



Haringey Safeguarding Children Partnership Annual Report 2022-2023



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Foreword

Welcome to the Annual Report produced on behalf of the Haringey Safeguarding Children Partnership (HSCP). The report covers the period from 1st April 2022 to 31st March 2023. The HSCP wishes to thank all partner agencies for their invaluable contribution to this report.

In line with the Multi-Agency Safeguarding Arrangements (MASA), 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 our 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 and challenge to ensure the effectiveness of our safeguarding arrangements.

At the core of these arrangements is a commitment from us, as the three key statutory 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 our children and young people 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.

As we now move forward, we recognise the continuing 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. 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.

During the forthcoming year we will be focusing on how we can further involve children, young people, and staff to provide scrutiny and feedback in the work that partners undertake, and we will consider how to introduce additional independent scrutiny and challenge to evidence the impact of our partnership's collective decisions and actions.

This report recognises the continued progress made by the HSCP and exemplifies the benefits we can draw on from proactive, collaborative partnership working.

Haringey Safeguarding Children Partnership Executive Group



Welcome

I am delighted to introduce the Annual Report for 2022-23 of Haringey Safeguarding Children Partnership, which covers the third 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 (Integrated Care Board, 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 a range of challenges which have emerged, including continuing challenges in relation to the COVID-19 pandemic. The partnership has responded rapidly and worked effectively together to ensure the effective safeguarding of children and young people. 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 effective and focussed 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 our children, young people, and families in Haringey. Evidence is from the activity of the sub-groups, training evaluations and the voices of children and families. Learning is from Local Safeguarding Practice Reviews, multi-agency and single-agency audits, the multi-agency practice week, 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 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 Partnership

Haringey's three statutory safeguarding partners are: Haringey Children's Services; NCL Integrated Care Board and the Metropolitan Police who have formed the Multi-Agency Safeguarding Arrangements since 2019 (MASA). The partnership has an Independent Chair and Scrutineer who provides scrutiny, challenge, and vision. The Partnership is responsible for ensuring that all partners contribute jointly and effectively to the work of the HSCP.

The Executive Group

The Executive Group consists of three equal and joint partners:

- Haringey Children's Services
- NCL Integrated Care Board
- Metropolitan Police Service

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. There were 7 Executive meetings undertaken during the period 2022/23 which 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.

Members of the Executive Group 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 role 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.

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 and ensuring they have access to the highest-quality, evidence-based support.

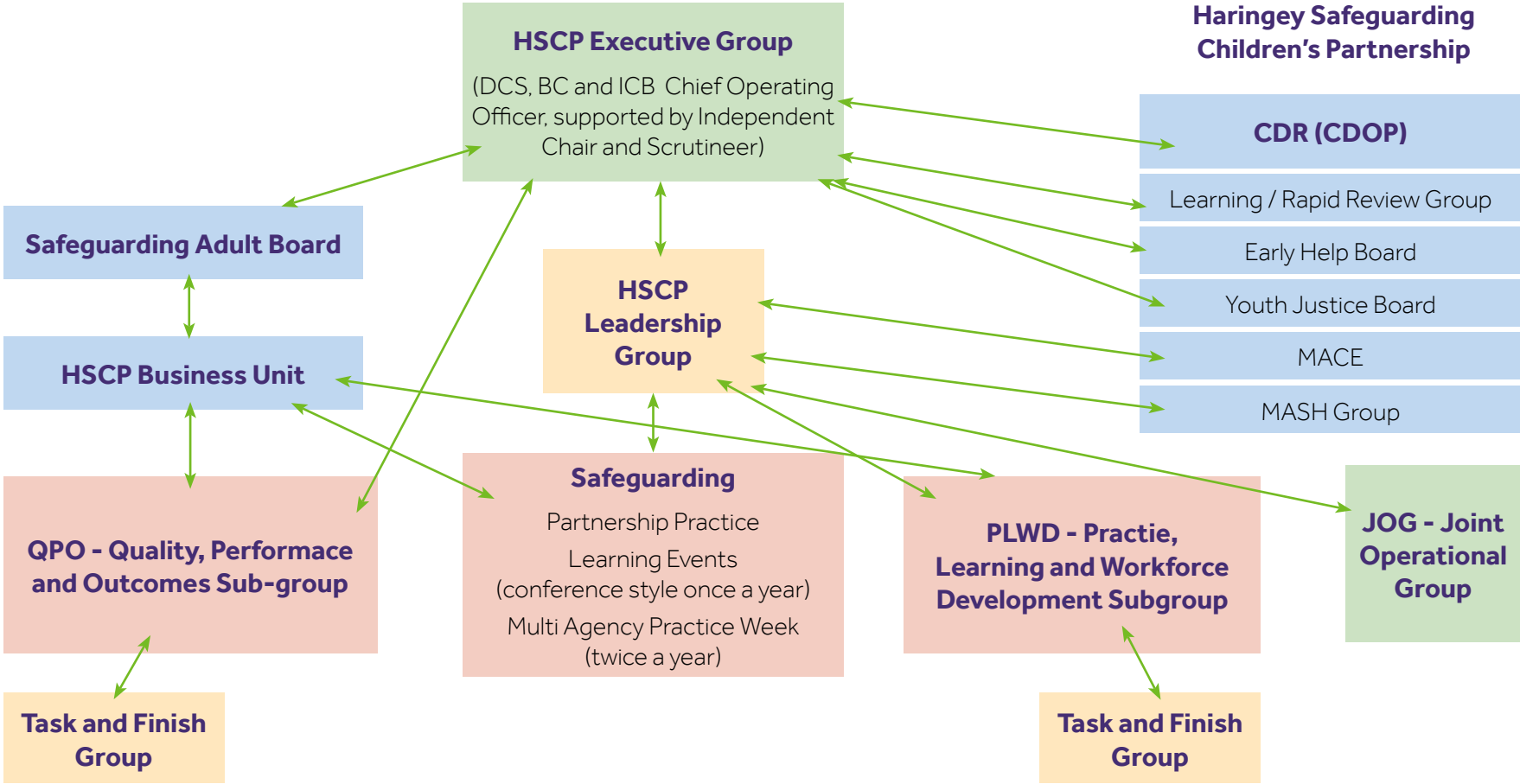
The Leadership Group

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 6 Leadership Group meetings held for

the period 2022/23 which focussed 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.

HSCP Structure

Executive Group and Leadership Group



Other strategic Partnership

that the HSCP liaise with



Local Background and Context

You will notice that some of the figures are slightly older in this section, the reason being that these are nationally annually reported figures and as such there is a delay in their publication. At the time of writing, these were the most up-to-date figures available.

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 a decrease of 19% in the last 2 years, from 13,849 in 2019/20 to 11,341 in 2021/22, however this is the 8th highest proportion of children in poverty in London (at 19.0%). Haringey had 1,023 Hospital admissions for alcohol related conditions (2021/22, 10th highest in London, worse than the previous position of 17th in London last year).
- 2% of Haringey's 16-64-years-olds claim Employment Support Allowance for mental health and behavioural disorders, which is the 5th 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, 51.1% are for mental health and behavioural disorders the same as the London average (Feb 2023).
- Haringey has the 8th highest rate of domestic abuse with violence out of all London boroughs and is above the London average (Two year rolling average from Apr-21 to Mar-23).
- 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:

- 93% of schools are judged as 'good' or 'outstanding' by Ofsted.
- 92% of Early Years settings are judged as 'good' or 'outstanding' by Ofsted.
- 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:

- Percentage of babies with low birth weight in Haringey fell to 2.6% (2021), lower than both London (3.3%) and England (which fell to 2.8%).
- Lower percentage of asthma-related hospital admissions among children and young people under 19-years-old compared to the England average (NCL wide stat, 63.4 per 100,000 vs 73.1 per 100,000, 2020-21), a significant improvement upon last year's figure (121.8 per 100,000 and 158.4 per 100,000).
- 21.1% of all Reception year pupils and 36.9% of all Year 6 pupils were recorded as overweight or obese in 2021-22. This is an increase on the previous year, though remains below the London averages (21.9% for Reception and 40.5% for year 6).

Our children and young people population:

In Haringey, there are 54,422 children aged 0-17 years, representing 21% of the overall population (Census 2021), 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 South Tottenham (29%), while the ward with the lowest is Stroud Green (15.4%). 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 the most commonly spoken languages are Turkish, Spanish, Polish, Bulgarian, and Somali (Census 2021)

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 2021-22, nearly one in five Haringey children lived in poverty (19.9%) - a higher rate than in London (16.9%), 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. Department for Work and Pensions (DWP) data shows the percentage of children in absolute poverty in workless households as 7.1% in West Green and 8.4% in White Hart Lane, while at the same time just 2.0% in Alexandra and Fortis Green.

Children's Social Care Dataset 2022/23



The Leadership Group HSCP Multi-Agency Dataset

The HSCP developed an agreed dataset in 2021/22 that monitors multi-agency child safeguarding arrangements, which proved successful with submissions by all partners. As a result of the success in collecting and analysing the data it was agreed to further develop the dataset for the financial year 2022/23. The three strategic partners, as well as other partner agencies, contribute data quarterly, which is reviewed by the Quality Performance and Outcomes sub-group, 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.

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.

