Haringey Safeguarding Children Board

Annual Report on the Effectiveness of Safeguarding Children in Haringey 2012-13 and Business Plan 2013-14

Foreword from the Independent Chair

In writing this foreword to the Annual Report, my last, having been in post for five years. I first wish to pay tribute and offer my thanks to the staff of all those agencies and organisations represented on the Board for their support and commitment to Child Protection.

The London Borough of Haringey is not an easy place to work in as the data contained in this report illustrates. It presents challenges to health, police, housing and social care staff alike. There is a need for constant vigilance and a willingness to challenge assumptions and seek new ways to solve old and persistent problems. Mistakes have occurred illustrated tragically by the death of Peter Connelly and later Serious Case Reviews.

However, within those Reviews positive change is discernible and the resilience of staff in the face of challenges by the LSCB and others is commendable. What no one should doubt is the commitment of the staff I have worked with to meet children's needs and defend their rights. Every child death or injury is tragic and regrettable but it must be remembered that hundreds of children thrive and grow as a consequence of the intervention of those agencies represented on the board – individually and collectively.

This report details achievement over the last year and does not shy away from the challenges of the future. A future set against the background of legislative change, new demands and a new audit regime led by Ofsted. Much is expected of LSCBs – (a far cry from the days of Child Protection Committees) in terms of analysis, liaison, training and joint working. Quite often good Child Protection is derived from doing simple things well, supervision being authoritative in practice, communication and so on. It remains to be seen if LSCBs nationwide are sufficiently well resourced to 'hold the ring' and ensure a climate of mutual accountability.

It has been a privilege to work here.

Graham Badman, Independent Chair

Contents

Foreword from the Independent Chair 2

Section one - Introduction 4

Section two – Summary of key areas of progress and achievements in 2012-13 8

Section three – Effectiveness of the LSCB - Governance and accountability arrangements...... 11

Section four –LSCB subgroup activities.. 16

Section Five – Local Safeguarding performance data 28

Section Eight Effectiveness of safeguarding in Haringey and Key recommendations................. 37

Section Seven Priorities for 2013- 2014.. 40

Section Eight Business Plan 2013 – 2014.. 41

Appendix 1 44

Appendix 2 46

Approved on: 27th November 2013

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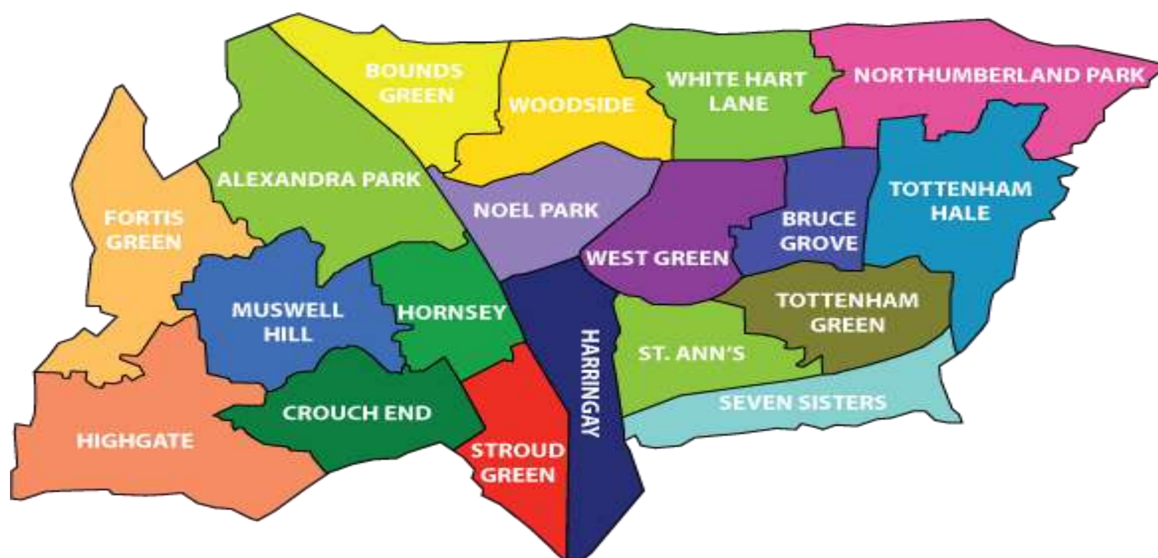
Section one - Introduction



