadership vision:

- At every opportunity, the lived experience of children and young people is integral to how we safeguard and protect .
- There are improved outcomes through strengthening partnership workforce and community resilience .
- Our relationship-based practice is strengthened, demonstrating continuous improvement.

**The Haringey Safeguarding Children Partnership Executive**

# The Executive Group

**The Executive Group consists of three equal and joint partners:**

- Haringey Children's Services
- Clinical Commissioning Group
- Haringey Police

The Executive Group is established, robust and effective, with a clear commitment from partners to review and improve working methods, building on strengths and innovation within the strong partnership relationships that exist.

As a strategic leadership group, the three lead safeguarding partners oversee the Haringey Safeguarding Children Partnership (HSCP). The HSCP Executive Group is the high-level, over-arching local governance partnership that primarily focuses on safeguarding systems, performance and resourcing. The Executive Group has statutory accountability for children's safeguarding arrangements in Haringey.

Members of the partnership must hold a strategic role within their organisations and be able to speak with authority, commit to policy matters and hold their organisation to account. All three lead safeguarding partners have equal and joint responsibility for local safeguarding arrangements. Part of the group's plan includes scrutiny, 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.

The Executive Group met once a month and focused upon the rapid and decisive partnership action required to safeguard Haringey's children, young people and families who are at risk of harm and abuse. As COVID-19 restrictions were relaxed, the Executive Group continued to lead the HSCP to a focus on recovery plans where necessary.

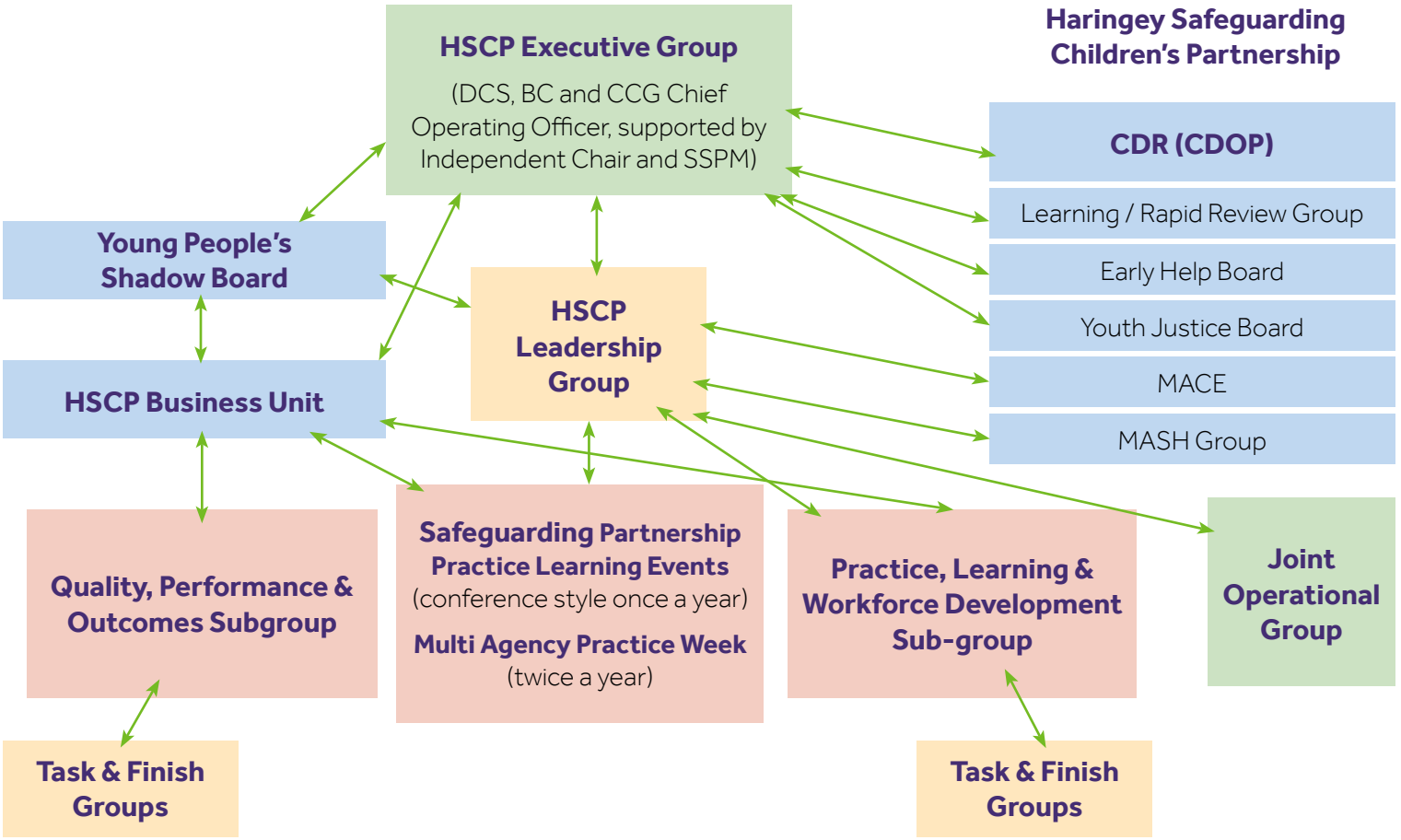
This Annual Report's findings will provide the reader with evidence that safeguarding remained a priority for all partner agencies, demonstrated by consistently high levels of attendance, engagement in new sub-groups and a strong culture of innovation, challenge and debate keeping children and local communities at the heart of the work.

To achieve the best possible outcomes, a key focus has been on the lived experiences of children and young people. The emphasis continues to be how, as a partnership we can work together to help keep them safe in their local communities, securing their physical and emotional wellbeing, engagement in learning in-person and online and ensuring they have access to the highest-quality, evidence-based support.

# The Leadership Group

The Haringey Safeguarding Children Partnership's Leadership Group consists of the lead safeguarding partners across Haringey plus the Independent Chair and Scrutineer. The group acts as the 'engine room' of the partnership. Senior officers from the statutory partners and the relevant agencies authorise the policy, process, strategy and guidance required to support partnership priorities and effective safeguarding. There were 11 meetings for the period 2021-22 which focused on agreed local and national safeguarding priorities, identified through data, audits and performance, focusing on outcomes. The Group is accountable to the HSCP Executive Group and the work taken forward through the three sub-groups and relevant task and finish groups.

## Executive Group and Leadership Group



# Strategic Partnerships

**Safeguarding Adults Board**

**Community Safety Partnership**

**Health and Wellbeing Board**

**Early Help Strategic Partnership Board**

**Violence Against Women and Girls Partnership (VAWG)**

**Joint Haringey Safeguarding Adult Board (HSAB) and Haringey Safeguarding Children Partnership (HSCP)**

The Joint Haringey Safeguarding Adult Board (HSAB) and the Haringey Safeguarding Children Partnership (HSCP) meet biannually to ensure joint collaborative working across both agencies. The main objective is to ensure that all agencies work together for the purpose of improving local safeguarding and promoting welfare of children and adults in care and support needs at risk in Haringey. It is worth noting that each Board has its own existing lines of accountability for safeguarding and promoting the welfare of children and adults by its services.

# Local Background And Context

**Local Context:**

Following the COVID-19 pandemic, the partnership continues to support high levels of need and complexity in families for the following reasons:

- Children living in (relative) low-income families show an increase of 10%, from 10,920 families in 2015-16 to 11,894 in 2020-21, according to the latest provisional data from the Department for Work and Pensions (DWP). Haringey had 1,150 hospital admissions for alcohol specific conditions (2020-21, 17th highest in London, which is a significant improvement from our previous position of being the eighth highest in the London region).
- 2.2% of Haringey's 16-64-years-olds claim Employment Support Allowance for mental health and behavioural disorders, which is the third-highest rate of all London boroughs and above the London average - however, this is largely due to the number of claimants overall. Of all ESA claimants in Haringey, 50.8% are for mental health and behavioural disorders - the same as the London average (May 2021).
- Haringey has the sixth-highest rate of domestic abuse with violence out of all London boroughs and is above the London average (two year rolling average from May 20-Apr 2022).
- Haringey has the third-highest rate of households in temporary accommodation in London and the population outnumbers the availability of housing by approximately 12,000 (average per Quarter 2021/22).

**Alongside these challenges, Haringey has many positives for children growing up in the area. It is a place that has a rich history, strong and vibrant communities, great transport links and excellent facilities with a range of cultural events. Key strengths include:**

- 97% of schools are judged as 'good' or 'outstanding' by Ofsted.
- 99% of Early Years settings are judged as 'good' or 'outstanding' by Ofsted.
- Our children's centres have significantly improved over the past year, with all eight now judged 'good' or 'outstanding' (8 out of 8)
- Diverse communities where more than 180 languages are spoken.
- Over a quarter of the borough is green space – with 25 Green Flag Parks and 120 venues where cultural activities take place.
- Residents report that they have good friendships and associations in their local area and good relations between different ethnic and religious communities.

**Outcomes for children and young people include:**

- Looked After Children in Haringey have above average educational outcomes. Looked After Children KS4 and Looked After Children achieving 9-4 pass in English and Maths GCSEs are performing in the top quartile in England (2020-21).
- Children with Special Educational Needs (SEN) have higher educational outcomes, with many featuring in the top quartile in England. Key Stage 4 achieving 9-4 in English and Maths for pupils with SEN Support is ranked 26th in England and KS4 SEN Pupils with EHCP going to, or remaining in, education & employment-training overall (including special schools) is ranked 19th in England (2020-21).

- Percentage of babies with low birth weight in Haringey rose to 2.97% (2020), lower than both London (which rose to 3.29%) but now higher than England (which fell to 2.86%).
- Lower percentage of asthma-related hospital admissions among children under 19-years-old compared to the London average (64.2 per 100,000 vs 72.9 per 100,000, 2020-21), a significant improvement upon last year's figure (120 per 1000,000 and 167 per 100,000) .
- 20.9% of all Reception year pupils and 36.7% of all Year 6 pupils were recorded as overweight or obese in 2020-21. This is an increase on the previous year, though 19-20 results should be taken with caution due to reduced measurements taken because of COVID-19. 20-21 results are still lower than 2016-2019.

## Our children and young people population:

In Haringey, there are 59,458 children aged 0-17 years, representing 22% of the overall population (ONS 2020 mid-year estimates), largely in line with statistical neighbours and London where 21% and 22% of people are aged 0-17 respectively. Notably, the ward with the highest proportion of 0-17-year-olds is Seven Sisters (31%), while the ward with the lowest is Harringay (17%). The number of under 18s is not expected to change significantly in future years and will remain most concentrated in the east of the borough.