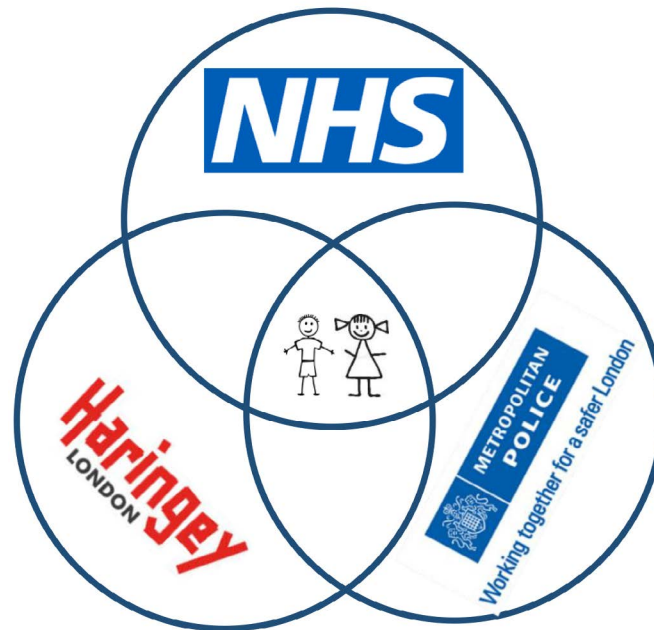
Why is the child’s voice important?

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. In Haringey, children and young people have many ways in which they are able to voice their opinions these range from capturing their views about individual service provision, support, recruitment, to wider community issues.

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 – highlights a deep commitment to active listening and emotional intelligence in how we engage with victims including children.

Full document can be found here: [the-mets-direction---our-strategy-2018---2025.pdf](#)

The voice of the child is routinely sought and captured in assessments within the Child and Adolescent Mental Health Service (CAMHS) in the following areas

- During assessment
- 1:1 session with keyworkers
- CPA meetings
- Ward rounds
- Family meetings
- An assistant psychologist regularly collects individual young people and carer’s feedback which is discussed and actioned in the governance meetings.

- Through visible leadership, The Triumvirate Leadership regularly visit the Children's Centre and attend some of the meetings to listen to concerns and issues raised and support the local leadership team in addressing the issues.
- 'Young Person's Forum Group' has been established where the service manager regularly meets with young people to discuss any issues on the ward.

A local Children's Centre has ensured that young people are able to raise concerns through informal and formal meetings. There is an established community meeting chaired by young people to empower them, attended by the leadership team and an Independent Advocate. Issues raised are addressed and updated on the "you said we did" board which is displayed in the day area. The independent Advocate also meets regularly with the young people and feeds back issues and concerns to the leadership team. This is addressed and fed back to the advocate and the young people.

Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) continue to strengthen the voice of a child 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. The HEADS questions are used in paediatrics to ask questions relating to the young person's life in general Health, Education, Activities, Drugs, Sexual health. Particular thought is given to the behaviour of preverbal/non-verbal children and how that reflects the voice of the child.

Haringey CYPS gather the views of children and young people 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.

- 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 utilise the group's voice in their development of services.
- Development and expansion of Young ASPIRE.
- Several young people's views consulted regarding murals for a local Family Centre.
- Several young people consulted regarding proposed murals for a Children's Home and about Welcome Packs for the home.
- Regular meetings with ASPIRE members to provide Q&A sessions regarding skills and experience young people believe social workers should have to advise and support children in care and Care Leavers.
- Foster Carers and several young people wrote a piece of writing about the importance and value of being a foster carer, to be used as an introduction by the Fostering and Adoption Team.
- ASPIRE young people contributing to a range of Interview panels, including, AD for Schools and Learning and Haringey's Strategic Partnership Manager.
- 5 members from ASPIRE met with Peer Reviewers to give an overview of the work they undertake in Haringey on behalf of CiCC and Care Leavers.
- Consultation with Young People on the new Stop and Search App.
- Currently we have 18 Young People who represent ASPIRE through several different avenues, aged 10-24 years [10 males & 8 females] & mixed ethnic representation.

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:

"Yes, she is amazing, and I am really happy with her"

"The Court visit was a wonderful experience. The judge was very generous with her time and patient with the children"

"Visiting the court and meeting the judge was an amazing experience"

"The Practitioner gives time to talk and is a good listener"

"... great, warm, easy going, gives good advice and is good with children."

"The Practitioner explains things clearly"

"My worker helped me with my problems, always listened and helps me make better decisions"

"The judge was warm and considered in her responses and it really was about a human connection and understanding"



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

The HSAB and the (HSCP) met in July 2022, November 2022, and January 2023 to ensure joint collaborative working continues across both settings. The main objective is to ensure that all agencies work together for the purpose of improving and developing local safeguarding arrangements and promoting the welfare of children who are transitioning into adulthood and require ongoing support in Haringey. It is worth noting that each Board has their own existing lines of accountability for safeguarding and promoting the welfare of children and adults by their 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. Sadly, we also recognise that some young adults may be exploited by organised crime gangs or engage in harmful behaviours that limit their life choices.

[The development and agreement of the Transitional Safeguarding Protocol](#)
(You can read the full transitional protocol [here](#))

Introduction

This protocol aims to create a foundation document to drive a major change agenda in the London Borough of Haringey. It briefly outlines both the local and national context; it describes the most relevant groups of young adults that are affected and sets out the principles and practice that are fundamental to a more integrated and collaborative approach - one that better prepares the most vulnerable young people for adulthood. Its aim is to eliminate - or at least minimise - the 'cliff edge' experiences for young adults in the borough by developing robust transitional arrangements that clarify responsibility for all agencies. It harnesses the views and wisdom of people who have lived experience and those that have worked in services.

Reflecting the 'Putting People First' philosophy and both child and adult-centred principles of practice, there is no precise formula to follow when dealing with

individuals facing the transition to adulthood. Every person will experience this journey differently and solutions need to be developed to meet specific needs that put the young person at the centre. Similarly, no single professional or single agency can address the challenges or provide the solutions on their own. Rather, a multi-agency response is required that transcends both children and adult safeguarding and adopts a holistic approach around the young person.

Whilst there are some inspiring community-led projects and organisations that are having a positive impact, as one of the most deprived boroughs in the country, the challenges young adults face, are immense. Under the leadership of both the safeguarding adults board and safeguarding children partnership, the protocol aims to mobilise both the commitment and coordination of resources to improve support so that young adults can achieve, thrive, and have an equal opportunity at this formative stage of their development.

Aims and Scope of this Protocol

The protocol aims to reach and influence the practice of all operational staff and managers as well as inspire senior leaders. The implementation of the protocol will lead to assurance for both the safeguarding adult board and safeguarding children partnership of a more effective multiagency approach, enabling earlier identification of risks and responses that embed transitional safeguarding as an integral strand of the Preparing for Adulthood pathway. This protocol is directed at all services that are represented on both the Haringey Safeguarding Children Partnership and Haringey Safeguarding Adults Board, namely:

- Adult and Children's Social Care
- Community Health Services
- Acute Health Services
- Mental Health Services

- Haringey Housing and housing related services
- Metropolitan Police
- Probation
- Department of Work and Pensions
- Voluntary Sector Partners

The development and agreement of a Think Family Protocol and Practice Guidance (full document can be found [here](#))

In November 2022, the Haringey Safeguarding Adults Board (HSAB) and Haringey Children Safeguarding Partnership launched their Think Family Protocol Practice Guidance, having considered the early learning from a number of Practice Reviews including where there were lessons for both partnerships around working with adults and children within one family by taking a joined-up approach ('Think Family'). The development of this protocol and practice guidance was agreed as a next step by both Executives to capture what Haringey means by Think Family and to set out best practice for all partner organisations.

The definition of 'practitioner' in this protocol is any professional who works with either adults with care and support needs or children and young people. In both cases, the protocol reinforces the need for practitioners to be curious and alert to circumstance, responsibilities and needs of all family members in the same household and to think in a holistic, joined up and Think Family way.

The protocol (including the accompanying practice guidance) promotes early intervention as key to best practice. This shared responsibility must be at the heart of practice across all organisations which make up Haringey Safeguarding Adults Board, and the Haringey Safeguarding Children Partnership, as well as any other partnership arrangements where safeguarding risks are discussed and shared. The protocol also sets out a framework for all practitioners to ascertain the views and wishes of individuals so that they are listened to and, wherever possible, acted upon.

This will help to ensure that individuals experience help and support that is both

joined up and effective, which will in turn achieve better outcomes. Equally, the protocol contributes to ensuring that communities and individuals are safe and protected from harm. Our Think Family approach has significant benefits for children, young people, adults, carers, families and for organisations, they include:

- Improved outcomes for children, young people, adults, carers and families (including in relation to safeguarding, health and wellbeing)
- Reduction in significant harm
- Enabling a system to embed new learning and implement best practice
- Better use of resources including finance and time
- Less duplication between organisations and services
- Improved record-keeping and information-sharing
- Improved staff morale.

Our Think Family principles

The overarching guiding principle will be 'Nothing about You, Without You'. Our core Think Family principles are:

- We will follow a multi-agency whole system approach to working with families (this includes extended family and friends). Adults and children will be assessed for services in a holistic manner and not in isolation.
- We will be individual-led and outcome-focused, engaging the individual adult or child in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving their quality of life, well-being, and safety
- We will promote effective multi agency working which puts children, young people, parents, carers and individuals at the centre.
- We understand that safeguarding is a shared responsibility and is 'everyone's business.'
- We will promote early intervention and support which are both crucial to provide better outcomes for all children and their families (and to avoid the

need for crisis intervention)

- We will encourage early multi-agency conversations taking place in a timely way between professionals and outside of statutory meetings
- We will encourage professionals to be curious about safeguarding issues (including potential issues) within a family and amongst its members
- We will support people within their cultural context, ensuring diversity is valued and understood
- We will share information and communicate with partner organisations, parents, carers, and children in a timely, appropriate, and accessible manner.
- We will involve and act upon children's wishes and feelings, ensuring the voice of the child is heard. The needs of the adults should not marginalise the needs of the child/children.