- Haringey is an exceptionally diverse and fast-changing borough with a population of about 225,000 residents (ONS). There are approximately 53,800 children and young people under 20 living in Haringey. The wards with the largest number of people aged under 20 in Haringey are: Seven Sisters, Northumberland Park, White Hart Lane and Tottenham Hale. Haringey has a relatively young population with almost a quarter of the population under the age of 20[1].

- Haringey is the 5th most ethnically diverse borough in the country. Nearly half of the residents and nearly 81% of our school children come from Black and minority ethnic (BME) communities; 190 different languages are spoken in our schools. The proportion of children from BME communities varies from 30% in Muswell Hill to 78% in Northumberland Park. Haringey is the 4th most deprived borough in London and the 13th most deprived in the country.[2]

- An estimated 21,595 (36.4%) children live in poverty, largely in the east of the borough. There are significant levels of homelessness; more than 3,000 households are officially in temporary accommodation, the highest in London. Just over 30% of households live in social housing with high concentrations in the east of the borough. The east of the borough is more densely populated than the west[3]

- This is the third Annual report of Haringey LSCB and this report builds upon the previous annual reports and business plans published by Haringey LSCB.

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[1] Haringey JSNA, 2012 summary
[2] Haringey JSNA, 2012 summary
[3] Haringey JSNA, 2012 summary

It has been compiled by representatives of the LSCB and safeguarding lead officers. The purpose of this report is to:

- provide an overview of LSCB activities and achievements during 2012/13
- provide an summary of the effectiveness of safeguarding activity in Haringey, including areas of weakness, the causes of those weaknesses and action being undertaken to address them,
- provide the public, practitioners and main stakeholders with an overview of how well children in Haringey are protected and,
- include proposals for action, lessons from reviews undertaken, and recommendations to strategic partners

Role and function of the LSCB

The LSCB is the statutory body for agreeing how the relevant organisations will co-operate to safeguard and promote the welfare of children in the London Borough of Haringey.

The objectives of the Board are:

- To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area
- To ensure the effectiveness of what is done by each such person or body for that purpose

Scope

The scope of the LSCB role falls into three categories:

1. To engage in activities that safeguard all children and aim to identify and prevent abuse and ensure that children grow up in circumstances consistent with safe care.
2. To lead and co-ordinate pro-active work that aims to target particular groups.
3. To lead and co-ordinate responsive work to protect children who are suffering or likely to suffer significant harm.

Function

Thresholds, policies and procedures

Developing policies and procedures for safeguarding and promoting the welfare of children, including policies and procedures in relation to:

- the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention.

Training

Training of people who work with children or services affecting the safety and welfare of children:

- LSCB has a responsibility to ensure that single-agency and interagency training on safeguarding and promoting welfare is provided in order to meet local needs.
- LSCBs are required to evaluate the quality of training, and ensure that relevant training is provided. This covers both the training provided by single-agencies to their own staff and multi-agency training organisation.
- Haringey develops, organises and delivers multi- agency training although this is not a core requirement for LSCBs

Safe workforce

Safe recruitment, management and supervision of people who work with children:

- Establishing effective safe workforce policies and procedures based on national guidance.
- Ensuring that robust quality assurance processes are in place to monitor compliance, e.g. audits of vetting practice.
- Investigating allegations concerning people working with children:
- Producing policies and procedures to ensure that allegations are dealt with properly and quickly.
- Monitoring the Safety and welfare of children who are privately fostered:
- Ensuring the co-ordination and effective implementation of measures designed to strengthen private fostering notification arrangements

Communication and raising awareness

Communicating the need to safeguard and promote the welfare of children, raising their awareness of how this can be best done, and encouraging individuals and partners to do so. This should involve listening to and consulting children and young people and ensuring their views are taken into account in planning and delivering services.