Almost half of the pupils in Haringey schools do not have English as a first language (47.4%). After English, Turkish, Spanish, Polish, Bulgarian, and Somalian are the most commonly spoken languages (May 2022 Census)

One of the most significant challenges is inequality in outcomes. Poverty is a crucial determinant of poor outcomes. Childhood deprivation is unequally distributed across the borough, mainly affecting the east. In 2020-21, nearly one in five Haringey children lived in poverty (19.9%) - a higher rate than in London (18.5%), meaning we are working with increasing levels of need in Haringey. Haringey's eastern wards also have more children living in poverty in workless households. DWP data shows the percentage of children in absolute poverty in workless households as 7.1% in Tottenham Green and 6.9% in White Hart Lane, while at the same time just 1.8% in Alexandra, Crouch End and Muswell Hill.

## Ukrainian families: Contacts to MASH from Families of Ukrainian Origin up to January 2022

- Five were for children with disabilities and one for a Family in acute stress (relating to a total of four children)
- February and March - of the 13 children with contacts, three were referred for social care assessment, seven to Early Help and three signposted to Universal Services.

# Children's Social Care In Numbers 2021-22

We received 13,079 contacts compared to 10,757 contacts received in 2020/21. The highest proportion of contacts come from the police (37%), followed by health services (18%) and schools (16%).

**13,079 CONTACTS**

3,378 referrals were received in the last 12 months compared to 2,851 referrals received in 2020/21.

Of the referrals received, 9% were re-referrals. Lower in comparison to 2020/21 when the re-referral rate was 16%

**3,378 REFERRALS**

2,919 assessments were completed in 2021/22 compared to 2,563 in 2020/21.

92% of assessments were completed within 45 working days; down on 2020/21 when 94% were completed within 45 working days.

**2,919 ASSESSMENTS**

There were 4,168 Children in Need who had received a service at any point within 2021/22 compared with 3,744 CIN in 2020/21. On 31/03/2022 2,151 children had an open of Children in Need episode.

**4,168 CHILDREN IN NEED**

At 31 March 2022 there were 387 Looked After Children.

As at March 2022 the rate of LAC was 65 per 10,000 children in Haringey, the same rate as 2020/21.

**387 LOOKED AFTER CHILDREN**

178 children were the subject of a Child Protection Plan at the end of 2022. A 33% decrease from the number of children at the end of 2021 (264).

231 children started and 307 ceased a CP plan in 2021/22.

**178 CP**

1,199 Early Help cases were closed with a successful outcome compared to 1,194 cases in 2020/21.

49% of the families engaging with Early Help were closed with a successful and sustained outcome, slightly higher than last year (48%).

**1,199 EARLY HELP**

1,164 children were the subject of a Section 47 enquiry in 2021/22.

This equates to a rate of 196 children with a S47 enquiry per 10,000 children in 2021/22, a slight decrease on the rate last year (184) as 7% increase.

**1,164 S47**

There were 230 Initial Child Protection Conferences in 2021/22, a 37% decrease on 2020/21 when 364 ICPCs were completed.

93% of these resulted in a child protection plan. ICPC rate has decreased from 61 to 39.

**230 ICPCS**

1,610 assessments were identified to have a Domestic Violence, Mental Health or Substance misuse factors at the end of the assessment in 2021/22. 50% of these had at least two factors of these groups identified.

**1,610 TOXIC TRIO**

At the end of March 2022, the number of people open to the Youth Offending Service with their Asset Plus Plans up to date was 71% down from 82% a year ago. The number of active young people on case load has dropped to 66 from 77 the year before.

**71% YOS ASSET +**

65% of 19-21 year old care leavers are in education, employment or training compared with 57% in 2020/21 and Haringey SNs (55% 2020/21). 87% are in suitable accommodation, the same as last year up on Haringey's SNs (85% 2020/21).

**65% CARE LEAVERS EET**

In 2021 there were 483 Education, Health and Care Plans requested, which is an 8% increase from 2020

34% of EHCPs were finalised in 20 weeks, down on 2020 when 66% were finalised in 20 weeks.

**483 EHCPS**

Children in Care Attainment 8 achievements continue to be within the top quartile nationally with an average attainment 8 score of 25.8, slightly down on the previous year when Haringey CiC had an average attainment 8 score of 26.7.

**25.8 ATTAINMENT 8**

Of the children who ceased to be LAC in 2021/22, 8 (5%) were adopted and 11 (7%) were subject to a Special Guardianship Order.

Haringey SNs achieved 5% adoptions and 9% SGOs in 2020/21

**19 PERMANENCY ORDERS**

# The HSCP Business Plan

The Business Plan also aims to ensure that the partnership oversees and advances improvements in its core business. The Business Plan and work programme developed in partnership with all agencies continued to progress a range of improvements during the reporting period of 2021-2022.

Multi-agency work within the HSCP groups and sub-groups promotes work to drive a range of improvements to the safety and welfare of children and young people to reduce risk factors while increasing resilience. Partnership membership extends across several sub-groups to provide robust multi-agency working and continuity.

## Impacting beyond our boundaries

While much of the Partnership's focus is support to our resident population, our impact reaches beyond that, and will continue to do so in the coming years. The HSCP is committed to efficiency, integration and building and sharing good practice.

- We have seen cross-borough projects tackling unemployment, health disparities, poverty, and crime.
- We have seen strengthened cross-borough alliances and programmes to deliver innovative, locally led solutions to crucial challenges affecting children and young people in Haringey.
- Locally, NCL CCG has made strides towards working to reorganise and become part of an Integrated Care System (ICS) in that five CCG's became One CCG in April 2020.
- Contributed to the Sector's response to SEND through the London Innovation and Improvement Alliance (LIIA).
- Haringey has contributed to the Pan London response to Every One's Invited.
- The Haringey Elective Home Education Team (EHE) partnered with the Barnet Safeguarding Children Partnership to raise awareness of electively home educated children in our community, developed an EHE Policy, and a new EHE website.

## Delivery

Many of the outcomes sought, and the impacts that we will achieve, will be the product of close partnership working with or through the delivery of our partners on shared areas of interest.

Our delivery in partnership, is shaped by the priorities of a range of strategies such as the Early Help Strategy, Young People at Risk Strategy and Action Plan. Health and Wellbeing Strategy, Children and Young People's Plan and Violence Against Women and Girls Strategy. These inform individual Partner and collective planning, driving activity that is overseen by Partner's governance structures, and will contribute to the delivery of this plan.

# Funding Arrangements

Working Together 2018 states that the three safeguarding partners should agree on the level of funding secured from each partner (which should be equitable and proportionate) and any contributions from each relevant agency to support the local arrangements.

Partner agencies continued to contribute to the HSCP budget for 2021/22 and provide staff time. Currently as a partnership we intend to work towards equalising the budget as part of our longer-term funding plan.

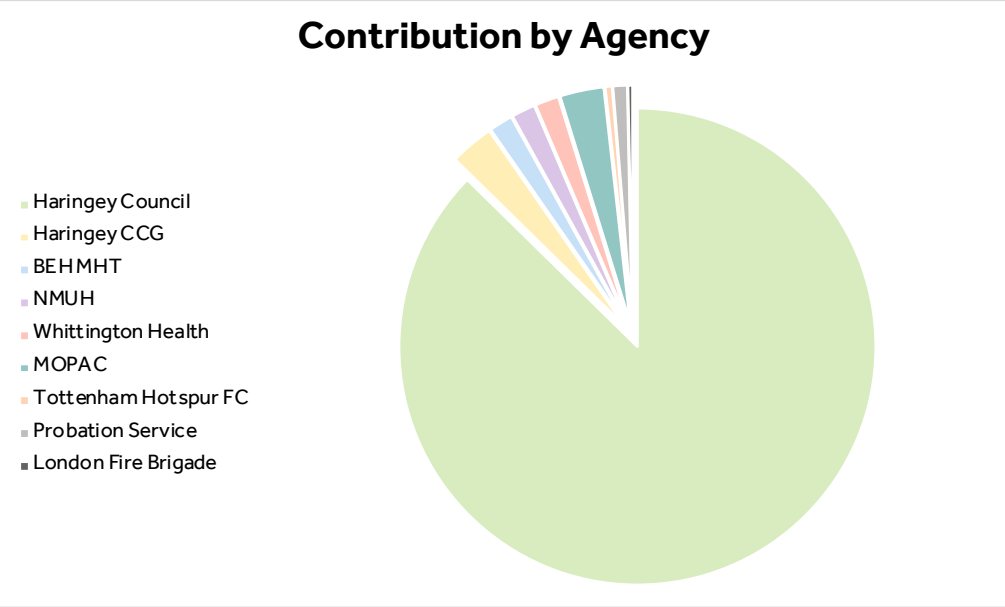
The partners in Haringey recognise the impact of the financial challenge facing many front-line services and the increasing complexity of need, demand and reduced funding from central government.

In total, the collective HSCP has contributed £314,419 towards the overall total cost for the year 2021-2022.

Work is underway within the partnership to address equitable funding, building on the commitment to sustaining the rigour of the partnership. Agencies have been finding alternative and innovative ways to contribute, including an 'in-kind' contribution via the secondment of a police staff to the HSCP for two days a week. Other partners have facilitated and supported the HSCP training and Health Partners now share the Chairing of the QPO & PWLD sub-groups.

## HSCP Partnership Contributions *Includes contribution toward SPRs

| | 2021-22 |
|---|---|
| Haringey Council | £274,672.35 (87.36%) |
| Haringey Clinical Commissioning Group * | £9,415 (2.99%) |
| BEH MHT (Barnet Enfield & Haringey Mental Health Service) | £5,115 (1.63%) |
| NMJH (North Middlesex University Hospital) | £5,115 (1.63%) |
| Whittington Health | £5,115 (1.63%) |
| MOPAC (Mayors Office for Policing and Crime) | £9,415 (2.99%) |
| Tottenham Hotspur FC | £1,500 (0.48%) |
| Probation Service | £3,071.65 (0.98%) |
| London Fire Brigade | £1,000 (0.32%) |
| **Total** | **£314,419** |



# Section 11 Audit

In total, eight organisations were requested to submit a return and every organisation fulfilled their responsibility by submitting their completed audit returns. The HSCP introduced support and challenge sessions, chaired by the HSCP Independent Chair and Scrutineer and the Strategic Safeguarding Partnership Manager, throughout November and December 2020. Agencies were scrutinised and asked to reflect on their safeguarding processes. Partners valued sessions with an opportunity to discuss responses to their Section 11 self-evaluation audits.