The creation of a Joint Housing subgroup

The HSCP and SAB has now developed a joint Housing Sub-group as a response to the tragic death of Awaab Ishak which was linked to poor housing conditions, i.e. damp and mould. Whilst this work remains in its infancy at the time of writing this Annual Report, we have agreed the membership, agreed a Terms of Reference, and developed an Action Plan which focuses on specific areas of work we intend to undertake. The overarching purpose of the Housing Sub-group is to safeguard and promote the welfare of vulnerable children and adults and to gain assurance that safeguarding arrangements are effective across the housing sector in Haringey.

At the time of writing this Annual Report, this subgroup was in its infancy. However, the outline of work undertaken, and progress made against the Action Plan will be reported in next year's HSCP Annual Report 2023/24.

Haringey children lived in poverty (18%) - a higher rate than in London (16.6%), meaning we are working with increasing levels of need in Haringey. Haringey's eastern wards also have more children living in all out-of-work benefit claimant households compared to the west of the borough. Department for Work and Pensions (DWP) data shows the percentage of children in absolute poverty in workless households as 7.4% in White Hart Lane and 7.3% in Northumberland Park, while at the same time just 1.3% in Highgate and 1.4% in Alexandra.

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. 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 learning events, team meetings, conferences and other HSCP promotional methods and helps to inform the training offer. During 2022/23, the HSCP undertook multiple activities and 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

→ Haringey Children and Young People Service

On 13th February 2023 Ofsted inspectors undertook an inspection of Haringey Children Services. The outcome of this inspection was that Haringey were graded "Good" for the first time. It must be recognised that whilst the inspection focused on Children Services, this result could not have been achieved without the support and engagement from all partner agencies. Ofsted recognised and commented on the strength of Haringey's Partnership.

- "Leaders have worked with partners to agree and pursue shared priorities that are informed by the experiences of local children and their families. This has strengthened relationships and joint work with partners. There is evidence of constructive professional challenge, joint training, auditing and continued discussions to improve multi-agency working with colleagues in justice, health and education, and through the safeguarding partnership." full report here: <https://reports.ofsted.gov.uk/provider/44/80498>

→ Health Partners:

Whittington Hospital maternity services were inspected in January 2023 and the CQC have marked services as 'requiring improvement'. A robust action plan is now in place to address this.

→ The Probation Service

Following the Probation reunification all staff have been completing their mandatory safeguarding e-training and classroom-based training. The London Performance and Quality team has created an electronic safeguarding dashboard which is monitored locally by the management team monthly. Data quality days are scheduled within the calendar to enable staff to focus on any recording gaps on our case management system in relation to safeguarding checks. A new MASH process has been agreed with Haringey LA whereby safeguarding checks are now handled by the Probation hub. This has streamlined the process and is mutually beneficial for all partners as this alleviates resource pressure.

→ Metropolitan Police Service (MPS)

Safeguarding is everyone's responsibility. The Metropolitan Police Service (MPS) continues to strive to improve the service further so that we are consistently protecting those most at risk. In 2022 the MPS Public Protection Improvement Plan aims to deliver improvement across 13 strands, with child abuse being one of the key strands within the plan.

Assurance

MPS has since published an updated guidance for all Child Abuse Investigation (CAIT), Referral Desk and Police Conference Liaison Officers (PCLO). This guidance outlines the duty of Police under the Child Abuse Investigation Command. It provides clarity and support on dealing with suspicions or allegations of abuse of children or child on child abuse, in co-operation with Local Authorities and other appropriate agencies.

All police officers working in CAIT North Area (NA) Basic Command Unit (BCU) have undergone the Specialist Child Abuse Investigators development program, an accredited training program developed by the College of Policing. This course provides our CAIT officers with the skills to identify and assess risk of abuse in child victims and draw out that information in a supporting environment.

Scrutiny

The Metropolitan Police Service continued to adhere to their new Performance Framework introduced in the financial year 2021/2022 for Child Protection and Child Abuse investigations. The monthly audit regime led by the Public Protection Delivery Group remains ongoing. It includes the specific requirement to consider the Voice of the Child in every case, every time. Audits are carried out by the Dedicated Inspection Team (DIT).

Child Abuse Investigation Team (CAIT) Key Performance Indicators:

1. Timeliness of investigation - broken down into 3 sub-headings:
 - Standard investigations to be completed within 30 days such as Common assault / battery / drunk in charge of a child under 7
 - Serious Investigation to be completed within 2 months such as ABH / GBH sec 20 / child cruelty / abandoning a child
 - Serious & Complex Investigation to be completed within 4 months such as GBH sec 18 / threats to kill / abduction / sexual assault / rape
2. Increase sanction detection (SD) rate to 30% of CAIT investigations.
3. Reduce outstanding named suspects over 28 days to 10%.

To ensure the most appropriate and effective case disposal outcome for offenders of child abuse offences. NA BCU CAIT team is developing a new quarterly multiagency scrutiny panel with internal and external partners, including colleagues from North West BCU, the Met Police Continuous Improvement Team and Crown Prosecution Service. The purpose is to review and scrutinise outcomes of child abuse investigations when out of court disposal is used. The pilot of the panel is scheduled for July 2023.

Inspection

Operation Aegis Team, an organisation wide improvement project team to deliver improvement in Public Protection came to North Area BCU and spent 11 weeks carrying out deep dive reviews in existing practice and processes; provided bespoke and enhanced support & coaching to all officers. 348 individual & small group support sessions were delivered to 731 officers across the BCU, along with bespoke briefings on risks assessments and investigative strategy.

Section 11 Audit

What is a Section 11 Audit

Assessing the effectiveness of safeguarding efforts by key people and organisations in the borough is crucial to improving outcomes for our children, young people, and their families. Section 11 (s11) of the Children Act 2004 places a statutory duty on key organisations to self-assess the extent to which they meet the safeguarding requirements and standards.

The Haringey Safeguarding Children Partnership is responsible for monitoring and evaluating these self-assessments and advising organisations on ways to develop / improve their current arrangements if required. The audits enable our partners to submit their evidence, create their action plans to address any identified areas for development, and to scrutinise and challenge the overall findings of the final S11 report. This process clearly contributes to the HSCP scrutiny function and is also a mechanism for understanding how we can support partner agencies in further developing any specific aspects of their individual and collective safeguarding arrangements.

It is important to remember that s11 does not give agencies any new functions or responsibilities, nor does it override their existing duties. Instead, it requires organisations to carry out their existing functions in a way that takes into account the need to safeguard and promote the welfare of children, young people, and their families. In addition, the s11 audit is an opportunity for each partner agency to demonstrate compliance with statutory guidance and showcase areas of good practice.

At the time of writing this Annual Report all partner agencies are now in the process of submitting their findings from their individual audits for 2023. A full report will be submitted to the HSCP Executive Group for consideration during the period 2023/24. Findings will then be reflected in the HSCP Annual Report 2023/24.

The previous s11 Audit was completed for the period 2021/22 and a number of issues were raised. Here is a look back at what we have done following this s11 Audit:

What our partners said: The Neglect Guidance, Toolkit and Checklist

Partners would like to see the Neglect Guidance, Toolkit and Checklist used more consistently across the partnership and welcome the forthcoming review of these documents. They would also wish to see training opportunities to accompany the revised documents. Partners felt strongly that this will support and improve a greater understanding of neglect and its impact, will help to develop the skills to identify neglect at the earliest opportunity and how a consistent approach will help to achieve improved outcomes for our children, young people, and their families.

WHAT WE HAVE DONE:

- We listened to the views of our frontline staff who felt that existing tools and support documents relating to identifying neglect needed to be revised
- We facilitated several multi-agency workshops, whereby we were able to draw on local knowledge and expertise from frontline practitioners to ensure we worked together to compile a suite of documents which were robust and fit for purpose for our Haringey staff
- We ensured that the revised documents focused on identifying early indicators of neglect and provided guidance for practitioners to assist them in achieving the best possible outcomes for Haringey's children, young people, and their families.
- The Neglect Guidance, Toolkit and Checklist has been revised, launched, and embedded across the partnership.
- We have excellent multi-agency engagement with "champions" from all partner agencies who are leading on facilitating the awareness training through 2022/23 and 2023/24.

- To further support the above, the HSCP will formally launch their revised Neglect Strategy in 2023 which has been agreed across the partnership. The launch will include a range of multi-agency partnership events and involvement by young people from the local college and community.
- Neglect continues to be a priority for the HSCP. This is reflected in the Performance Framework. This enables us to analyse statistical data as to current trends regarding neglect and will help us to measure the impact of this work. The HSCP has received positive feedback from all agencies and frontline staff.

WHAT OUR PARTNERS SAID:

The Voice of the Child

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.

WHAT WE HAVE DONE:

The Voice of the Child continues to be at the forefront of our safeguarding arrangements and embedded in agency practice. Key agencies have contributed to this annual report, to evidence how this is embedded in their service setting and across the partnership.

- All commissioned training must clearly evidence how the voice of the child is incorporated in HSCP training opportunities.
- Children and young people have the opportunity to voice their opinions in a wide range of community settings.
- There is a specific evidence-based focus on how partners capture the voice of the child in all audits undertaken. This offers assurance to the HSCP that not only are children/young people listened to, but they are also encouraged and supported in engaging in decision making processes.

- The borough of Haringey actively encourages children/young people to provide a wider community voice.

WHAT OUR PARTNERS SAID:

Review of the existing HSCP Audit Cycle 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 NCL 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.