Monitoring and evaluation

Monitoring and evaluating the effectiveness of what is done by the Local Authority and Board partners (individually and collectively) to safeguard and promote the welfare of children and advise them on ways to improve.

Participating in planning and commissioning

The LSCB must participate in local planning and commissioning of children's services to ensure that they take safeguarding and promoting the welfare of children into account:

- This is achieved to a large extent by contributing to the Children and Young People's Plan, and ensuring in discussion with The Children Trust and agency leaders that planning and commissioning of services for children takes account of their responsibility to safeguard and promote the welfare of children.
- The LSCB is the responsible authority for matters relating to the protection of children from harm.

Child Death Review Function

The LSCB holds responsibility for the compulsory functions regarding all child deaths. These include:

- Collecting and analysing information about the deaths of all children normally resident in Haringey with a view to:
    - Identifying any matters of concern including any case giving rise to the need for a Serious Case Review.
    - Identifying any general public health or safety concerns arising from the deaths of children

The Board's scope is wide and covers universal, targeted and responsive safeguarding. The Board aims to address all areas, but remains focussed on its core business of ensuring that children who are suspected or know to be at risk of significant harm are being protected effectively.

Section two – Summary of key areas of progress and achievements in 2012-13

In last year's annual report Haringey LSCB outlined 7 priorities in its role in co-ordinating local work to safeguard and promote the welfare of children. These were:

- *The engagement of Children, young People and their families to influence the work of the LSCB*
- *Strengthen governance and accountability arrangements between the LSCB and other partnership Boards*
- *Implement and review response to identified local safeguarding issues*
- *Implementation of the New Working Together to Safeguarding Children Guidance*
- *Developing a co-ordinated link between Schools and safeguarding*
- *Identification of Children at risk of Sexual Exploitation*
- *Supporting and monitoring organisations in the identification and response to Neglect in the borough.*

Whilst a lot of work has been done on every priority, work remains. National Research (Local Safeguarding Children Boards, a review of progress DCSF 2008) has shown that more effective Boards are those who concentrate on a few clearly articulated priorities which are continually reviewed and updated to meet changing needs and pressures.

The engagement of Children, young People and their families to influence the work of the LSCB

- This year the board initiated links with children and young people's groups, most notably Haringey's youth council who have worked alongside the LSCB to develop key questions to ask young people on how safe they feel.

Strengthen governance and accountability arrangements between the LSCB and other partnership Boards

- Haringey's Children Trust Board has been reinstated and the chair of the LSCB is a member, strengthening links and accountability.
- The director of Public health attended the board to inform partners of the priorities of the Health and Wellbeing Board.
- In February 2013 the 2011/12 LSCB annual report was presented to the Health and Wellbeing board.

Implement and review response to identified local safeguarding issues

- A review of Haringey's safeguarding action plan took place and all areas have now been addressed.

Implementation of the New Working Together to Safeguarding Children Guidance

- The partnership responded to the government Working Together consultation. There were variety of views to the changes and the New Working Together statutory guidance came in to effect on 15th April 2013.

Developing a co-ordinated link between Schools and safeguarding

- The designated teacher's forum was refreshed and reinstated facilitated by the LSCB and now includes the involvement of other partner agencies including health.

- The board welcomed 2 new Head teachers who joined the board from primary and secondary schools

- A newly designed designated Child Protection training course offers Designated Child Protection Officers an opportunity to develop their skills; this should also improve the quality and timeliness of referrals.

- The vacant LADO post has now been filled.

- The LSCB provided joint training with the Local Authorities Human Resource team on safer recruitment for schools.

Identification of Children at risk of Sexual Exploitation

- The LSCB has responded to the national issue of children and young people at risk of sexual exploitation through a strategic multi-agency group tasked with reviewing the local multi-agency protocols, mapping out the prevalence of CSE and identifying the intervention resources in the borough.

- The local authority reviewed how they collate information and have imbedded changes into the ICS system, enabling easy and clear access to known cases of concern.

- A CSE themed audit was undertaken to have an overview of multi-agency practice in identifying and responding to allegations of CSE.