Overall, the partnership demonstrated a strong commitment to safeguarding via dedicated safeguarding teams and officers who provided clear, accountable governance processes and procedures and excellent evidence of safeguarding documentation. The S11 audits illustrated a desire to deliver best practice around safeguarding.

Across agencies, there was evidence of a real commitment by senior management to promote safeguarding throughout individual agencies. It was demonstrated that staff had knowledge of the management structure and could approach individual safeguarding teams for advice if required. Partners showed commitment to attending partnership meetings and disseminate any learning. Each agency was proud of its dedicated safeguarding team and the commitment they demonstrate daily.

### Recommendations

- Work to be undertaken to improve and promote the HSCP brand, this should include a refresh of the HSCP website, with a focus on ensuring that all documentation, policies and procedures are up to date with a clear date of review evident.
- Consideration to be given to the reporting structure of the HSCP in order to maximise the time the Executive Group can focus on the HSCP's strategic priorities.
- Continued close working relationship between HSCP and Safeguarding Adults Board (SAB), with a view to progressing the joint action plan to tackle poverty in Haringey.
- Widening the range of agencies to engage in the s.11 including Educational Establishments and faith communities

We have seen a real commitment and the impact of agencies involving children and young people in recruitment panels and processes for senior managers and improved use of the Voice of the Child, with more mechanisms introduced to capture their feedback.

# Areas of Strength

## EXCELLENT LEADERSHIP AND STAFF COMMITMENT TO SAFEGUARDING

Overall, the partnership demonstrated a strong commitment to safeguarding via dedicated safeguarding teams and officers' who provided very clear accountable governance processes and procedures and excellent evidence of safeguarding documentation. The S11 audits illustrated a desire to deliver best practice around safeguarding.

Across all agencies it was highlighted that there is a real commitment by senior management to promote safeguarding throughout individual agencies and achieve the best possible outcome for children and young people. It was demonstrated that staff had knowledge of the management structure and approach individual safeguarding teams for advice if required. Partners showed real commitment to attend partnership meetings and disseminate any learning. Each agency was proud of their dedicated safeguarding team and the commitment they demonstrate daily.

Across the partnership, senior managers have been described as demonstrating a strong understanding of safeguarding through firmly embracing innovation, ensuring a focus on continuous practice improvement, and strengthening services for children and young people. They are ambitious and passionate about raising standards and strive for excellence.

## ROBUST MULTI-AGENCY WORKING AND INFORMATION SHARING

Overall, all partners were of the same view that the MASH is working extremely well with good, pro-active communication and information sharing occurring on a daily basis. The MASH is now recognised widely as the "front door" between partner agencies and MASH colleagues are regularly approached by front line staff for advice and guidance on a range of safeguarding issues.

The effective and timely sharing of information is essential across the partnership when in delivering high quality services focused on the needs of the child. Partners continue to work hard collectively to ensure that children with identified needs get the services they require and deserve when they most need them and when they can have the most impact. Whilst information sharing as a whole across the partnership appears to be very positive, some partners did highlight the fact that on occasion information sharing was not always reciprocated, especially across boroughs.

## "THINK FAMILY" APPROACH FOR HOLISTIC SAFEGUARDING

Several HSCP partner agencies continue to better align their Safeguarding Children and Safeguarding Adult teams to bring a more holistic approach of Safeguarding to the partnership. In many cases this has resulted in a positive way of how "Think Family" approach has embedded itself into everyday working practices of frontline staff. This is evidenced by timely and appropriate referrals. Partners continue to jointly work on this approach to have the same consistent level of understanding.

Due to the success in embedding the "Think Family" approach, agencies are now expanding this and looking for ways to further engage with those individuals who are reluctant to engage with services, such as regular missing persons or "invisible fathers".

## SAFEGUARDING TRAINING FOR STAFF

All partners highlighted that the benchmark for safeguarding training of their staff had been achieved. The majority of training remains online as a remnant of the Covid-19 pandemic and agencies adapted very well to this arrangement. (It is hoped that as time goes on, a healthy balance between face to face and virtual training will be struck)

Partners continue to help to deliver the multi-agency training opportunities facilitated by the partnership. This continues to be well received by all attendees as local skills, knowledge and expertise is utilised to help deliver the training.

## COMMUNICATION TO STAFF

Safeguarding is included in all job descriptions, so that individuals clearly understand their roles and responsibilities. This is communicated to all new beginners through induction programmes and mandatory safeguarding training.

Several agencies highlighted the effectiveness of the 7-minute briefings for awareness raising around specific safeguarding issues, e.g. bruising in non-mobile babies, which are communicated to staff.

## BETTER USE OF "VOICE OF THE CHILD"

Last year's S11 report highlighted a need for the better use of Voice of the Child in some agencies. This year's S11 reports showed that a lot of innovative work to improve this has been undertaken and representatives felt confident that this is now very well embedded with practitioners.

The Voice of the Child now takes a central focus in assessments / reports and is easily identified. Agencies ensure that the Voice of the Child is central to any child protection processes where age appropriate and that children feel heard and listened to. IT systems have been adapted to make it easier for staff to record evidence of the Voice of the Child. Additionally, a number of agencies have developed child friendly documentation, such as complaints procedures.

## SAFER RECRUITMENT

Agency representatives were keen to evidence that since the last S11 report they had made changes to existing processes and checking mechanisms to their safer recruitment process and subsequent DBS checks. These processes are supported by robust policies, safer recruitment training and guidance documentation.

# Areas for Development

## THE NEGLECT TOOLKIT

Partners would like to see the Neglect Toolkit used more consistently and welcome the forthcoming review of the Neglect Toolkit and training opportunities to accompany this. Partners consider this will support an improved understanding of Neglect, its impact and how a consistent approach will help to achieve improved outcomes for children, young people and their families.

## DISCHARGE PLANNING MEETINGS

The partnership recognised the challenges faced by designated safeguarding leads in Haringey by not having a hospital in borough. This recognition supported the interim agreement of a Discharge Policy for Haringey Children and Young People whilst the Integrated Care Board (ICB) across North Central London (NCL) embed a strategic hospital discharge protocol for all children and young people in the region.

## REVIEW OF AUDITS UNDERTAKEN IS REQUIRED

Through the Section 11 audit the partnership also recognised the challenges experienced by respective agencies that participate in audit activities across a number of local authorities, namely the NC L region (as well as beyond this region). Partner agencies remain very committed to the need for scrutiny of practice through audit activity and would welcome a review of the audit programme to enable them to promote this valuable work and learning derived from it in order to shape and influence practice improvement.

## HSCP AS A BRAND

During the Section 11 audit process some partner agencies made really helpful suggestions regarding how the Haringey Safeguarding Children's Partnership could promote its brand across the local authority area and beyond to maintain its prominence, to enable the partnership to respond to staff during and since the impact of the pandemic. In tandem with this the HSCP will be refreshing policies, procedures and various aspects published on the HSCP website to optimise support to partner agencies as well as Children, Young People and Families within Haringey.

## STAFFING

Partners, locally and across the North Central London region continue developing innovative ways to respond to the impact of staff movement through a variety of measures to optimise service delivery within their respective organisations and recognise the challenges encountered during active and robust recruitment campaigns in a very competitive local and national employment market.

In reference to the above point, partners did want to emphasise that it is due to the dedication, commitment and professionalism of existing staff that positive outcomes are still being achieved for the most vulnerable families in Haringey.

# S11 Recommendations 2020/21

**Progress made since 2021 includes:**

- Partner Agencies are continuing to take a pro-active approach to information sharing at the earliest opportunity. This assists in achieving the best possible outcomes for children, young people and their families.
- Information sharing between agencies includes outcomes of cases to alert partners of any potential gaps in provision.
- Partner Agencies have reviewed their safer recruitment processes
- Partner Agencies have continued to use and develop innovative practice to ensure that the voice of the child plays an active role in agency's decision making, this includes recruitment of senior management.
- Agencies have continued to strengthen their relationship with the Local Area Designated Officer (LADO), resulting in the LADO receiving an increase in requests for advice in order to resolve concerns at an earlier stage. Throughout 2022/23 the LADO will facilitate a rolling programme of awareness raising sessions across the partnership.

# HSCP Multi-Agency Data-Set

HSCP developed an agreed dataset in 2020/21 that monitors multi-agency child safeguarding arrangements, which proved successful with submissions by all partners. As a result of the success in collecting and collating the data it was agreed to further develop the dataset for the financial year 2021/22. The three strategic partners, as well as other partner agencies, contribute data quarterly, which is reviewed by the QPO, the HSCP Leadership Board and HSCP Executive. This data includes analysis by the Leadership Group linked to safeguarding priorities, which enables partners to understand how their services perform and highlights any emerging issues requiring strategic intervention across the partnership.

The dataset demonstrates the partnership's performance in terms of its strategy to improve outcomes for children. Clear explanations of upward and downward trends are shared and scrutinised. This focus on evidence, analysis and data identifies further opportunities to strengthen practice and investigate and resolve any issues at the earliest point by enabling partners to take forward areas identified in the dashboard requiring further analysis, strategic intervention, and oversight.

This supports the earliest intervention and analysis of new safeguarding issues, areas of improvement and emerging trends.

Referrals were the priority for partners during COVID-19 in 2020/21 and due to the ongoing concerns around the pandemic and the impact on service delivery it potentially had. This continued to be monitored closely and scrutinised monthly by the Executive Group, the Leadership Group and the Quality, Performance and Outcomes sub-group. This provided assurance to the HSCP that children, young people and their families in Haringey, continue to receive timely support when necessary.

### Performance Framework Proposal for 2021-22:

The development of a revised Dashboard commenced during the current reporting period and progressed to consultation with all relevant partner agencies. It is anticipated this will be approved, launched and embedded during the 2022-2023 period.

The new proposal is a more focused approach in data collection, linking it to the partnerships priorities and areas of focus. Additionally, this will allow for areas of persistent concern to be monitored via data collection.

This enhanced data collection will support triangulating audit activity with intelligence that will enrich practice improvement.

### Performance Framework Proposal for 2021-22:

- Children in need of help and protection
- Children affected by Domestic Abuse
- Children living with Mental Health issues

# Scrutiny and Assurance

The Haringey Safeguarding Children Partnership (HSCP) undertakes regular auditing and scrutiny of multi-agency safeguarding arrangements. The work is carried out through the Quality, Performance and Outcomes sub-group. The sub-group developed a partnership learning log from thematic audits to monitor progress against actions identified. All actions arising from thematic audits are compiled into a themed learning log - a live document to ensure actions are implemented and sustained. Learning is disseminated to front-line practitioners through events and conferences and informs the training offer. Over the last 18 months, the HSCP undertook multiple activities or sought assurance to establish how agencies work together to identify and respond to crucial safeguarding issues. An overview of these activities is provided below.