WHAT WE HAVE DONE:

- All partner agencies continue to recognise their commitment to undertaking a S11 Audit and at the time of compiling this annual report, are actively engaged in the process for 2023/24.
- The HSCP in response to the above has reviewed its existing yearly audit cycle, which will now comprise of 2 multi-agency practice weeks and 2 JOG audits in addition to thematic audits
- During 2023/24 schools will completing their equivalent of the Section 11 audit (S175 and S157 of the Education Act 2002)

WHAT OUR PARTNERS SAID:

What our partners said: Discharge Planning Meetings

The partnership recognised the challenges faced by designated safeguarding leads in Haringey by not having a hospital in the 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) agree a strategic hospital discharge protocol for all children and young people in the region.

WHAT WE HAVE DONE:

- A Discharge Planning Protocol has been agreed by the Partnership. This document sets out clearly the process and procedure for the safe discharge of children and young people from hospitals in the NCL region.

WHAT OUR PARTNERS SAID:

Joint working with the Safeguarding Adults Board

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.

What we have done:

- The HSCP and SAB continue to meet to work closely to progress a number of safeguarding issues pertinent to both.
- Work has been completed to agree and embed a joint Transitional Protocol.
- Following the national media coverage and government directives around poor housing conditions and the impact on health, we have set up a joint SAB and HSCP housing subgroup to help us address this issue locally. An agreed action plan will support specific areas of work required. This will include raising the profile of poor housing conditions and the link to safeguarding. The action plan will be progressed throughout 2023/24

WHAT OUR PARTNERS SAID:

HSCP as a Brand

During the Section 11 audit process some partner agencies made 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.

WHAT WE HAVE DONE:

- The HSCP continues to review existing local safeguarding policies and procedures to ensure that all our staff have access to documentation that is current and in line with safeguarding requirements
- All local documentation is 'badged' with the prominence of the HSCP logo
- The most up to date national guidance has been made is easily accessible
- The HSCP Website has had a major refresh making it user friendly to both staff and members of the community
- Through multi-agency engagement, we continue to develop a suite of 7-minute briefings
- We have continued to circulate short briefings and flyers across the partnership to promote the work of the HSCP
- Our partners are continuing to promote the work of the HSCP across their individual agency settings

WHAT OUR PARTNERS SAID:

Staffing

Partners locally and across the North Central London region continue to develop 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.

THE PARTNER'S VOICE:

In reference to this 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, which has been reflected in the Haringey Ofsted inspection in February 2023

Multi-agency Practice Week

Introduction

Going forward Practice Week will take place twice per year in the period 2023/24 and enables the group to develop a shared understanding of the quality of practice and service delivery, learning from best practice, to improve professional relationships, and secure multi agency ownership to enable practice systems to change and have a positive impact on the children and young people that are reviewed. Practice Week provides an opportunity for a multi-agency collaborative lens on practice and audit activities on an agreed theme.

The theme agreed by the partnership in 2022/23 was Domestic Abuse, which is related to a current and valuable area of safeguarding which would benefit from further consideration. The Practice week took place February 27th, 2023, to 3rd March 2023.

The purpose of Practice Week is:

- To highlight good practice and strengthen areas that require developing within front line practice relating safeguarding children and young people.
- To provide a consistent multi-agency agreed response to practice challenges.
- To ensure that children are at the centre of service delivery through relationship-based practice.
- To disseminate key learning from case discussion across the partnership
- To examine the themes and patterns from audit findings

Methodology

As part of Practice Week practice observations, joint training and audits were organised to take place within and by each agency with an audit template was created by the HSCP in consultation with all partners. Audits were disseminated by the Partner Leads within their own organisations to complete. It was agreed that

this report by the Children Service Quality Assurance Team would be provided. An identified partner from Health agreed to develop a guide from the learning whilst the HSCP business unit would be responsible for developing an action plan which should be agreed with partner agencies. The action plan will then be monitored for progress by Quality Performance & Outcomes (QPO) subgroup and triangulated with learning from all quality assurance activity within the HSCP.

The 3 focussed activities of Practice Observations, Audits and Learning events took place over a period of one week (27th February 2023). The event was attended by 118 people across the partnership. On day 4 of practice week, the QA Audit team gathered the data and analysed the information from the returned audits for presentation of the main themes at the close of the practice day.

The Chair of the HSCP presented findings from audits on the final day of Practice Week.

Practice Observations

Each partner agency was asked to attend another agency meeting to observe and provide feedback on a detailed practice observation form. Meetings across the partnership included health clinics, practitioner supervisions, multi-agency meetings, home visits, office appointments, meeting with parents and professionals Meetings. Observers fed back information which can be used for further embedding good practice:

- Meetings are well led, focussed, and facilitate involvement of all participants with appropriate inclusion of views.
- Child centred meetings evidenced good practice when working with children and families.
- Scrutiny and challenge were evident with robust interrogation of issues
- Children's voices were incorporated in discussions.

- SMART planning and outcomes were rated as positive in meetings
- Equality of opportunity discussions were often part of the meetings.
- Benefits of multi- agency attendance and suggestions of the benefits of key agency attendance at meetings were provided – an example was, education to attend early help meeting to add information.

Haringey Domestic Abuse cases

Seven cases where domestic abuse was the dominant issue were chosen for each partner agency to provide an audit from their agency perspective using a devised audit tool. The audit tool asked the HSCP members to consider the issues highlighted by the National Review regarding Arthur Labinjo-Hughes and Star Hobson and think about how legislation, such as the Domestic Abuse Act 2021 is being employed within their service and across the partnership.

Main themes

Factors that co-existed with domestic abuse for children were the impact of injury, neglect, parental mental ill health, issues of diversity and those factors linked to the national review such as invisible fathers etc. Cases chosen noted children of all ages are affected by domestic abuse, unborn through to 18 years old and that it affects all children who are part of the family.

Learning points:

- Agencies felt that they would like to have more use of Family Group Conferences to strengthen family support.
- Practitioners highlighted the need to continue to identify and encourage maternal / paternal grandparents to be protective factors for victims of domestic abuse.
- Continued attendance and engagement at strategy meetings by all agencies involved will support identifying the needs of the family, creating, and implementing an effective support plan.
- Further training would be helpful regarding domestic abuse processes including the risk indicators of coercive control when a MARAC meeting is

convened and what could/should happen next would further help to develop existing skills and knowledge

- There is a range of direct tools available for practitioners to use with children and how they can form part of the assessment of the children's wellbeing in domestic abuse cases.
- Practitioners should continue to consider the lived experiences of the child as well as considering the trauma they have experienced and its impact.
- Specific training was identified regarding working with victims and children who have a lived experience characterised by domestic abuse.
- Practitioners should continue to explore culture, religion and belief systems of parents and the interface with domestic abuse victims.

“Lite Bite” Sessions

These sessions were held each day of practice week led by specialist workers in the field of Domestic Abuse which were informative and well attended. Slide presentations and question & answer sessions formed a good group discussion with contributions from 345 attendees from 7 HSCP agencies across the practice week.

Conclusion:

The practice week highlighted the important aspect of recognising signs of domestic abuse, its impact upon children and how they are also victims of domestic abuse who may exhibit a range of emotional and behavioural symptoms such as anxiety, depression, aggression, and difficulty concentrating. It is essential that professionals working with children are aware of these signs and respond promptly to interrupt the impact with a focus on improving a child's holistic well-being.

The importance of early intervention and a timely response to cases of domestic abuse play a key part in disrupting its adversarial path and instead, implementing safeguarding measures that promote social, physical, emotional, and mental well-being.

Key learning and outcomes:

- There has been a strong partnership contribution across Haringey via the multi-agency practice week.
- An opportunity enabled the partnership to demonstrate how partner agencies alongside the community, voluntary and faith sectors work collaboratively to respond to the harmful impact of domestic abuse.
- Dissemination of learning throughout the week and via further cascading amongst each partner agency illustrates the robust approach taken to embed the learning and timely response towards incidents of domestic abuse to promote the well-being of children and families.
- Partners strongly agreed to continue their focus on children who are experiencing domestic abuse.
- The partnership agreed there is a need to respond to a child's trauma at the earliest juncture to try to prevent this escalating into more significant mental ill health episodes throughout their lifespan.
- Audits showed how the multi-agency partnership work is undertaken where domestic abuse cases come to notice, what impacts children and how best to respond to their holistic needs.

Recommendations and Next steps

- A Pathway of support for Haringey children in domestic abuse situations across their lived experiences
- Joined up commissioning of services for children and families affected by domestic abuse, including working with non-engaging parents, invisible parents, extended family members and communities.
- Strengthen the provision of services to ensure equality of access and opportunity.
- Domestic Abuse training needs analysis across the partnership

Themed Audit: Early Help and the local context

The landscape of reasons for early help targeted interventions has changed since the pandemic. Prior to 2020, the main presenting factor for assessment was domestic abuse. The top 10 presenting factors identified at assessment for families in June 2022 are outlined in the table below.

Presenting Factor	Count of Families
Mental health - Parent	26
Mental health - Child	22
Domestic Violence	19
Learning disability - Child	13
Families under financial pressure	25
Physical disability or illness - Parent	15
Physical disability or illness - Other Adult	15
In receipt of out of work benefits	18
Other	16

It is noted that parent and child mental health, along with financial hardship are more prevalent factors impacting on a family's situation.

The objective of the audit was to focus on and understand the multi-agency response in relation to these presenting factors, with a focus on cases where there had been a step and step down from social care, alongside the presenting need of mental health/emotional well-being.

The task and finish group agencies were:

- Haringey Safeguarding Children's Partnership (HSCP)
- Health Providers: (Barnet Enfield Haringey Mental Health Trust (BEH), Whittington Health NHS Trust (WH) and North Middlesex University Hospital NHS Trust (NMUH).
- Children Social Care (CSC)
- Police
- Education
- Early Help

Methodology

Initially the task and finish group reviewed ten cases that met the criteria of receiving services from early help. The cases were picked at random from the data team within the early help service and partner agencies advocated for cases to be audited.