- Multi-agency training with Barnados was delivered by the LSCB as well as a learning lunch where local workers shared their experience of working with CSE in the area and informing agencies to the services in the borough.

- In recognition of the link between group and gangs and child sexual exploitation, a learning lunch workshop was held in February and

safeguarding and gangs has been included in the 2013/14 multi-agency training programme.

Supporting and monitoring organisations in the identification and response to Neglect in the borough.

- In April 2012, the LSCB published a SCIE review of a family where neglect was a key issue. It raised a number of concerns over agencies ability to identify and respond to Neglect.

- Neglect was the theme of the LSCB's 2nd Annual Safeguarding conference with National and local speakers including Action for Children.

Key areas of progress and achievements in 2012-13

- Completion of Section 11 audit of safeguarding arrangements in eight agencies; including the police service, housing and children services.

- The development of a bi monthly LSCB newsletter to facilitate communication of local and national safeguarding issues

- Development of Learning lunches providing bite-size learning opportunities for professionals across all agencies, sharing local experience

- Building on 3rd sector's (voluntary services) involvement with safeguarding by holding two joint 3rd sector safeguarding events which included the involvement of adult safeguarding leads

- Revised multi-agency pre-birth guidance document with the aim of :

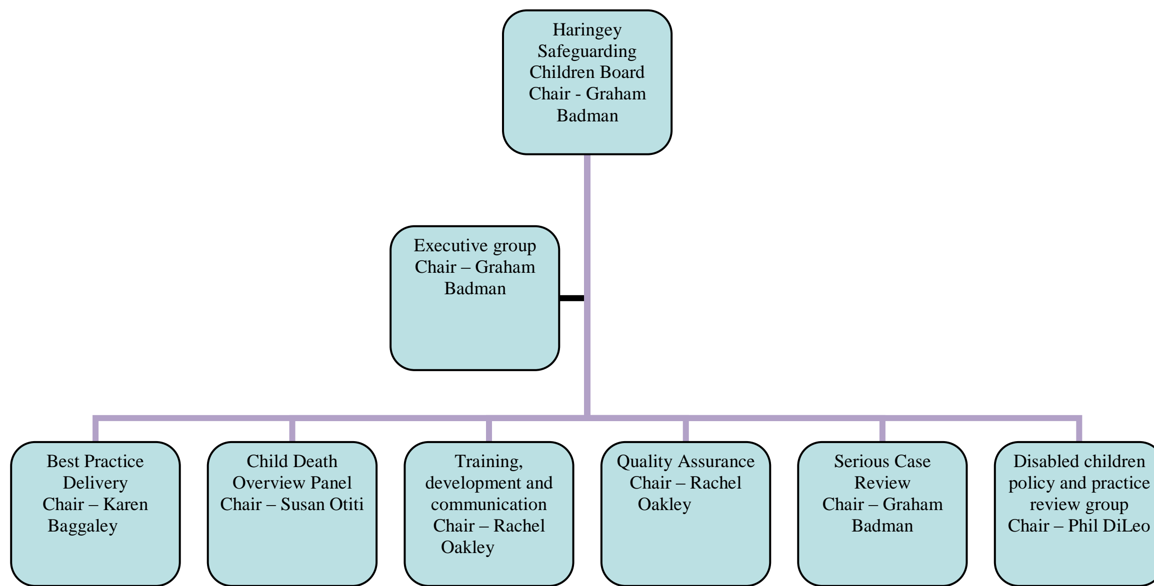
  - Increasing awareness across the partnership
  - Increasing referrals to the Family Nurse Partnership (FNP)
  - Increasing use of pre-discharge planning meetings
  - Reducing late referrals to the Safeguarding panel.
  - Increasing pre-birth planning and support for young people previously Looked After or those currently Looked After.

- Continued to deliver and develop high quality and up to date multi-agency training

Section 4 includes more detail on the work of the LSCB and its partners.