## Outcome of Activities

- Ofsted Focused Visit – see letter either click https://files.ofsted.gov.uk/v1/file/50162852 or copy it into your browser.
- **Health Partners**

  The most recent CQC Inspection summary for services for children and young people at The Whittington Hospital was rated 'Good' overall.

  Barnet, Enfield and Haringey Mental Health NHS Trust's most recent Inspection summary for child and adolescent mental health wards and specialist community mental health services for children and young people were rated 'Good'.
- **Probation Service**

  Following the Probation unification in June 2021 all staff have been will re-visit mandatory safeguarding training. The London Performance and Quality team has created an electronic safeguarding dashboard which will be monitored locally on a monthly basis. There was a planned safeguarding conference held in March 2022 within the Haringey Probation Delivery Unit to ensure MASH partners agree information sharing protocols and priorities
- **Metropolitan Police Service KPI Framework**

  The Metropolitan Police Service has reviewed its key performance indicators regarding Child Protection. The new framework, which encompasses all areas of safeguarding (including Child Protection) is now embedded with a regular thematic ongoing monthly audit regime led by the Public Protection Delivery Group. It includes a specific requirement to consider the Voice of the Child in every case, every time.

## Child Abuse Investigation Team (CAIT) KPIs

An overview of these activities is provided below.

- 1. Timeliness of investigation - broken down into three sub-headings:
  - Standard investigations to be completed within 30 days such as Common assault / battery /drunk in charge of a child under seven
  - Serious Investigation to be completed within two months such as ABH / GBH sec 20 / child cruelty / abandoning a child
  - Serious & Complex Investigation to be completed within four months such as GBH sec 18 / threats to kill / abduction / sexual assault / rape
- Increase sanction detection (SD) rate to 30% of CAIT investigations.
- Reduce outstanding named suspects over 28 days to 10%.

Audits are carried out by dedicated inspection team (DIT).

The police have set ambitious targets for these KPIs, and although it took some time to achieve the targets, our dedicated and professional Child Abuse Investigation Teams are now either hitting or exceeding these targets. Going forward the CAIT KPI will change and be measured in relation to sanction detections rates.

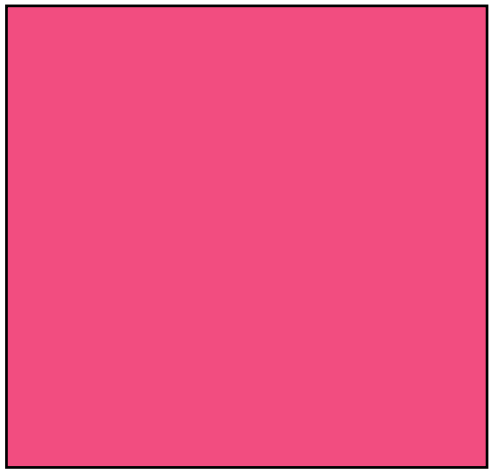
# The "Voice of the Child"

### What do we mean by 'the child's voice'?

This not only refers to what children say directly, but to many other aspects of their presentation. It means seeing their experiences from their point of view.

### Why is the child's voice important?

Child focused work means children feel listened to, plans are more successful when they are involved and prompt decisions are made about safeguarding when necessary.



Effective safeguarding systems must be child centred. Problems can arise in safeguarding systems when practitioners in agencies lose sight of the needs and views of the children within them, or place the interests of adults ahead of the needs of children.

Everyone working with children and families must seek the voice of the child and reflect and respond to it in all aspects of work. This is rooted in legislation and good practice.

The HSCP encourages partners to regularly seek opportunities to gather the views of children, young people, and their families to inform initiatives and partnership developments.

In the Metropolitan Police Service, the voice of the child is embedded in every interaction with children at each stage of an investigation. This begins from initial contact, usually by uniformed Police, up to the culmination of a case with court proceedings. The Met Direction Strategy 2018 – 2025: Achieve the best outcomes in pursuit of justice and in the support of victims - a deep commitment to active listening and emotional intelligence in how we engage with victims.

The voice of the child is routinely sought and captured in assessments within CAMHS. Following learning from a SPR, CAMHS undertook an audit that evidenced the voice of the child being captured in assessments and safeguarding referrals. An area of potential development would be to strengthen the voice of the child being captured where adults have care giving responsibilities.

The child protection medical provides an opportunity for children's and young people's voices to be heard in terms of their health but also all aspects of their wellbeing. They can be seen by themselves. The HEADS questions have been incorporated into the child protection medical to allow discussion with the young person on important topics. Particular thought is given to the behaviour of pre-verbal/non-verbal children and how that reflects the voice of the child.

### Haringey CYPS gather the views of Children and Young in a variety of ways:

- C&YP in care are always at the centre of their Children Looked After Review. They are supported to fully participate in their Statutory Review. Some young people choose to chair their own reviews and others contribute in other ways such as choosing who attends review, where the review is held and so forth.
- ASPIRE (the Children in Care and Care Leavers Council) send out surveys regularly to the C&YP in Care and Care Leavers to gain their views, which are then collated and used to improve services.
- ASPIRE also attend quarterly meetings with Members and DCS and ADCS whereby their views are gained and used to develop service provision
- ASPIRE are involved in recruitment of senior managers via an interview panel and their feedback is taken on board during the selection process
- Care experienced young people have been actively involved in shaping the Transitional Safeguarding Protocol and continue to support us to embed this across the partnerships.

- Haringey have a Voice of the Child policy that stipulates that C&YP are consulted on the update or launch of policies that affect them and this is facilitated via ASPIRE. Partnerships also utilise the group's voice in their development of services.
- The Haringey Children and Young People Quality Assurance Framework involves gaining the views of children and young people on a monthly basis and this feedback is used to inform the development of services for children and young people.

**Children and Young People's Contributions – What they said:**

**"He was like on it all the time, did what he said he was gonna do."**

**"I hardly smoke weed anymore – my case worker – helped me get the help I needed to cut down, I reckon I will quit like completely soon."**

**"They always helped, like with opportunities."**

**"My case worker helped understand my feelings – I don't get angry so quick anymore, I try and think first."**

**"Yeah they were always kind and listened."**

**"My worker helped me with my problems, always listened and help me make better decisions."**

**"I've met some amazing people since working with the YJS."**

**"They didn't judge me, she just listened."**

# Joint Work Undertaken

## Transitional Safeguarding

Work is underway to produce the Haringey Transitional Safeguarding Protocol. The aim of the protocol is to develop a multiagency approach to preparing young people for adulthood that enables a transitional safeguarding response to support the most vulnerable young people and adults in Haringey who are at risk of abuse and exploitation. It aims to reach and influence the practice of all operational staff and managers as well as inspire senior leaders in their visioning and commissioning of future services.

We recognise the challenges faced by many young adults who may lack support of families or services to address the many risks adulthood can bring. Some young adults may be exploited by organised crime gangs or engage in harmful behaviours that limit their life choices.

The implementation of this protocol and action plan will lead to assurance for both the safeguarding adult board and safeguarding children partnership of a more effective multiagency approach for young people, enabling earlier identification of risks and responses that embed transitional safeguarding as an integral strand of the Preparing for Adulthood pathway. The final protocol is expected to be published in 2022.

The Joint HSAB/HSCP agreed to jointly commission a study of the experiences of Haringey young adults who are care leavers, to learn more about how adults and children's services/agencies can best support care leavers in their transition into independent adulthood. This will support better shaping the future organisation and delivery of services to this vulnerable group of people and complement the developing Vulnerable Adults Protocol. Furthermore, the joint Board agreed to a Learning Together systems approach so that the approach and potential findings of the commissioned study is not limited to what is currently possible within existing national, legal and policy imperatives, but points to what would be of benefit to care leavers and inform Haringey's approach to nominating across adult agencies lead professionals.

## Vulnerable Peoples Protocol

The Vulnerable People Protocol (VPP) is being led by both Assistant Directors (Children's and Adults) with the support of both Principal Social Workers across Adults and Children services. A Vulnerable Persons Working group has been set up to look at the different areas to embed in the Protocol. There has been a mapping of case scenarios to ensure good practice in areas of development in the current systems and identifying any gaps. There has been positive progress around young adults and care leavers through the regular meetings between Children Social Care, the Mental Health Service, and Adult Social Services.

# Multi-Agency Audits

The HSCP agreed with partner agencies to undertake three thematic multi-agency audits, in addition to other audit activity. Themes and time scales were agreed and leads were identified from partner agencies. In addition there is a HSCP multi-agency practice week planned to take place in February 2023.

## Themed Audit 1: Children and Young People's Mental Health

The audit aimed to focus on a multi-agency deep dive into how Haringey local services respond to children and young people living with mental ill-health.

The safeguarding children lead nurse for Barnet, Enfield and Haringey Mental Health NHS Trust led the audit. We developed a Terms of Reference (ToR) based on children experiencing mental ill-health and a themed deep-dive audit tool. The sampling focused on the children with early signs or living with mental ill-health where there is multi-agency or single-agency involvement. The exercise allowed the audit group a closer look at the experiences of children, focusing on their journeys.

### KEY FINDINGS

- The thematic analysis noted an increase in complex cases within the partnership and to children's social care where mental health was a feature.
- Also noted was the need for mutual exchange of knowledge between mental health, housing, Children's Social Care pertaining to the interface of the Mental Health Act (1983) and safeguarding issues.
- Staff were acutely aware of exploitation risks in adolescents.
- There were distinctions between mental health concerns and behavioural concerns.
- Staff knew who to communicate with in the professional network.
- Mental health risk assessment was completed prior to section 17 leave being granted for young people subject to the Mental Health Act (1983).

### OPPORTUNITIES FOR STRENGTHENING PRACTICE THAT WERE IDENTIFIED

- The 'voice of the child' in action, going beyond the scope of what a child has said, looking at behaviours and what this means in the context of the child's experience.
- Appraising risk from a system perspective (multi-agency), which includes safety planning and management of risk,
- Further develop resources and practice from a trauma informed perspective.
- Strengthening the use of cumulative risk to inform interagency planning
- Continue to further develop the interface with the Mental Health Act and safeguarding procedures to ensure that all practitioners have access to up-to-date guidance and legislation.
- Resource identification and develop support pathways where children do not meet threshold for mental health input rather displaying signs of trauma.