Key Findings - Strengths

Effective and timely information sharing: There was evidence from all partners of timely and appropriate information sharing. In circumstances where information was required for MARAC and assessment there was evidence from partners that this was shared, as well as part of the referral process to MASH.

Thresholds appropriately applied: There is evidence from both social care and early help audits that where step up, step down has occurred, the thresholds

have been appropriately applied. The audit of the three cases commented on the appropriateness of threshold decisions.

Heath Issues recognised: Practitioners understood the role of CAMHS and were able to ensure that they were part of the multi-agency response to families.

Case oversight and Supervision: Early help found good evidence of cases having regular supervision and oversight from seniors and managers. This ensured that the casework was monitored for quality and that appropriate management oversight and advice was given.

Risk of Domestic Abuse and Impact Recognised: In cases 2 and 3 there was a clear recognition of historical domestic abuse and reflection on how this was impacting on the presenting situation that they were dealing with. The audit reflected that training and learning around this issue was evident in the work being undertaken, with staff putting this into practice.

Areas for development:

Awareness Raising: The audit highlighted the need for some further development with GPs around the role of early help. In all cases, whilst there was good evidence of knowledge of referrals and social care involvement, this has not always been extended to families at the early help threshold.

Engagement of school nursing in early help cases: Improved knowledge of the role and responsibilities of school nursing would further improve the multi-agency response to young people, with a particular emphasis on emotional and physical health.

Working Models between Early Help and Social Care: The audits from social care recognised that the interface between social care and early help can be challenging for families to understand and can lead to families having several professionals moving in and out of their lives. It was noted that families do not always understand the processes or why workers change. For cases stepping up or down between early help and social care, the process was evidenced as being understood and followed by professionals.

Conclusion & Recommendations

The following recommendations are made to further strengthen working across the partnership.

- To strengthen working arrangements between early help and GPs to ensure that GPs are aware of any work being undertaken with the children and families they are working with
- The early help offer on a page can be reshared with practices so that they understand the wider early help system and the role of family support
- Training to be delivered across the partnership to increase the awareness of the links between physical health symptoms and the emotional well-being of children and young people.
- Joint training should offer the opportunity to discuss case studies to further explore the issues. Training available through the Haringey Academy should be promoted, with a particular emphasis on the health training offer.
- Increase each service understanding about the role and responsibilities of each area, holding joint awareness sessions and build on relationship through work in family hubs.
- A more detailed piece of work to be undertaken to look at options of joint case working between early help and social care, with a focus on providing continuity for families. This would benefit from including hearing the voice of families to understand the challenges the current processes present them.

The development of family hubs to explore models of whole family supervision, enabling practitioners to reflect with partners about practice issues and impact of work.

Local Authority Designated Officer (LADO)

Introduction and Summary

Please note this is an extract of the LADO annual report. The full LADO Annual Report can be found here: [LADO Report](#)

The LADO Service has grown in capacity to match the increase in workflow over recent years. The service is now staffed by a permanent LADO manager, an interim LADO and a Senior Business Support Officer. This enables the service to respond effectively and to develop the systems required to record the data accurately, thus reflecting the work achieved in the service. It is recommended that the annual report should be read in conjunction with the LADO Operational procedures updated in January 2023.

Changes in the number of provisions, particularly in the Private and Independent sector occur and may change annually.

All LADO Contacts

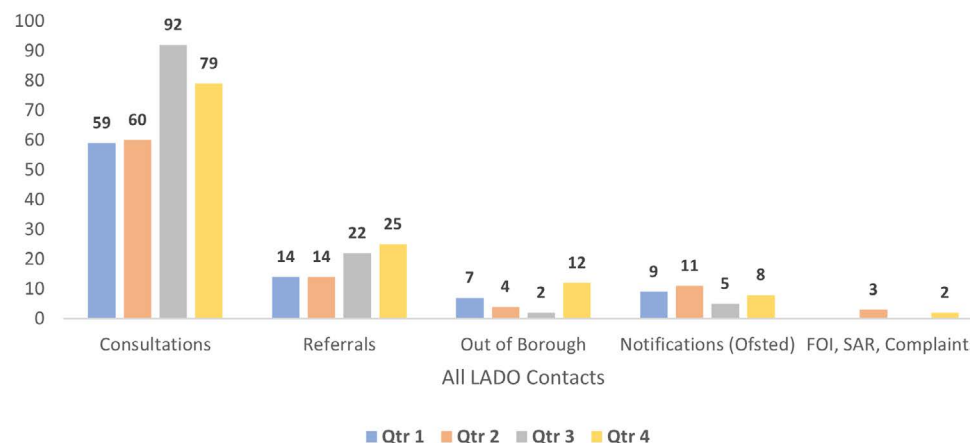


Table 1

The most notable aspect of the annual data is that the majority of LADO service delivery is in Consultations, with 290 consultations taking place this year. All LADO contacts for 2022-2023 total 428, with Consultations forming the majority (67%) of the recorded work. Referrals are always cases where the threshold of harm has been met.

The data tells us that 17% of the contacts LADO received met threshold to consider under the Allegations against Staff and Volunteers (ASV) process in relation to allegations against professionals working in Haringey.

CONSULTATIONS

Consultations

2021-22 compared to 2022-23

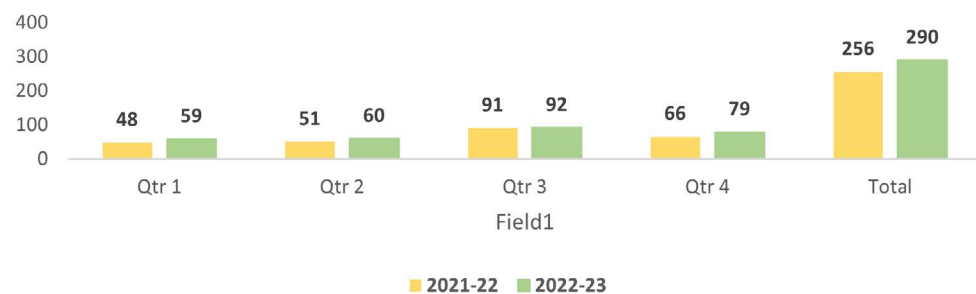


Table 2

Out of 290 consultations in 2022- 2023, more consultations (n92=31%) took place in Quarter 3, which repeats the pattern of last year's consultation figures, similarly high in Quarter 3. It is notable that the figures for consultation in consecutive years are reflective of each other, with a slight increase of 290 (13%) in 2022-2023 from 256 in 2021- 2022. The consultation figures suggest that contact with LADO seeking advice increases as the year progresses.

Consultations - Agency of Referrer

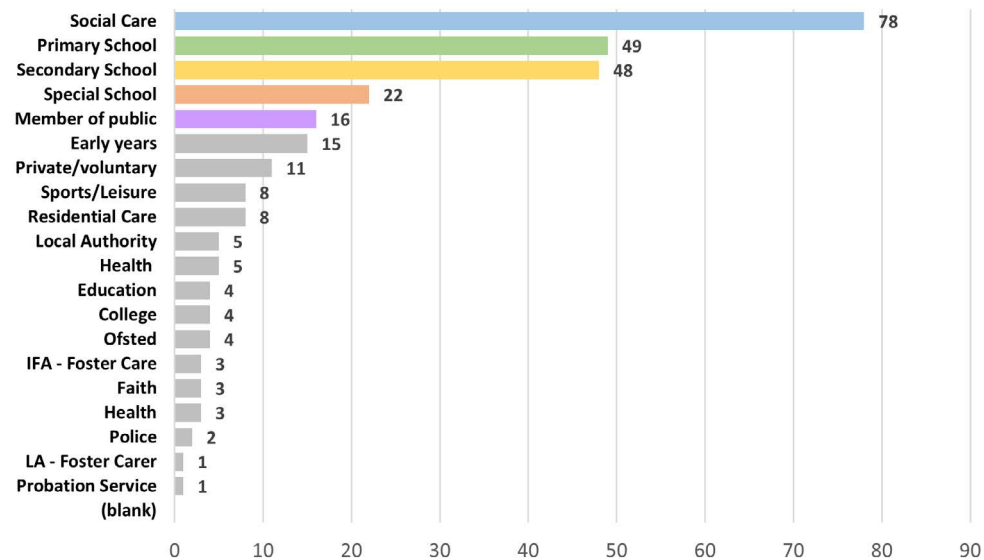


Table 3

Table 3 is a breakdown of the agencies who have contacted the LADO service for consultation. The agency who contacted the LADO most is Social Care. This is a positive indicator, which suggests that our colleagues in Haringey contact us for advice about situations that may indicate professional harm. The contacts from social care come primarily from Childrens Services and include social care in other, usually neighbouring authorities as well as Adults Services. The highest number of contacts with LADO is from schools in Haringey, in line with patterns seen later in the report. Schools had 119 contacts with LADO, being 41% of the total. There were 15 contacts from Early Years settings or Early Years' service for advice and 11 contacts from the private and voluntary sector. Most sectors, including Faith had some contact with LADO. This suggests awareness of the availability of the LADO service for guidance and support exists and suggests that further publicity in harder to reach sectors should increase their contact with us.