Section three – Effectiveness of the LSCB - Governance and accountability arrangements

Structure chart



Chairing and membership arrangements

- Graham Badman continues to be the Independent chair of the board, a post he has held since 2009.
- The board met every two months throughout the year, a total of 6 times.
- The work of the board is progressed through its sub groups and time limited working groups. Haringey has six subgroups - each has an annual work plan that is agreed by the board.
- There is also a task group which reports to the board on Child Sexual Exploitation.
- As of October 2012, the working group that focuses on disabled children, which previously reported into the Quality Assurance sub group, was recognised as a sub group in itself and now reports directly to the LSCB.
- There is also an executive group of the LSCB Board, which comprises leads from each of the key statutory agencies, together with the Independent chair and Business manager. Changes are being made to include the chairs of all the sub groups; this will strengthen the board's oversight of its own

performance and effectiveness as well as provide sharper focus on evaluating the improvements of the help, care and protection being provided to children and young people in Haringey.

- The board will become even more transparent and have further scrutiny and challenge with the inclusion of the newly appointed lay member. The Lay person will be in post summer 2013.

- The board regularly reviews its priorities and the work of its groups through the board and executive group. It takes into account learning from other boards and national research.

- The board work will continue to review how it can demonstrate the impact of safeguarding activity on the outcomes for children and young people

Engagement of partners

- To ensure that safeguarding work is co-ordinated and monitored effectively it is important the board has the right representatives and that they have a clear understanding of their roles and responsibilities. There is always a balance between needing the right people and the optimum size for a meeting to progress business effectively. The current board has 35 members.

- Member's attendance is good for a Board of this size. A full schedule on attendance can be found in appendix 2

- There were changes in representation from schools, but in late 2012 the board welcomed Head teachers from both primary and secondary who have added much value.

- This year has seen the joining of the London Ambulance Service and the re-joining of the voluntary sector to the board.

Relationship between the LSCB and the Children Trust and other strategic boards

- The Children's Trust was re-established this year and the chair of the LSCB is a member and is there to provide challenge and share the views of the LSCB so consideration can be given when commissioning and developing services. In addition the lead member for children services chairs the Children Trust and is a member of the LSCB

- Haringey has a Shadow Health and Wellbeing board. Boards will take on their statutory functions from April 2013 and will be a forum for key personnel from health and care systems to work together to improve the health and wellbeing of their local population and reduce health inequalities. In February 2013, the LSCB annual report was presented to the Shadow board.

- In addition health will have significant changes with the establishment of the clinical commissioning group. The lead doctor has been invited to join the LSCB.

Role of elected members and directors of children services

- In May 2012, Councillor Lorna Reith left her post as lead member for children. New lead Member for children Councillor Ann Waters, who took up her place on the LSCB as a participant observer.

- The DCS continued to work closely with the LSCB chair and hold the chair to account for the effectiveness of the LSCB.

Financial arrangements

Income 2012/13

Agency	Contributions (£)
Children Services	£189,697.02
Metropolitan Police	£5,000
Whittington Health	NIL
North Middlesex University Hospital	NIL
BEH –MHT	NIL
Cafcass	£550
Probation	£2000
Tottenham Hotspur	£2000
Total	£199,247.02

Expenditure 2012/13

Narrative	Budget (£)
Salaries	132,879.12
Trainers	14,410
Administration/Equipment	1341.15

Catering	2021.82
Consultancy	35,208.09
Other (LSCB expenses)	550.92
Publicity	1901.70
Venues	5150
Total	193,462.80

- Contributions to the board are both financial and non-financial. Due to the changes around the administration of the board, 2012/13 demonstrated some of the challenges that can arise when financial contributions are not agreed in the preceding year. Although in 2012-13 the financial contributions were highly dependent upon Children's Services, other agencies (particularly health) have made notable contributions in terms of release of staff time.

- As some agencies cover other boroughs there can also be variations in the amounts contributed.