### RECOMMENDATIONS THAT ARE BEING TAKEN FORWARD

- The establishment of a Named/Designate forum that will enable discussion, challenge, engender resolution, and innovative ways to solve identified issues. This has been successfully established.
- Creation of a CAMHS/Social care liaison meeting to support discussion at an operational level with a focus on the child, building better working relationships and shared risk assessment. This was paused due to the creation of the CAMHS division. Social care and Haringey CAMHS leaders have been building on their professional relationships and communicating at earlier stages in order to achieve the best possible outcome.

- Prioritise training across the partnership regarding children's mental health issues in respect of the Mental Health Act 1983. HSCP training offer continues to be reviewed and additional training gaps in provision are addressed.
- Strengthen joint risk planning in cases where children have mental health and safeguarding concerns.
- Continue to further develop the interface with the Mental Health Act and safeguarding procedures to ensure that all practitioners have access to up-to-date guidance and legislation.
- Resource identification and develop support pathways where children do not meet threshold for mental health input rather displaying signs of trauma.

## Themed Audit 2: Child in Need of Support & Protection Audit

This audit activity was undertaken to focus upon children in need, in particular those where concerns arose in relation to neglect.

The impact of the pandemic in Haringey has been exceptionally severe with a large minority of the population from Black, Asian or minority ethnic heritage who have experienced a disproportionate impact on mortality from COVID-19 with a greater likelihood around children and young people experiencing neglect due to social isolation, poverty, school closures and increase in parental & family stresses because of the lockdowns.

The Audit was led by the Interim Deputy Head of Service, EDT, MASH & Assessment on behalf of the partnership. The audits provided an in depth analysis of the circumstances of the Haringey families subject to the audit. The learning is set out below.

### KEY FINDINGS

- There were timely referrals into the MASH and robust decision making
- There was a high degree of visibility to professionals
- There was a high degree of visibility to professionals
- During the first lockdown the children continued to attend school due to their vulnerabilities
- There was evidence of robust multi-agency working across the children's centre, and two schools.
- This is a good example of a clear support plan in place to directly address the needs of the children and family in the short term.

### OPPORTUNITIES FOR STRENGTHENING PRACTICE THAT WERE IDENTIFIED

- There is a need for continued growth regarding availability of suitable, affordable housing that meets the holistic needs of families.
- The completion of the current review of the Neglect Tool and Strategy, followed by a re-launch and focus upon embedding across all partner agencies would further shape and support responding to children in need in Haringey.
- Strengthening clarity regarding specialist roles across services responsible for working with and responding to children with additional needs.
- Prompt identification and assessment of young carers with clearly devised plans to support their holistic needs.
- Building upon previous learning and development of foster carers to extend expertise in supporting young people who misuse substances.

### RECOMMENDATIONS THAT ARE BEING TAKEN FORWARD

- To further embed the Young Carer's Strategy across the Haringey Safeguarding Children's Partnership.
- Complete the review of the neglect strategy, toolkit, and guidance, to launch the revised suite of documents and provide training to support embedding the revised process.
- Continue to embed the core offer of the Disabled Children's Team across the partnership, including enhancing its profile within Haringey and how it supports parents and carers.

- Renewed focus to support timely recognition, assessment of need and the multi-agency response to substance misuse during pregnancy.
- For the Police to continue to strengthen their timely responses to children in need and collaborative working arrangements with the MASH service.

## Themed Audit 3: Children Affected by Domestic Abuse (DA)

A Task and Finish Group was created from the Haringey Safeguarding Children Partnership (HSCP) Quality, Performance and Outcomes (QPO) subgroup to provide a child-centred assessment in relation to the provision of services available for children affected by Domestic Abuse in the London Borough of Haringey. The audits were one of the themes agreed by the Haringey Safeguarding Children Partnership (HSCP) audit work plan for 2021.

This audit was led by senior Police Officers and cases with a rich multi-agency involvement were selected from a list of six relevant cases presented by Children's Social Care (CSC).

### KEY FINDINGS

- A number of young people have been referred to a specialist support agency since the Domestic Abuse Act, 2021.
- It was recognised that the Voice of the Child was captured by most of the professionals involved in the cases discussed.
- There was evidence of strong multi-agency partnership working in the cases.
- Social workers in schools (SWIS) have given quick access to a valuable source of support to children who need it and there was positive feedback.
- The HSCP commissioned a two-part "Understanding DA" training course with a number of professionals now trained.
- Identification and Referral to Increase Safety (IRIS) has trained 25 out of 36 GP practices in Haringey.

### OPPORTUNITIES FOR STRENGTHENING PRACTICE THAT WERE IDENTIFIED

- Capturing the Voice of the Child: For all agencies there needs to be a continued and consistent understanding that behaviours act as the Voice of the Child as well as what children actually say. Whilst we know that all agencies have made huge developments regarding this issue, we also acknowledge that we cannot be complacent and developing skills around this issue remains a priority.
- Limited child-focused support: It was noted that support provisions for children affected by Domestic Abuse (DA) were often instigated as a result of the DA survivor receiving initial support, with limited opportunities for children to seek or obtain assistance directly themselves. For example, a GP can refer a survivor of DA to Solace in Haringey. Solace has a waiting list. There are no similar services for the children and the psychological impact on the children is significant. Access to support for children often focuses on children who have witnessed or experienced abuse, with little focus on the emotional affect change resulting from DA, such as a change in home, school, friends, proximity to family, may have on a child.
- Current support for children will need to be provided by generic services for example Open Door or CAMHS or services provided by schools. From the GP records in these three cases, it appears Children and Adolescent Mental Health Services (CAMHS) were not involved with any of the three families discussed. Children are accepted by CAMHS when there is concern of a mental health diagnosis however children witnessing DA this is an emotional impact on the children and doesn't fall within the CAMHS remit. Other resources are required, there are effective platforms for other concerns such as Insight platform for drug use, however not for DA.
- Unequal access to services: There is a number of areas where there appears to be unequal access to services for children and young people:
  - The IRIS project is not commissioned for all of the GP practices in Haringey.
  - Schools will have different things in place within the school to meet children's emotional needs. There will be variation in the type of provision and the waiting time for provision of support between schools.

- The Social Workers in School (SWIS) project is not available in all schools.
- Language as an additional barrier when services need to be applied for online and the survivors require additional support in applying, this adds to the delay in the children receiving any required support.

- Training: Improved training for schools around DA and the effects of witnessing DA could help professionals identify signs in children and provide early interventions. Training inputs to children around unhealthy relationships may assist children in identifying issues they may have witnessed at home and seeking support.

## RECOMMENDATIONS THAT ARE BEING TAKEN FORWARD

- Formal mapping of domestic abuse services available in Haringey for adults and children which identifies gaps and disparities and commissioning of services to fill those gaps.
- Use of the mapping exercise to inform development of a Haringey 'offer' for children affected by domestic abuse including the pathway for emotional/ therapeutic support for children affected by domestic abuse.
- HSCP to create and distribute a flowchart mapping how and when professionals in Haringey become involved in a case and how information is shared with partner agencies to understand the support provided to families, and children, affected by DA, and to enable wider awareness by other agencies. This to be publicised and 'launched' so front line professionals are aware of it.
- For DA to continue to be a training priority for multiagency training. For this training to have a focus on the detrimental effects of domestic abuse on children and young people and how to identify and mitigate these effects.
- All partner agencies to continue to raise awareness and access relevant training in promoting identification and explicitly recording the Voice of the child with this being central to all decision making mechanisms.
- The GP IRIS Programme to continue to extend throughout all GP practices within Haringey.

# Local Authority Designated Officer (LADO)

All local authorities have a statutory role of Local Authority Designated Officer (LADO) / Designated Officer or Team of officers.

The LADO Team is responsible for coordinating the response to concerns that any person aged 16+ who works with children / is in a position of trust has, or may have, caused children (under 18s) harm, either at work or in their personal life.

LADO provision responds to professionals working in the borough rather than the demographics of children. Therefore, the profile of the borough must be considered in the resourcing of the LADO service.

| Children & Young People's Providers | |
|---|---|
| Schools | 65 LA maintained Schools<br>16 Academies<br>12 independent schools<br>5 Free Schools<br>1 College<br>7 Special schools, including the Haringey Learning Partnership |
| Early Years providers | 68 Nurseries<br>43 Nursery schools |
| Tier 4 NH provision and educational establishment | 1 Adolescent Unit |
| Foster care | 3 IFAs<br>A disproportionate number of foster carers living in the borough.<br>390 Haringey children currently in care.<br>400 children placed by other LAs, living in Haringey [Source: Brokerage Service]. |
| Semi-independent | 16 Semi-independent settings |
| Children's Residential Homes | 3 |

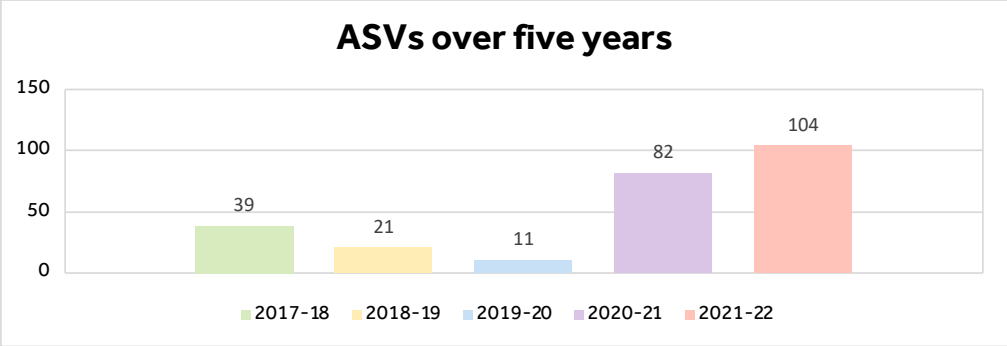
The overall figures for LADO contact are noted in this table 2021-2022:

| Children & Young People's Providers | | | | | |
|---|---|---|---|---|---|
| **Consultations** | 48 | 51 | 91 | 66 | 256 |
| **ASVs** | 27 | 20 | 26 | 31 | 104 |
| **Out of Borough LADO case involvement** | 9 | 3 | 11 | 5 | 28 |
| **Regulatory Complaints & Notifications (Ofsted, EFSA, Regulators, etc.)** | 5 | 9 | 10 | 14 | 38 |
| **Regulatory Information Requests** (DBS, TRA, FOIs, SARs, etc.) | 5 | 13 | 7 | 2 | 27 |
| **Total LADO Contacts** | **94** | **96** | **145** | **118** | **453** |

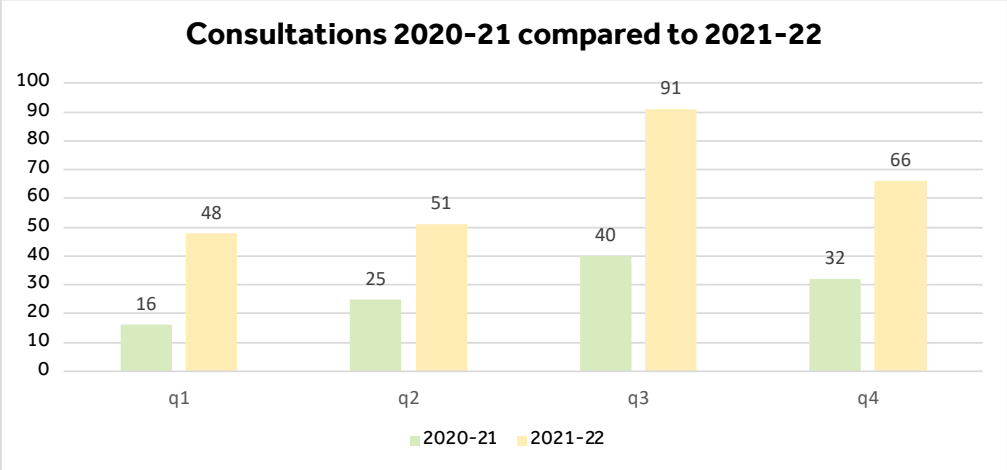
Overall, in this period 453 LADO contacts.