ALLEGATIONS AGAINST STAFF AND VOLUNTEERS (ASVs)

ASVs - comparison over 5 years

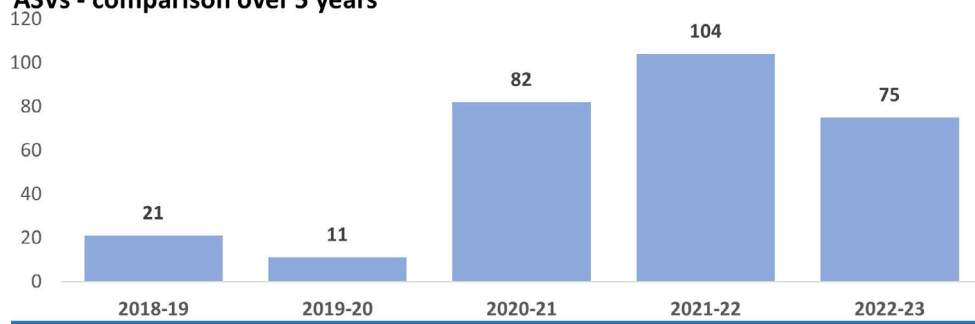


Table 4

The mainstay of LADO work is in the statutory, Allegations against Professionals process detailed in Chapter 7 of the London Child Protection Procedures. For details click here (external website).

The graph above shows that the overall rate of referral to LADO has increased from 2021, over the last 3 financial years.

ASV Outcome

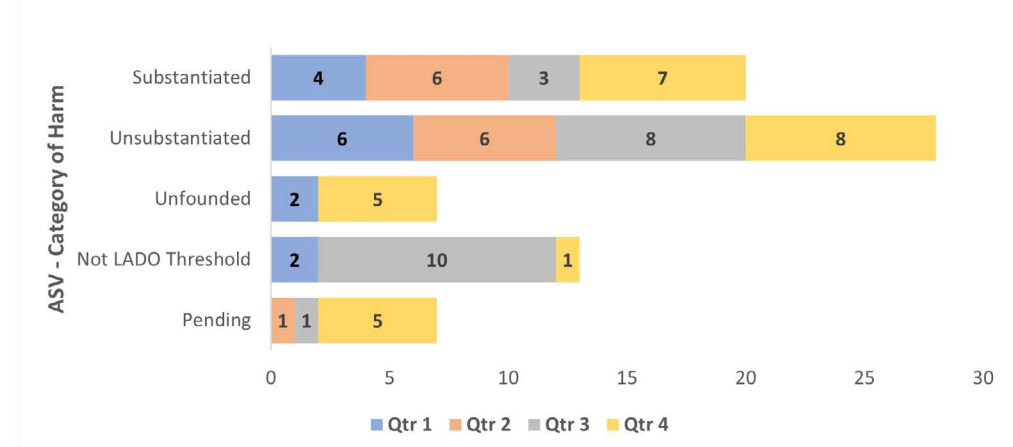


Table 5

Table 5 shows the outcome of the referrals which met threshold for the ASV process. Most referrals ended in Unsubstantiated (n=28, 37%) or Unfounded (n=7, 9.5%) outcomes or did not meet threshold for the ASV process (n=13, 17%). Allegations in 20 cases (26% of referrals) culminated in a Substantiated LADO outcome. From the total of 68 finalised cases, 47 (62%) did not reach substantiated outcomes.

ASV Referral by Agency

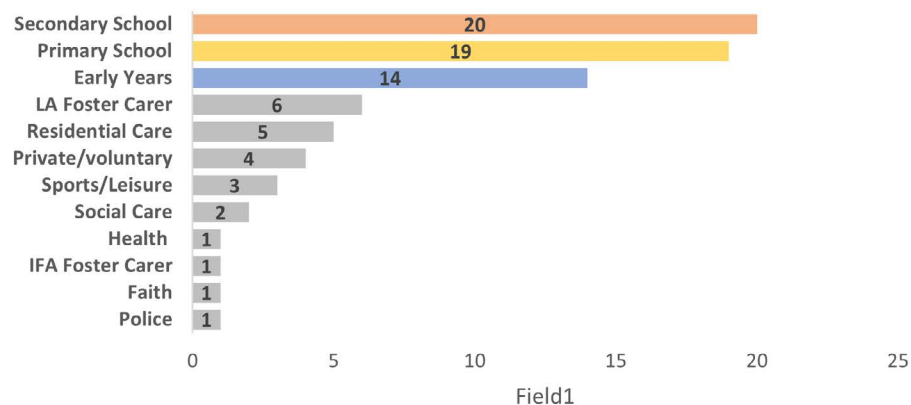


Table 6

Table 6 shows us the level of allegation referral from each agency with whom the LADO has received referrals in 2022-2023. All the agencies represent professionals who work directly with children. Schools make the majority of referrals: primary schools made 19 referrals (25%) and secondary schools 18 referrals (24%); the majority of LADO referrals (49%) are from schools.

It is important to reflect that the 3rd highest referral comes from Early Years settings – namely nurseries, who made up just over 18% of the referrals to LADO. There were 6 (8%) referrals in relation to Haringey foster carers, and only one referral from an Independent Fostering agency, namely a private fostering provider. Five referrals from residential homes based in Haringey were received which are private providers with homes in Haringey, again a referral rate of just below 4%. It is a positive indicator that we are receiving referrals from placements in Haringey and that we received 3 referrals from sports provisions who work with children (2%). There were low representations from Health, Police and Faith communities (0.75%) but it indicates development potential to build knowledge of the ASV process in these sectors.

Development of the LADO Service

WHAT WE HAVE DONE WELL

2022- 2023 has seen the development of the LADO service. Following a 'settling-in' period the following areas have progressed:

- **Data Reporting:** LADO provides quarterly reports which enable the service to reflect on the work achieved, including the areas and agencies who are most and least present in consultation and referral to LADO. With a Senior Business Support Officer in place in the LADO Service a system of accurate data recording and reporting has been established. A change in format was introduced in Quarter 2 which focuses primarily on the production of data.
- **Practice Improvement:** We have used data collection to inform us of practice improvement requirements – including reducing the number of ASV meetings held prior to conclusion, adapting our templates and ensuring that new guidance is integrated into our practice. We regularly attend the London LADO network meetings which take place bimonthly including training opportunities offered by this and the national LADO network
- **Policy and Procedure:** Haringey LADO operational procedure was updated in January 2023, updated in line with changes in procedure in statutory guidance. The process of referral to LADO was simplified to 2 stages in July 2022 – namely Consultation and Referral, reducing complexity and increasing our availability to partners.
- **Publicity:** We publicised the LADO service and what we do. This includes providing briefings to social work teams, SEND services, Schools and Education services, and through training, detailed below.
- **Professional relationships:** There is a positive relationship between LADO and Haringey police (CAIT) team who are responsive to enquiries and supportive of the LADO process.
- **Training:** There has been progress in the provision of LADO training which is part of an ongoing development plan.

WHAT NEEDS TO BE DEVELOPED:

Plans in place for 2023-2024

- Regular quarterly training with HSCP. We will increase this training where necessary and offer bespoke training to partner agencies where there is a specific, identified need
- Collaboration with Faith sectors in Haringey, includes being available for briefings and events to raise the LADO profile. We are seeking the support of our Private and Voluntary partners to assist in this process
- Future training development and publicity to include Faith, Health, and Private and Voluntary sectors
- Bespoke training offers to include training to Children's Services teams and departments, Human Resources department, Designated Safeguarding Leads in Schools and other areas where there is an identified need.
- Increase publicity of the requirement of children's departments to notify LADO of any Haringey child subject to allegations in another Local Authority
- Increase publicity of the requirement of children's department social workers to notify LADO of special needs children placed in residential homes in other Local Authorities who are subject to allegations or where there is a safeguarding practice concern (in line with the Hesley review recommendations)
- Increased focus on the voice of the child, their vulnerabilities and sensitivity to the impact of trauma will be evidenced through the recording of referrals and ASV meetings
- Implementation of the transition of LADO recording to Liquid Logic from September '23

It has been a formative year for the LADO service, in which we have made adaptations developed in line with LADO principles. We continue to aim to be an accessible service to partners in Haringey and encourage partners to contact us for advice and guidance when they may be uncertain whether criteria are met.

Development of the service is the goal for 2023 -2024 when we look forward to actioning the plans that we have outlined above.

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)

This 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 of the group is from health setting a vice chair is yet to be appointed. The suggestion is for an education representative, to ensure adequate input from this key partner.

This subgroup of the HSCP continues to meet virtually and enables each agency to scrutinise the data and analysis relating to the most vulnerable children, young people, and their families; 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 HSCP has a multi-agency audit cycle and conducts multi-agency audits based on agreed priority areas. The audits enable the partnership to focus on safeguarding practice and identify strengths and as well as areas needing improvement.

The Terms of Reference for the QPO have been reviewed and strengthened 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 group now meet every 2 months

The QPO undertook a themed audit with a focus on Early Help

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 emerging 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 HSCP 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. Gathering the data across the partnership has evidenced that there is strong stakeholder engagement and continual development and refinement to the data will ensure it captures activity, trends and opportunities for further work.

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.
- Further development of the Multi-agency Data Sharing Agreement in line with the development of the HSCP Performance Framework
- S11 Audit undertaken
- All action plans pertaining to Audits, Rapid Reviews and Safeguarding Practice Reviews 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 and promotion of the Private Fostering App.
- Supporting implementation of a revised Child Protection Conference Process.
- Review, revision and ratification of 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 developed Performance Framework has provided 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 continued to respond to the recommendations contained in Action Plans (arising from reviews) in order to continue to develop frontline practice so that better outcomes for children, young people and their families can be achieved

We continue to strengthen our response by

- Further embedding of the Performance Framework
- The interface of the QPO and Joint Operational Group (JOG) as the JOG also undertakes audits, 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 JOG audit process takes place four times per year and the learning reviews enable the multi-agency group of professionals to work together, share information, to develop a shared understanding of the quality-of-service delivery, learn from best practice, improve / develop professional relationships, and secure multi agency ownership to enable practice systems to change and have a positive impact on the children and young people that are reviewed. The group examines themes and patterns from audit findings and disseminates key learning from case discussions across the partnership, we then agree an action plan that each partnership takes responsibility for progressing.