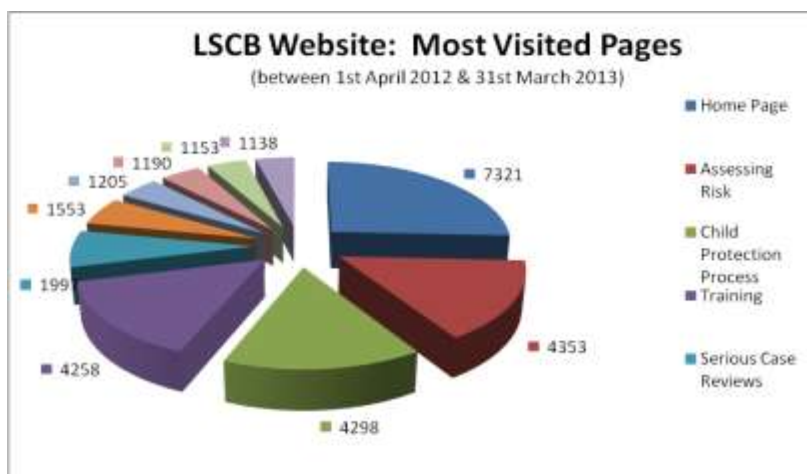
- For the year coming contribution amounts have been agreed in advance, which will lead to more effective planning and moving tasks forward.

Haringey LSCB Website and communication

- Over the year the LSCB has made attempts to improve how it communicates information and feeds back progress to practitioners across all organisations.
- The introduction of a regular newsletter and the improvement of the News website page enable's the LSCB to detail local and national safeguarding activity. This in turns enables professionals and the public to have an understanding of what work is been carried out.
- The regular "inside story" feature in the newsletter has been very welcomed and allows practitioners to share their child protection experiences from their view and has included stories from; a GP, teaching assistant and youth offending officer.

	April	May	June	July	August	September	October	November	December	January	February	March
2010-11	1692	1820	1674	1561	1210	3116	4045	2743	2414	3385	2425	3010
2011-12	2534	3408	3042	3303	2166	2979	3062	3173	1982	4106	3809	3967
2012-13	5108	5054	3033	3668	3075	3602	5301	4564	3397	4435	4148	7116

- There has been a significant increase in people accessing the LSCB website this year



- The chart above shows the top 10 most visited pages with number of hits.
- The LSCB training programme 2012-13 was downloaded 688 times between April 2012 and March 2013.
- The Scie Review on our Serious Case Review page was downloaded 741 times between April 2012 and March 2013 and had the longest page view of 8minutes 3 seconds.

Section four –LSCB subgroup activities

The key aim of the work of Haringey's LSCB sub groups and working groups is to impact on local arrangements and outcomes for children.

This section provides a summary of each sub group's work this year.

LSCB Sub groups

Child Death Overview Panel (CDOP) Chair - Assistant Director, Public Health

Remit: To review the circumstances surrounding all child deaths and make preventative recommendations where possible; to ensure a rapid response to any that are unexpected.

Over the year:

- There were 3 Child Death Overview panel meetings and 1 rapid response meeting.
- There were 20 deaths notified; a decrease on last year.
- The panel closed 15 cases, though none were for the current year.
    - Two children were known to the social services disability team and one child had a child protection plan due to parental mental health. This was unrelated to the death of the baby at four days old.
    - There were no suspicious deaths and no particular patterns of disease.
- An analysis of a single year's deaths, because of the small numbers involved, would be limited in its value. As the CDOP process has now been in place for five years (2008-2013) a review of this period is being carried out with the local authority public health department."

Quality Assurance Sub Group Chair - Head of Safeguarding, quality assurance and development, CYPS

Remit: To monitor the effectiveness of multi-agency child protection work through data analysis and audit processes

- The Quality Assurance sub group met 5 times and had a change of chair towards the end of 2012. As the LSCB's key group to oversee the performance of agencies, this years has been a challenge and has involved a review of the dataset and its effectiveness. As a result, the LSCB QA Sub-Group has undertaken a commitment to develop a new performance framework, based on a model developed by LSCBs in the Eastern Region as

part of the region's sector-led improvement work. The model is based on linking vision to performance, and understanding "what good looks like". It identifies priority outcomes and asks the question 'how will we know?' that these are achieved.