- 104 of these contacts led to ASVs. This is a rise in ASVs over 2020-21 by 26%.
- There were over 200 ASV meetings undertaken in the period.

This picture demonstrates a continued growth in service demand:

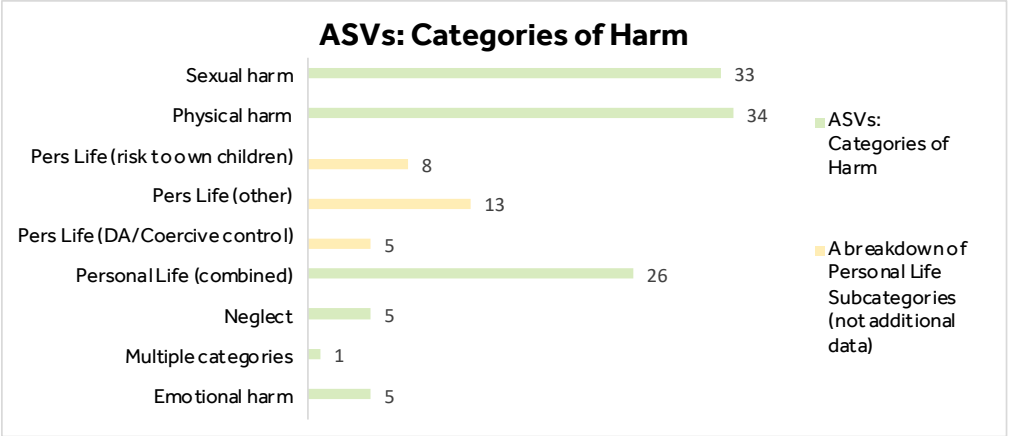



Consultations have increased by 126%




The increase in remit of the LADO role over past years with the addition of the suitability threshold, and the low-level concerns by education staff set the standards for other guidance to follow suit.

Statute continues to develop the role. The likely ongoing increasing of the LADO role moving forward is therefore a matter for partnership consideration in terms of the structure/establishment of the team. The impact upon LADO work volume reflects an increase from 113 consultations during 2020-2021 to 256 during the 2021-2022 period (126%).




In terms of categories of harm referred to LADO, sexual and physical harm, and concerns in personal life (suitability / transferable risk) dominate:

Of the 104 ASV cases, 91 have outcomes agreed at time of writing:

- 37 are substantiated
- 34 are unsubstantiated (not a finding of guilt or innocence but a reflection of available evidence to agree a substantiated or false/unfounded outcome).

The Unsubstantiated outcome represents a potential ongoing risk, that is not managed statutorily. It is positive that partners are referring concerns as they arise and that referrals are largely appropriate.

The full report can be found here:
https://haringeyscp.org.uk/assets/1/lado_annual_report_2021-22_final.docx

# Haringey Safeguarding Children Partnership sub-groups

## Quality Performance and Outcomes

- The **Quality, Performance & Outcomes (QPO)** sub-group organises and implements audit exercises, including case audits, as well as consultations and discussions with practitioners
- These multi agency audits help to measure the quality, effectiveness and outcomes of safeguarding work across the partnership. The group triangulates information obtained from these audits to improve the quality of safeguarding delivery and to identify areas that require further development and influence system change

## Joint Operational Group

The **Joint Operational Group (JOG)** brings together representatives from statutory safeguarding partners and relevant agencies to have a deep dive into concerning complex cases.

The purpose of the group is to:

- Improve front-line practice around complex safeguarding cases and address blockages to effective safeguarding
- Provide an agreed consistent multi-agency response to practice challenges
- Ensure that children are at the centre of service delivery through relationship-based practice
- Disseminate key learning from case discussion across the partnership
- Create a multi-agency forum to reflect on risks, priorities to change and to act as constructive, critical colleagues
- Examine the themes and patterns from audit findings

## Practice, Learning and Workforce Development (PLWD)

The **Practice, Learning and Workforce Development (PLWD)** sub-group produces an annual work plan, outlining practice, learning and workforce activities scheduled for the year. It focuses on developing a safeguarding development framework around effectively working together, dissemination of learning from practice and innovative opportunities (including practice learning events). Evaluation of the delivered training tests 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

# Quality Performance and Outcome (QPO) sub-group

The Quality, Performance and Outcome (QPO) sub-group organises and implements audit exercises, including case audits and consultations and discussions with practitioners. The Chair and vice chair of the group are both from health settings

This subgroup of the HSCP continued to meet virtually during the pandemic which enabled each agency to scrutinise its response to the pandemic and data on the most vulnerable children; thus, acknowledging its key role in changing and improving the quality and effectiveness of multi-agency working at the heart of keeping children and young people safe in Haringey.

The QPO sought reassurance that partners used and updated their Business Continuity Plans. Partners recognised a need to maintain standards and business as usual as much as possible. This summary will provide an overview of the activity undertaken by the QPO and areas identify areas for strengthening.

The HSCP has a multi-agency audit programme and conducts multi-agency audits based on agreed priority areas. The audits enable the partnership to focus on safeguarding practice and identify strengths and areas needing improvement.

The Terms of Reference for the QPO were reviewed and strengthen with agreement of QPO members, to extend the length of the meeting and frequency and refine areas of focus for the group demonstrating a commitment across the partnership to the work of this group

**The QPO undertook audits in the following areas:**

- Children in need of help and protection
- Children affected by Domestic Abuse and
- Children affected by Mental Ill-Health

The thematic audits additionally focused on the impact of these issues during the pandemic. Presentations were made to highlight the findings of the audits and next steps.

The audits have developed tangible recommendations with some of the work still in progress. In addition, the learning from audits has on occasion also highlighted the need for specific training. The QPO continues to have robust links with the PLWD and Haringey Academy which then assists in addressing any training needs.

The HSCP has developed the Partnership Quality Assurance Framework, which sets out our partnership practice standards, how we monitor our impact, and use our information to improve services. In revising the Performance framework to provide meaningful data, the framework has been aligned to the HSCP's priorities.

By embedding the newly refined performance framework, the HSCP is provide with meaningful data, by having named individuals that can populate the framework. This now enables the QPO to interrogate the data, consider the narrative around the data provided, monitor trends, and hold agencies to account who do not provide their performance data within the timescales required.

**The work undertaken in this reporting period includes:**

- Local Protocol with Housing and Jigsaw identifies how concerns will be escalated between agencies and linked to the wider Safeguarding Children's Partnership Protocols.
- Multi-agency Data Sharing Agreement now in place
- S11 Audit undertaken
- Threshold Guide Revised, disseminated, and embedded across the partnership
- All action plans are robustly monitored to ensure progression and sustained improvement.

- The group reviewed and endorsed a range of significant reports and findings from partner agencies.
- Review of local processes were implemented i.e. the Child Protection Medical Service alongside training to enhance consistency of standards and approach.
- The group received, monitored and responded to inspections across partner agencies.
- A learning conference was delivered to partner agencies in April 2022.
- Successful implementation of the Private Fostering App.
- Supporting implementation of a revised Child Protection Conference Process.
- Review and revision of several partnership policy and guidance documents.
- A review of existing QA arrangements and audit tools.

## IMPACT

- Multi-agency learning has enabled professionals from all organisations to improve their safeguarding knowledge and skills. HSCP training has incorporated learning derived from this sub-group.
- The revised and implemented Performance Framework will provide members of the Executive Group and the wider partnership with up-to-date performance data, analysis and narrative. The partnership performance can be 'interrogated' to seek out specific trends and areas for improvement at the earliest opportunity. It can also highlight what we are doing well and why.
- We have developed an action plan that captures identified learning through thematic audits to improve practice. We have monitored progress against identified actions, and the QPO sought assurance that learning from audit activities was consistently shared and embedded in practice.
- We have responded to the recommendations contained in Action Plans (arising from reviews) in order to improve frontline practice so that better outcomes for children, young people and their families can be achieved.
- A private fostering presentation was developed for circulation to be cascaded and discussed regularly in teams, training undertaken, and the Private Fostering campaign relaunched, and a new app was introduced which can be found on the HSCP website.

## WE CONTINUE TO STRENGTHEN OUR RESPONSE IN:

- Further embedding of the Performance Framework
- The interface of the QPO and Joint Operational Group (JOG) as the JOG also undertakes audit, with an aim to strengthen their individual functions and consideration of a governance structure.
- The dissemination of learning to staff across the partnership to enhance practice.

# The Joint Operational Group (JOG) – Scrutiny and Assurance

The Joint Operational Group (JOG) brings together representatives from safeguarding statutory partners and relevant agencies to conduct a deep dive into complex cases.

The learning reviews enable the group to develop a shared understanding of the quality-of-service delivery, learn from best practices, improve professional relationships, and secure multi-agency ownership to allow practice systems to change and positively impact the children and young people.

The group examines themes and patterns from reviews and disseminates key learning from case discussions across the partnership. All professionals within the partnership can refer cases or events involving a child or family for discussion where agencies have raised concerns. These referrals do not meet statutory guidance for a safeguarding practice learning review. Following case reviews, an action plan is developed and is monitored for progress by the QPO subgroup and triangulated with learning from all QA activity (serious case reviews/practice learning reviews, thematic audits, multi-agency practice week).