The HSCP business unit is responsible for developing a multi-agency agreed action plan. The action plan is then monitored for progress by Quality Performance & Outcomes (QPO) subgroup and triangulated with learning from all QA activity (SCRs, thematic audits, Practice Week). To embed learning, the Partnership might consider multi agency workshop development for practitioners across the partnership.

Purpose

The purpose of the group is:

- To continue to develop front line practice around complex safeguarding cases and address blockages to effective safeguarding
- To provide a consistent multi-agency agreed response to practice challenges.
- To ensure that children and young people are at the centre of service delivery through relationship-based practice.

- To disseminate key learning from case discussion across the partnership
- To create a multi-agency forum to reflect on risks, priorities to change and to act as constructive critical friends.
- To examine the themes and patterns from audit findings

Methodology

All professionals within the partnership can refer cases or events involving a child or family for discussion where concerns have been raised by agencies; the referrer will need to provide a synopsis of the case and reasons why the case would benefit from discussions; Cases will be presented to the group by professionals within the partnership for discussion and agreement. Once the case has been agreed, the HSCP business unit will circulate the case and professionals will complete the Audit tool, which includes a single agency chronology. These will then be combined into an integrated multi agency chronology by the HSCP business unit.

An integrated chronology forms part of a specific multi agency intervention, it includes only information extracted from single agency chronologies that is relevant and proportionate to support that intervention. This type of chronology is useful when there are worries between professionals about families we are involved with, reflecting cases selected for JOG audits, it provides clarity about the family situation and our specific roles within this.

JOG meetings are chaired by the Principal Social Worker and the lead agency presenting the case will provide a brief synopsis of the case to attendees. Case presentations are rotated amongst agencies.

Case Themes for the Year of 2022-2023

June 2022- Contextual Safeguarding

September 2022- Domestic Abuse

December 2022- Neglect

March 2023- Housing Concerns

Key Learning for Partners - Areas of Good Practice

- Good Multi-agency Information/Intelligence Sharing
- Professionals' devotion in listening to and offering advice to families, who are hesitant to work with us.
- Good Multi-agency Working
- Comprehensive Case Recording and Reports/Assessments
- Supervision utilised well.
- Childrens Voices clearly captured.
- Professional Curiosity

Area's that require further Development

- Partnership knowledge of Housing Pathways requires to be strengthened.
- Documenting the lived experience and impact of abuse on Children and Young People could be strengthened.
- Minutes not always being shared with partners, who were unable to attend meetings.
- Vulnerable Children being de-registered by the GP Surgery without having registered with a new surgery.
- Fathers' involvement with Professionals regarding their children could be strengthened.
- Notification to allocated workers; regarding discharge of parents from Mental Health Services could be strengthened.
- The importance of requesting information from Adult Services when there are concerns regarding mental health of parents.

Review of JOG Frequency

There is a proposal for a change to the frequency of the JOG audits in 2023/24 to take place to twice per year, with the additional proposal of having two multi-agency

Practice Weeks. There was a unanimous agreement across the partnership that this would be beneficial to enable the learning to be absorbed and re-visit practices. It will also give us the opportunity to disseminate practice strengths and areas of development within each agency and facilitate workshops/update identified policies.

Conclusion

The JOG concept is now well embedded has enabled the multi-agency partnership the opportunity to jointly deliberate learning from cases that have been identified as complex and would benefit from a partnership consideration regards best practice in safeguarding children. The group is well attended and has provided an opportunity to explore together, areas of good practice within the partnership response to safeguarding children, which can be built upon and areas of practice which would benefit from further strengthening.

The process has enabled the group to consider the system in which we support our families to function and to make recommendations regarding further training and practice improvement, which will inevitably improve the outcomes for our families. We have explored four different themes this year, which after audit activity and multi-agency consideration have led to a number of recommendations.

Recommendations

- Training to be facilitated by Housing on pathways.
- GP's to be reminded of their policy around de-registering vulnerable children.
- Workshops to be set up to support practitioners around the recording of Children and Young Peoples Lived experience.
- Training on Promoting the engagement of fathers to be facilitated.
- Partnership to re-disseminate their policy around the sharing of meeting minutes.
- Health to re-circulate their policy around informing Childrens Services when a parent is being discharged from Mental Health Services.
- Health to disseminate their new birth template.
- Health to Jointly Facilitate a DNA Multiple non-attendance workshop for the Partnership.
- Neglect Tool Training- ongoing.

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 agency'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. In addition, the PLWD continue to oversee the further development of the HSCP website. Through the support of our expert partners, we have developed and delivered a range of multi-agency training opportunities.

In 2022/23 HSCP continued to offer a range of multi-agency training opportunities designed to continue to upskill our frontline workforce. Our training in the main is facilitated by partner representatives who are able to bring in their local expertise and knowledge. We have however commissioned some training such as Signs of Safety, Trauma Informed Practice by David Shemmings and Fabricated or Induced Illness & Perplexing Presentation Training by Dr Danya Glaser.

The courses offered over the last reporting year include:

- Child & Teenage Neglect
- Contemporary topics in Child Protection Leadership and Practice
- Contextual Safeguarding in Haringey
- DVA Awareness Training Workshop (RiP)
- FII & PP Training (Fabricated Induced Illness & Perplexing Presentation Training)

- Haringey & Mental Health Think Family Familiarisation Session
- Introduction to Alcohol Awareness
- LADO Training
- Neglect Training
- Prevent Training
- Safeguarding Level 3
- SCR Learning event/training (now under revision to incorporate Star and Arthur Review and learning from local SPRs)
- Signs of Safety half day Briefing
- Social Care Threshold
- SoS (Signs of Safety) half day briefing
- Trauma Informed Practise

Overall, the HSCP offered 36 different training opportunities for all partnership staff as well as other members of our Haringey community who work with children, young people and their families.

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

We have consulted with our training attendees, who have expressed that the virtual learning environment works well for the majority of courses and as such have continued to offer them virtually where possible. However, it should be acknowledged that some courses benefit from face to face attendance which we have facilitated.

The work undertaken in this reporting period included:

- All meetings continue to be held via 'Teams.' Whilst it was recognised that the Covid 19 pandemic nationally had eased, it was also recognised that there were still huge pressures on agency settings. Therefore, the HSCP continued to listen and respond to the needs of its partner agencies and agreed that all meetings and multi-agency training opportunities would be delivered virtually until such time that it is safe and appropriate to make changes. However, it should be acknowledged that at some point in 2023/24 training opportunities and meetings will begin to be held on a face-to-face arrangement.
- A review of the subgroup membership and the Terms of Reference (TOR) has been undertaken. This is to ensure that the membership of the group fully reflects the wider engagement of the partnership, and that the TOR is robust and fit for purpose. As a result of the review, we are pleased to confirm regular engagement by Housing and Education.
- A full review of the existing Neglect Guidance, Toolkit, Checklist, and training slides has been completed by a multi-agency working group. These documents have been designed to support front line practitioners to focus upon the identification of neglect at the earliest opportunity. The revised documentation had a 'soft' launch in 2022. Members of the working group trialled the revised documents in their agency settings by facilitating 1.5hr awareness raising sessions via Teams as well drawing attention to the new document during supervision sessions and team meetings. A full launch will take place early 2023. There will be a rolling programme of awareness sessions, which highlights the commitment by all partner agencies to reduce the effects of Neglect on Haringey's children and young people.
- The HSCP has now agreed the final version of the Neglect Strategy. The planned launch will take place in 2023 to coincide with the full launch and implementation of the revised Neglect documentation.

- The existing Learning and Development Framework was revised and continues to be a 'live document' to take into account the changing developmental needs of staff across the partnership which emerge from learning gleaned from reviews and themed audits that have been undertaken.
- All commissioned trainers are requested to provide the HSCP with details of the course content that they facilitate. This continues to be undertaken prior to agreements being made as part of the HSCP Quality Assurance process. This mechanism was implemented by the PLWD and helps members to be assured that all training opportunities continue to be fit for purpose and meet the needs of partnership practitioners.
- Alternative training resources, innovative and imaginative ways to keep in touch with children and families continue to be shared across the partnership, including different technology platforms.

The Core training is booked through the Haringey Academy Website. This continues to be a positive arrangement as it enables the HSCP 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.

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 post the pandemic. Part of the feedback form asks attendees whether they prefer online or face to face training. As a result, some courses have reverted to being face to face, whilst others remain virtual training. The situation is closely monitored to ensure our high standards are maintained.

WHAT WE NEED TO DO MOVING FORWARD:

- Continue to implement the Training and Development Work plan
- Commission training courses based on analysis of gaps and local learning needs
- Continue to 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
- Continue to develop alternative training resources and innovative and imaginative ways to keep in touch with children, families, and practitioners including different technology platforms. Examples being considered are Podcasts, video's animations.
- The sub-group will need to continue to measure the impact of training on frontline practice by 'interrogating' and analysing feedback from delegates on how they are transferring learning into practice and how this has made a difference to outcomes for children, young people and their families
- Continue the promotion of training opportunities across the partnership
- Continue to develop a suite of '7-minute' briefings on specific safeguarding issues
- Continue to develop the HSCP website in order to ensure it is always up to date and topical
- Consider the training needs of the partnership workforce for 2023/24 and beyond

ADDITIONAL MULTI-AGENCY TRAINING TO BE CONSIDERED FOR 2023/24 INCLUDE:

- Exploring the risks of Extreme Misogyny and Incel Ideology
- Improving Housing Standards in the Private Rented Sector
- Cultural Boundaries Training
- When is it Safeguarding?
- Working with 'invisible fathers'
- Adulthoodification
- Understanding Mental Health and its impact
- Joint training with Housing i.e. the impact of poor housing conditions and how this is linked to safeguarding

Feedback continues to be overwhelmingly positive, and we continue to listen and consider practitioner requests for additional courses. Planning for the 2023/24 training programme is almost complete at the time of writing this annual report. 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:



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 sadly, children die. The two fundamental mechanisms that help us achieve this are Local Child Safeguarding Practice Reviews (LCSPR) and Child Death Reviews.