- The aim is to base this on the current priorities already agreed by LSCB, and to use the framework to provide a clear view of progress on the journey to realising them. If used successfully it is hoped that the framework will help to focus the board's attention on measuring achievement against its ambition, and reduce duplication of 'in agency' monitoring which can commonly be a distraction for LSCBs. It is also the intention that the framework will make more visible the contribution of partners, who will need to be fully engaged with its development.

- The framework gathers together a range of types of evidence including data and statistics, messages from audit, the voice of the customer and of staff, and professional expertise or other evidence. It is expected that the process of identifying the necessary evidence will include a range of existing measures and material, but will also highlight where development of further evidence sources may be necessary, or where new insights might be gained by bringing together information held by partners. It will also be necessary to define a tightly focused set of data which is required to monitor the core functions of the LSCB. The approach is both mindful of, and supports, the new requirements of the DfE Safeguarding Performance Information Framework[4] [born of the recommendations of the Munro Review], and some of the more soft-edged local information requirements it contains. Many of the "How do you know...?" questions which are a large part of the local information component [i.e. those which should be monitored in local areas, but which are not reported to central government] fit closely with the framework's use of customer and staff feedback.

The development of the framework is scheduled to begin during the first quarter of the 2013/14 financial year.

Serious Case Review Sub Group Chair - LSCB independent chair

Remit: To decide when to undertake a review and to monitor implementation of action plans.

- When a child dies and abuse or neglect is known or suspected to be a factor in the death, the LSCB should always conduct a Serious Case Review. The LSCB should consider undertaking a review whenever a child has been seriously harmed and the case gives rise to concerns about the way in which local professionals and services worked together to safeguard the welfare of the child.

[4] http://www.education.gov.uk/childrenandyoungpeople/safeguardingchildren/protection/b00209694/perf-info

- The LSCB undertook 2 management reviews during the year, one of which became a Serious Case review.
  - 1 review involved a SUDI (sudden unexplained death of an infant) – this raised learning over co-sleeping and the advice given by professionals to parents.
  - 1 review involved a child under 5 and concerns over physical harm, the findings resulted in the SCR sub group agreeing a Serious Case Review should be undertaken. This is now underway and should be completed Summer 2013
- There were no SCR's completed during this year.
- The learning from reviews conducted during this year will be published in next year's Annual Report.
- Professor Eileen Munro recommends that LSCBs adopt 'system' methodology in conducting Serious Case Reviews in order to move beyond identifying what happened to explain why it happened. In their response the Government has clearly agreed that such approaches should inform further consideration. Haringey LSCB took the opportunity as part of the pan London pilots to trial a SCIE methodology review on a case
- This review was completed in 2012/13 and looked at the neglect of children in a family.
- The process engaged both frontline practitioners and managers in a reflective process of learning and action planning. The response from those directly involved in the process has continued to be very positive. The report can be found on our website. Details of the learning from this review are in section five.
- A session was held on the findings of the SCIE and involved staff and managers in the learning process. It is the responsibility of each partner agency to ensure that lessons from Serious Case Reviews are disseminated to both managers and frontline staff.
- There have been changes to raise the standards to the process of referring cases to the SCR sub group with the introduction of a referral form as well as guidance notes being provided to assist agencies with the completion of their Individual Management Review reports (IMRs).

Best Practice Delivery Sub Group (BPD) Chair - Designated Nurse for Child Protection, North Central London

Remit: To turn the learning from serious and other forms of case review into effective operational practice

- There were six meetings held this year and a range of safeguarding issues were reviewed including:

  - Early Years provided a report of safeguarding arrangements for child-minders, children centres and are now members of the sub group. The report set out the approaches being taken which include the Haringey Quality Improvement and Accreditation Scheme in use across all private, voluntary and independent providers (PVIs) who deliver the 3&4 year old free entitlement and the requirement of all designated Child Protection officers to attend a termly safeguarding forum to support their expertise.

  - A similar scheme has been developed and is now in place for child minders. Support is available for child-minders regarding Ofsted registration. All child-minders are required to attend basic safeguarding children training with updates every three years. This training is specifically tailored to meet the needs of child-minders and since 2012 an advanced training is also available.