**The work undertaken in this reporting period included:**

The subgroup completed four audits, which were selected by partner agencies. Rationale was provided for each selection by the relevant partner agency, i.e. repeatedly coming to notice for one or more partner agencies or due to complex issues that required significant levels of statutory and/or partner involvement.

During this period the JOG subgroup moved towards an operational model of partner agencies rotation of chairing the meeting and the emergence of a vice chair.

Key themes explored include:

- Perplexing presentations and parental mental health
- Trauma experienced child through domestic abuse and disguised compliance
- Adolescent mental health, bereavement, separation anxiety, trauma experienced, criminal exploitation, school exclusion and parental physical health.
- Emotional harm, parental alienation in context of domestic abuse, parental physical and mental health

**Key Learning Identified by JOG included:**

- Robust multi-agency working arrangements play an integral role when working with cases relating to perplexing presentations.
- Continued improvement regarding information sharing supports practice development
- Importance of maintaining a focus on the child in light of complex circumstances
- Strengthen awareness regarding support services available to children and young people who have been exposed to domestic abuse.
- The importance of bereavement services to support children and families
- Continue to support whole family systems approach including holistic assessments that consider the needs of all family members informed by family history
- The benefits of working closely with adult services when responding to complex issues i.e. mental health and domestic abuse.
- Benefit of well informed, succinct, chronology to inform analysis and decision making

**Recommendations:**

- Multiagency initiative to consider promoting whole-family working,
- Continue to improve how we work with parents who present with their own complex needs
- All professionals to continue to strengthen how they hear the voice of the child and understand and respond to the needs arising from their lived experience
- Strengthen awareness and implementation across the multi-agency partnership in respect of the Neglect Strategy, Toolkit and Guidance.
- Partners to benefit from refresher training relating to domestic abuse via the HSCP and/or HCA during 2022-2023 period.

## IMPACT

- Prominence of domestic abuse training across the partnership during 2022-2023
- Conference planned in autumn 2022 relating to the theme of contextual safeguarding.
- Conference planned for 2022-2023 period relating to Transitional Safeguarding to raise awareness of trauma informed young people who may have developed complex mental health needs and need to transition to adult services.
- Contextual Safeguarding Meetings via Child in Need processes planned to implement during 2022-2023.
- Ongoing commitment to training relating to perplexing presentations to partner agencies.
- Health Ongoing commitment to utilise the escalation process when needed and strengthening relationships between CAMHS and CSC.
- In 2021-2022, the JOG audit tool was reviewed to strengthen the ability to identify learning, reflecting and actions:
  - I. Partners see the benefits of the infinity loop to develop, implement and sustain learning.
  - II. The learning feeds into the learning and development offer for the HSCP and Haringey Children's Academy.
  - III. To embed learning, the JOG has informed multi-agency training for practitioners across the partnership.

## WE CONTINUE TO STRENGTHEN OUR RESPONSE IN:

- In 2022-23, we have again prioritised Child Criminal Exploitation (CSE) training. In 2022-23 we will add child sexual abuse training for the learning and development programme.
- In 2022-23, we again are delivering bespoke training from the Lucy Faithfull Foundation for children's social care. In 2022-23 we have commissioned Child Sexual Abuse Awareness-raising training for the partnership.
- We continued to strengthen evidence of Professional Curiosity when working with children and families.
- We continued to strengthen the Think Family, whole system approach within assessments including family history.
- There is a further awareness raising and training commitment to the partnership via the HSCP in autumn 2022.

# Practice, Learning and Workforce Development (PLWD) sub-group

The sub-group is responsible for planning, organising, and evaluating appropriate multi-agency safeguarding learning and development activities and challenging, supporting or influencing the training delivered by individual agencies. The group ensures identified multi-agency safeguarding learning needs are addressed for the children's workforces and that learning, and development activities incorporate relevant research, good national practice and learning from case reviews and safeguarding adult reviews. The group also takes ownership for maintaining and further developing the partnership training pool and managing partnership communications and the HSCP website.

**The work undertaken in this reporting period included:**

- All meetings were held via 'Teams' – this was in the context of the continued response to the Covid19 pandemic. Whilst it was recognised that the situation nationally had eased slightly, it was also recognised that there were still huge pressures on agency settings due to levels of sickness and staff cover. The HSCP listened and responded to the needs of its partner agencies and therefore, readily agreed that all meetings and multi-agency training opportunities would be delivered virtually until such time that is was safe and appropriate to make changes. Partner agencies adapted quickly, offering enhanced access to training, including bite-size sessions on e-learning platforms for self-directed learning
- A review of the subgroup membership and the Terms of Reference (TOR) was undertaken. This was to ensure that the membership of the group fully reflected the wider engagement of the partnership, and that the TOR was robust and fit for purpose.
- The Graded Care Profile 2 was considered/contrasted with the existing Neglect Strategy, Toolkit and Guidance by a range of individuals representing the wider partnership. It was agreed to review the existing Neglect strategy, Toolkit and Guidance, with a view of relaunching it upon completion. A multi-agency task and finish group will address this issue.
- The existing Learning and Development Framework was revised. This work was undertaken at the request of partners who felt that more details about the course content and who the intended audience ought to be. This work has been completed.
- All commissioned trainers were requested to provide the HSCP with details of the course content that they were facilitating. This was undertaken prior to agreements being made. The was part of the quality assurance mechanisms implemented by the PLWD to assure themselves that all training opportunities were fit for purpose and met needs of partnership practitioners.
- Agreement was reached to Quality Assure all training opportunities. This is to assure the HSCP that all training provided on behalf of the HSCP is of a high quality and meets the needs of the partnership workforce. Why would be include this if we have not implemented it of do not have a plan to do so – or do we? (I may not be up to date)
- Alternative training resources and innovative and imaginative ways to keep in touch with children and families were shared, including different technology platforms.

**Additional multi-agency training opportunities include:**

- Agreement to commission Contextual Safeguarding Training
- WRAP training to help raise awareness around Prevent Duty
- Domestic Violence training
- Commissioned Trauma Informed Practice
- Safeguarding Supervision

A Partnership Learning Event took place in October 2021 which was attended by a range of partnership practitioners. The focus of the event was upon collective learning from Serious Case Reviews.

The Core training is now booked through the Haringey Academy. This has been a positive arrangement as this enables us to receive data and analysis as to the take up of training, the quality of the training offers and feedback from attendees. Agency attendance is also monitored.

The HSCP website, including a collaborative training booking platform with the Haringey Children's Academy. The new site contains multiple features, including auto-fill features for evaluations and course certificates. It also collects data on course bookings and attendance, and we can create group bookings for partners, making monitoring of training data more manageable for the HSCP.

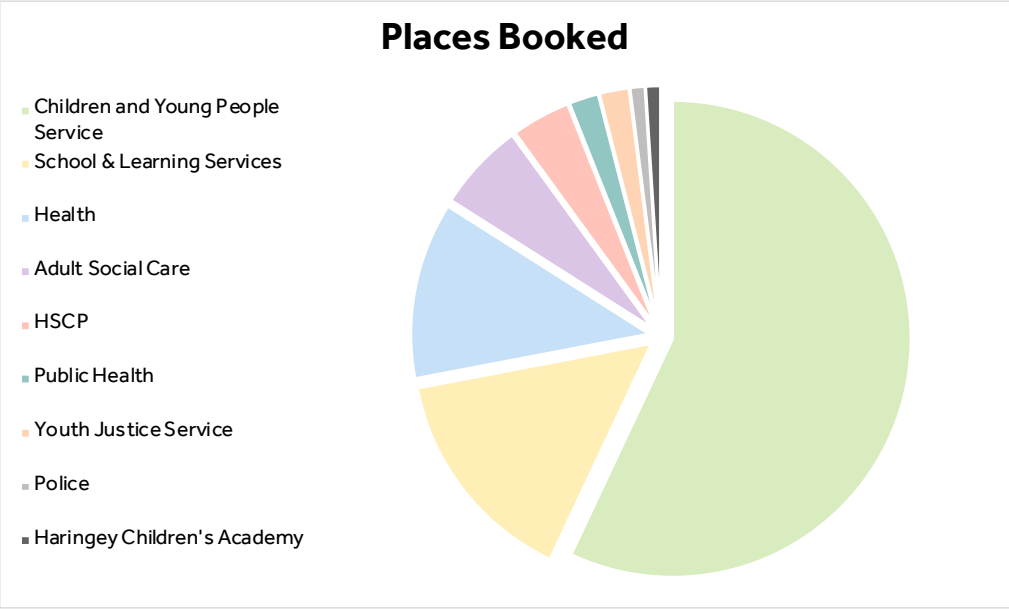
## IMPACT

- Practitioners have a greater awareness and understanding of safeguarding and have applied their developed skills and knowledge to inform an improved identification and response to children at risk across the partnership.
- Increased attendance at multi-agency training has resulted in upskilling the partnership workforce.
- Higher quality and a broader range of training offered and delivered by local partnership staff has received very positive feedback.
- The majority of current training provision remains online in response to the pandemic. As the situation eases, further consideration will be given to a return to face-to-face training when it is safe to do so. However, it should be acknowledged, that even in the most difficult of times, the HSCP has continued to support staff in their professional development.

## WHAT WE NEED TO DO MOVING FORWARD

- Continue to implement the Training and Development Work plan.
- Training courses to be commissioned based on analysis of gaps and local learning needs.
- Ensure that learning from audits and reviews is considered and where gaps in knowledge have emerged as a theme, specific training / awareness raising is facilitated by the HSCP to address this.
- Develop alternative training resources and innovative and imaginative ways to keep in touch with children, families, and practitioners including different technology platforms.
- The sub-group will need to continue to measure the impact of training and feedback from delegates on how they are transferring learning into practice and how,
- Improve the promotion of training opportunities across the partnership.
- Continue to develop '7-minute' briefings on specific safeguarding issues.
- Further develop the HSCP website so that it becomes more interactive.
- Consider the training needs of the partnership workforce for 2022/23.

In 2021/22 HSCP had another strong offering of Multi-Agency Training. HSCP offered 2678 free spaces to professionals for 24 courses and learning events. These are fully funded and taught by professionals from the partnership who are experts in their respective fields. The trainers can speak and teach with confidence due to their many years of hands-on experience.



Due to the lingering effects of the COVID-19 pandemic the majority of courses are still taught virtually via MS Teams.

- We held a total of 59 training sessions throughout the year.
- 1060 places were booked (up 8% from the previous year), however non-attendance persisted as an issue, particularly for courses with limited capacity.

As previously, the most popular workshop continues to be 'Managing Fabricated Induced Illness and Perplexing Presentations' and due to this more dates have been secured for 2022/23.