Local Child Safeguarding Practice Reviews (LCSPR)

Sometimes a child suffers a serious injury or death due to child abuse and/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 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.

In April 2022 the HSCP Child Safeguarding Practice Review Guidance was launched in line with legislative requirements. This document will help to guide all partners through the process of safeguarding practice reviews, including their roles and responsibilities. However, it should be noted that the legislation around safeguarding practice and processes is likely to change following the Government review into the tragic deaths of Arthur Labinjo-Hughes and Star Hobson, as well as a proposed revised Working Together 2018.

From 1st April 2022 – 31st March 2023 the HSCP received 8 notifications where a Virtual Threshold Meeting with Statutory Partners took place.

Of the eight cases referred to the HSCP:

- 7 resulted in a Rapid Review
- 1 did not meet the threshold to progress to a Rapid Review and was dealt with via the Child Death Overview Panel (CDOP) process

At the time of this annual report, the HSCP had three CSRP in progress. It should be noted that these three cases commenced in 2021-2022 and whilst they have concluded, the final reports have not yet been published due to ongoing criminal proceedings.

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.

All current cases are robustly monitored by the Quality, Performance and Outcomes subgroup with the Executive Group appraised regularly regarding progress. This process adds an additional line of scrutiny and challenge. The Executive Group will where necessary 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
- Revision of the Forced Marriage Protocol
- The embedding of the Neglect Guidance, Toolkit and Checklist to support practitioners to identify neglect at the earliest opportunity.
- Greater awareness of families who do not have Recourse to Public Funds
- Implementation of a partnership Discharge Policy
- Raising awareness, and developing skills and knowledge around Fabricated or Induced Illness (FII) and Perplexing Presentations (PP)
- Continued review, development, and progression to improve information sharing processes.
- Specific elements in HSCP training to raise awareness around professional safeguarding curiosity with a focus on 'absent fathers'
- Further consideration of Trauma Informed Practice supported by commissioned training opportunities
- Cross-Border working arrangements reviewed and continue to improve

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

Child Death Reviews

Child Death Overview Panel

The Child Death Review (CDR) Partners continue to embed the child death review statutory guidance across NCL. The CDR Partners continue to work closely to ensure each child death in North Central London is thoroughly reviewed and each family is allocated an identified keyworker.

The NCL Lead Nurse for Child Death is linked with each of the 5 Safeguarding Children Partnerships. In Haringey, the Lead Nurse is a member of the Practice, Learning & Workforce Development Group and the Quality Performance & Outcomes subgroup.

In 2022-23, NCL CDOP received 95 notifications of child deaths through the eCDOP system. Of these cases, 21 were for Haringey children.

Joint Agency Response meetings

A Joint Agency Response (JAR) meeting is convened for all unexpected deaths, ideally within 72 hours and is triggered if a child's death:

- is or could be due to external causes;
- is sudden and there is no immediately apparent cause (including sudden unexpected death in infancy/childhood (SUDI/C));
- occurs in custody, or where the child was detained under the Mental Health Act;
- where the initial circumstances raise any suspicions that the death may not have been natural; or
- in the case of a stillbirth where no healthcare professional was in attendance.

There were 9 JAR meetings in Haringey in 2022/23.

Reason for notification for each JAR

The reasons for JARs were SUDI, Infection, Trauma and Unexpected, unknown underlying medical conditions, however for confidentiality reasons and to avoid any possible identification of individual cases the exact numbers of the above reasons were redacted prior to publication of this report.

- Immediate safeguarding steps were taken where appropriate in relation to siblings and family support.
- Immediate learning highlights the ongoing need to raise awareness on safer sleeping and the impact of knife crime.
- There was a significant delay in notification for 1 child who would have met the criteria for a JAR. This is being reviewed by police and education colleagues.
- Three of the child deaths are also being reviewed under the NHS Serious Incident Framework.

Rapid Reviews

Three of the child deaths were referred to the Partnership for consideration of a more in-depth review of multi-agency practice. NCL CDOP Lead Nurse involved in all three Rapid Review meetings.

Year	Child Deaths Reported	Overseas Deaths	Joint Agency Response meetings	Rapid Reviews	Child Deaths Reviews
2019-20	16	1	5	1	15
2020-21	22	2	4	1	15
2021-22	13	0	3	0	3
2022-23	21	0	8	3	16 (including PMRT)

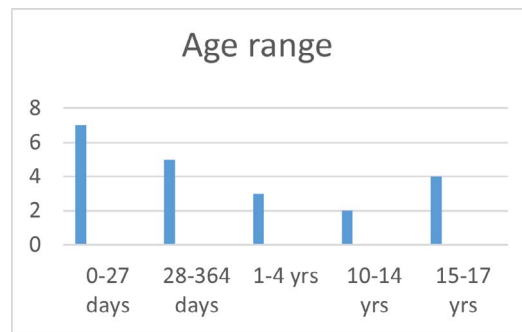
*Peri-natal Mortality Review tool used for deaths due to prematurity

Further data analysis



Sex

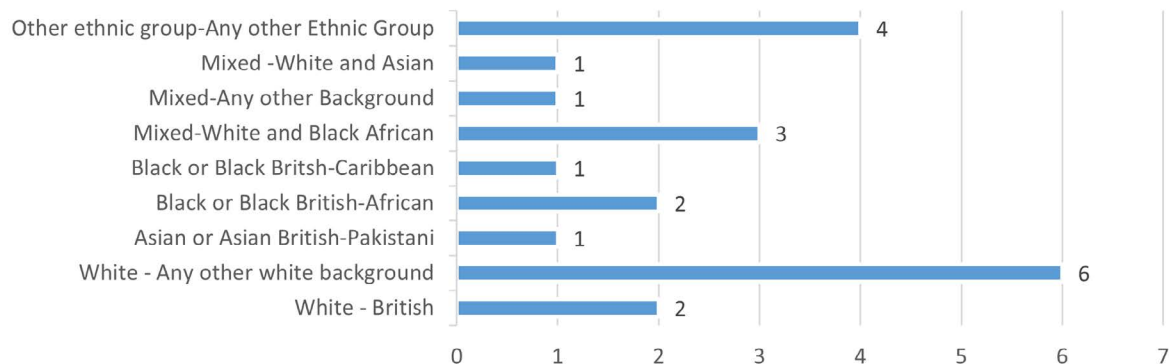
60% were male with 40% female



Age group

The age group are listed above with the largest number happening the first year of life.

Ethnicity



Learning from Child Death Review Meetings

In 2022-23, there were 16 child death review meetings (5 PMRTs & 11 CDRMs) held for Haringey children, some of which were held for children who died outside of the reporting year.

Of the 16 cases reviewed, 14 out of 16 cases were assessed as having no modifiable factors. There were a number of local action plans developed where the learning highlighted service provision may have enhanced the care provided and the experience of the family. Learning also included the need for earlier genetic screening.

Of the 16 cases, 2 were assessed as modifiable. Both cases were considered as modifiable due to the ongoing serious youth violence work and the prevention of knife crime.

The HSCP Business Plan

Our Business Plan aims to ensure that the partnership oversees and advances improvements in its core business. The Business Plan and work programme was developed in partnership with all agencies and continued to progress a range of improvements during the reporting period of 2022/23. Preparation has already taken place to agree the HSCP Business Plan for 2023/24. The Business Plan will be supported by an Action Plan which will be monitored by the Quality, Performance and Outcomes subgroup and ultimately the Executive Group.

Multi-agency work within the HSCP groups and sub-groups promote 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 subgroups 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, building and sharing good practice.

We continue to strengthen cross-borough alliances and programmes to deliver innovative, locally led solutions to crucial challenges affecting children and young people in Haringey.

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 Partners and collective planning, driving activity that is overseen by Partner's governance structures, and will contribute to the delivery of this plan.

Priority objectives, outcomes, activities, and measures:

For 2022-24 we are continuing to implement deliver on our three key priorities. These are

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

In addition, the HSCP MASA Focus and Strategy comprises four key elements which are summarised below:

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

Within these areas there will also be consideration of:

- Transitional Safeguarding with the Safeguarding Adults Board
- Neglect with the Early Help and Health & Wellbeing Boards
- System for managing the risk to children who go missing. An example is the continued development and promotion of the Missing Prevention App

It should be noted however, that during 2023/24, the HCP will be considering and agreeing their priorities for the Business Plan 2024/27.

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 2022/23, both financially and provide staff time 'in kind'. Work is underway within the partnership to address equitable funding, building on the commitment to sustaining the rigour of the partnership. Agencies have continued to find alternative and innovative ways to contribute, including an 'in-kind' contribution as referred to above via the secondment of a police staff individual to the HSCP for 2.5 days per week. Other partners have shared their expertise and knowledge by facilitating and supporting the HSCP training. In addition, Health Partners now share the Charing of the QPO & PWLD sub-groups whilst remaining actively engaged in the wider work of the partnership.
- However, it has been acknowledged that the partners in Haringey recognise the impact of the financial challenges facing many front-line services and the increasing complexity of need, demand, and reduced funding from central government. An away day for the members of the HSCP Executive Group has been agreed to take place in the autumn of 2023 to further explore this issue.

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

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

ICB – Integrated Care Board

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