Additionally, we have successfully launched a two-part course in relation to Domestic Abuse - Understanding Domestic Abuse (Level 1) and Understanding the Impact of Domestic Abuse and how myths about domestic abuse led to victim-blaming; Level 2

Feedback continues to be overwhelmingly positive and when asked the majority of attendees wish to continue with virtual training. Delegates stated that the learning objectives had either been met 'absolutely' or 'mostly'. The standard of facilitation was either 'excellent' or 'very good. Here are some quotes:

**"The programme was well structured and delivered at a perfect pace. Participant were included and given a chance to engage Case scenarios and the questions were helpful."**

**"Everything, the facilitator was patient and thorough in his explanations."**

**"I appreciated to see how safeguarding is approached in a non-medical organisation."**

**"The session was engaging I was able to take lots of notes I will share with my colleagues."**

As with all training offers, the HSCP continuously monitor emerging trends and look for new training opportunities, we welcome requests from all partners and if possible, try to incorporate these in our training catalogue.

# Learning from Reviews: Child Safeguarding Practice Reviews

The HSCP continues to have a vital role in commissioning and coordinating learning from a range of reviews following a serious incident or in situations where children die. The two fundamental mechanisms that help us achieve this are Local Child Safeguarding Practice Reviews (LCSPR) and Child Death Reviews.

**The QPO undertook audits in the following areas:**

Sometimes a child suffers a serious injury or death due to child abuse or neglect. Understanding not only what happened, but also why things happened, can help improve our response in the future. Understanding the impact that the actions of different organisations and agencies had on the child's life and the lives of their family, and whether or not other approaches or efforts may have resulted in a different outcome, is essential to improve our collective knowledge. In this way, we can make sound judgements about what might need to change at a local or national level.

The purpose of reviews of serious child safeguarding cases, at both local and national levels, is to identify improvements to be made to safeguard and promote the welfare of children.

Serious child safeguarding cases are those in which:

- abuse or neglect of a child is known or suspected, and
- the child has died or been seriously harmed

When a serious incident becomes known to the safeguarding partners, they must consider whether the case meets the criteria for a local review. Meeting the criteria does not mean that safeguarding partners must automatically carry out a local Child Safeguarding Practice Review. It is for them to determine whether a review is appropriate, being mindful that the overall purpose of a review is to identify improvements to practice.

The responsibility for how the system learns the lessons from serious child safeguarding incidents lies at a national level with the Child Safeguarding Practice Review Panel and at local level with the safeguarding partners.

The safeguarding partners are responsible for commissioning and supervising independent reviewers for local reviews, including a summary of any recommended improvements and an analysis of any systemic or underlying reasons why actions were taken or not. The safeguarding partners should take account of the findings from their local reviews and all national reviews to consider how identified improvements should be implemented locally, including how organisations and agencies work together to safeguard and promote the welfare of children. The safeguarding partners should highlight findings from reviews with relevant parties locally and regularly audit progress on implementing recommended improvements.

In April 2021 the Child Safeguarding Practice Review Guidance was launched. This document helps to guide all partners through the process of safeguarding practice reviews, including their roles and responsibilities.

From 1 April 2021 – 31 March 2022 the HSCP received five notifications where a Virtual Threshold Meeting with Statutory Partners took place.

Of the five cases referred to the HSCP:

- Three resulted in a Local Child Safeguarding Practice Review (CSPR) being undertaken
- Two did not meet the threshold to progress to a formal Safeguarding Practice Review - however some learning was taken forward.

At the time of this annual report, the HSCP has three CSPR in progress. It is anticipated that all will be completed by the end of October 2022.

In addition, we are currently in the process of concluding a SCR which originally commenced in 2018. The reason for the delay is following the intervention by the HSCP to ensure the circumstances surrounding the case were fully investigated, a criminal trial ensued. The National Panel have been informed of the various stages of progress regarding this highly complex case. It should be noted that whilst the final report was delayed due to criminal proceedings, initial findings and recommendations contained in the draft report, were progressed. It is anticipated that additional work required to complete the independent report, will conclude at the end of 2022.

All current cases are robustly monitored with the Executive Group appraised regularly regarding progress. This adds an additional line of scrutiny and challenge. The Executive Group will hold any partner to account to ensure recommendations are promptly progressed and/or pieces of work are completed.

In the past year learning, actions and impact as a result of the reviews have included:

- Review of the Escalation Policy –
- Continued review, development and progression to improve information sharing processes.
- Professional safeguarding curiosity
- How the multi-agency approach manages complex cases involving children with mental health issues and those with additional needs.
- "Think Family" approach continues to be embedded
- Extra familial harm/contextual safeguarding learning progressed to training being delivered
- Cross-Border working arrangements reviewed and continue to improve

HSCP is committed to learning and improvement sustained through regular monitoring and follow-up actions so that the findings from these and national reviews make a real impact on improving outcomes for children. A combined LSCPR action plan is in place to track actions and evidence the impact of implementing this learning across the system to ensure the reviews influence practice.

Learning from these reviews, Serious Case Reviews and national reviews have informed current HSCP work streams and training opportunities for front-line professionals, including dedicated sessions which focused on:

- The impact of Domestic Abuse,
- Learning from Local and National Reviews,
- Trauma Informed Practice
- Child and adolescent Neglect.

Learning has informed the revision of the existing Learning & Development Framework which includes:

- Signs of Safety,
- Parental Drug Misuse,
- Fabricated or Induced Illness (FII) and Perplexing Presentations (PP),
- Threshold
- Child sexual/criminal exploitation awareness.

## Child Death Reviews

New national statutory operational guidance relating to child deaths was published in October 2018 and put into place as per the national guidance on 29 September 2019. The rationale for the new model was based on numerous factors including to:

- Improve the experience of bereaved families and the professionals working with them
- Ensure information would be systematically captured to enable local learning, and
- Inform changes in policy and practice through the National Child Mortality Database

### North Central London (NCL)

North Central London (NCL) Child Death Review (CDR) partners consisting of North Central London NHS Clinical Commissioning Group and the five local authority areas of Barnet, Camden, Enfield, Haringey and Islington are statutorily responsible for the immediate actions that should be taken after a child's death. This includes:

- local review of a child's death,
- investigation after the child's death.
- through to the final stage of the child death review process.

In 2021-22 a business case for joint funding with the five local authority areas was agreed with the CCG which resulted in the establishment of a central team to provide oversight of all Child Deaths. NCL CCG recruited to the central team consisting of a full-time administrator, a part time administrator (joined December 2021) and a lead nurse (joined February 2022). The team, work alongside the local Single Point Of Contacts and the Designated Doctors for Child Death to co-ordinate Joint Agency Response meetings when required and the Child Death Review Meetings.

All partner agencies working in NCL, have implemented the eCDOP system to notify the central team of each child death. eCDOP is an electronic system that supports the administration process for notification of a child death, gathering information and supports the Child Death Review meetings held by the hospitals.

In February 2022, the NCL CDOP moved to one eCDOP platform - www.ecdop.co.uk/NCLondon/Live/public  The system is linked to the Child Health Information system and to the National Child Mortality Database. The electronic system, supported by QES is funded through the joint funding resource from NCL CCG and the five local authority Public Health teams.

NCL CDOP has membership from across each of the five boroughs and was chaired by the Haringey Assistant Director for Public Health during this reporting period. An independent chair has been recruited and is due to start in April 2022.

The business case included funding for a co-ordinated bereavement support offer for all families in NCL, as well as support and training for key workers. NCL CDOP commissioned Child Bereavement UK to deliver training to practitioners, with a pilot session held in March 2022. Feedback from the session will be co-ordinated and used to develop a training resource for all practitioners across NCL.

The NCL Child Death Review partners held four panel meetings in the reporting period 2021/22. A total of 67 cases across the NCL region were presented for review and discussion by the panel. Of the 67 cases, 62 were closed with minor actions for completion. The remaining cases will be re-presented to panel with the additional detail requests to the Trust Child Death Lead Doctors.

**2021-22**

Of the 100 cases referred via eCDOP in 2021-22, 13 were Haringey cases. Of those 13:

- Three have had a Child Death Review undertaken
- A Joint Agency Response meeting was held for three cases
- There were no referrals for rapid reviews

| Year | Child Deaths Reported | Overseas Deaths | J. A. R. Meetings | Rapid Review | Child Death Reviews |
|---|---|---|---|---|---|
| **2019-20** | 16 | 1 | 5 | 1 | 15 |
| **2020-21** | 22 | 2 | 4 | 1 | 15 |
| **2021-22** | 13 | 0 | 3 | 0 | 3 |

During the Child Death Review process the CDOP is responsible for confirming if there are any modifiable factors in relation to the child's death. A modifiable factor is defined as any factor which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

Learning from modifiable factors are shared at the Child Death Review meetings and included in the NCL CDOP work and training plans.

# Haringey Safeguarding Children Partnership Action Plan 2021-24

**HSCP MASA priorities: The statutory partners agreed that over the next three years from April 2021 to March 2024, the Partnership priorities will be the following three Ofsted JTAI themes:**

- Children living with mental health issues
- Prevention and early intervention
- Older children in need of help and protection, and contextual safeguarding, including exploitation.

**HSCP MASA Focus:**

- Measuring impact linked to practice
- A strong evidence base
- Workforce development
- Sustainability.

# Glossary

AD - Assistant Director

BC - Borough Commander

CAFCASS - The Children and Family Court Advisory and Support Service

CAIT – Child Abuse Investigation Team

CAMHS - Child and Adolescent Mental Health Services

CCE – Child Criminal Exploitation

CCG - Clinical Commissioning Group

CDOP - Child Death Overview Panel

CDR - Child Death Review arrangements

CRC - Community Rehabilitation Company

CSC - Children's Social Care

CSE - Child Sexual Exploitation

CSP - Community Safety Partnership

CYP - Children and Young People

DCI - Detective Chief Inspector

DCS - Director Children's Services

EDT – Emergency Duty Team

EH - Early Help

FGM - Female Genital Mutilation

HSCP - Haringey Safeguarding Children Partnership

JTAI - Joint Targeted Area Inspection

LA - Local Authority

LAC - Looked After Child

LCSPR - Local Child Safeguarding Practice Reviews

LSCB - Local Safeguarding Children's Board

MACE – Multi-Agency (meeting for) Criminal Exploitation

MASA – Multi-Agency Safeguarding Arrangements

MARAC – Multi-Agency Risk Assessment Conference

MASH – Multi-Agency Safeguarding Hub

MOPAC - Mayors 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

SSPM - Strategic Safeguarding Partnership Manager

WT 2018 - Working Together to Safeguard Children 2018

YJS - Youth Justice Service