  - The Safeguarding Forums held for children's centres led by children's social care and each centre has an identified Family Support Worker. All children's centres receive an updated list of children subject to a child protection plan each month.

  - Child Protection Conference Process pilot was reviewed. This was a large scale piece of work which began in November 2011 whereby all the reports for the conference are read in the 30 minutes available prior to the start of the conference leaving more time for discussion and analysis of risk and need by participants and family. Each attendee of the conference records his/her analysis and view as to whether a child protection plan is required before each person is asked. A plan is then made to address the needs and reduce the risk.

  - The final evaluation report was discussed at the sub group in February and circulated to agencies.

  - Parents, carers and, where appropriate, children informed the evaluation report of the child protection process.

  - An audit on the involvement of GPs in the child protection process was discussed in the sub group which highlighted a number of issues: significant number of incorrect GPs being invited to the initial conference (this was largely resolved by the review conference), number of reports from GPs recorded on the minutes, and quality of the reports. Joint work is currently underway between Haringey Clinical Commissioning Group and Children and Young People Service (CYPS) to address these issues.

Training, Development and Communications Sub Group Chair - Head of Safeguarding, Quality Assurance and Practice Development (CYPS)

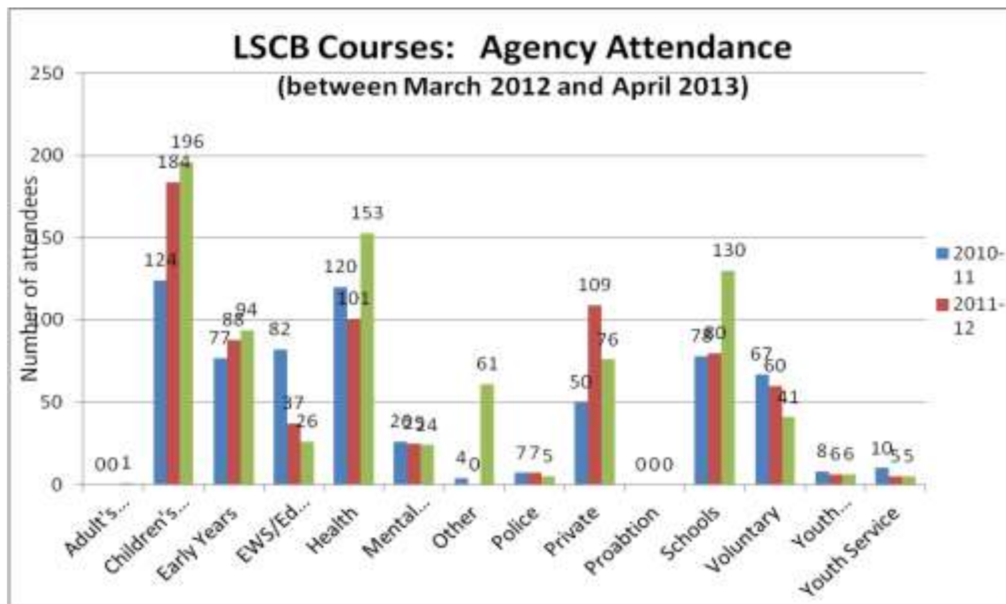
Remit: To oversee the delivery and evaluation of a multi-agency training programme and monitor the degree to which partner organisations are ensuring a 'safeguarding-aware' workforce

- There were 6 meetings held of the training, development and communication sub group.
- This year there were significant changes in the training programme which included the introduction of courses such as E-safety, to support professionals around safeguarding children in the digital world.
- The programme also had the inclusion of learning lunches, an opportunity for agencies to get bite size learning during their lunch hour. These sessions have been a great success seeing numbers of participants exceed 60 for some sessions. These sessions provided a local context to a variety of issues raising awareness of the local picture and the local response. Sessions have included Child Sexual Exploitation and Female Genital Mutilation.
- As part of the ongoing evaluation of training the LSCB training officer carried out a review of the impact of training, producing a report for the board.

Impact of training

- Haringey LSCB uses a range of approaches to ensure the quality of single and multi-agency training, including the Annual Training Return (that seeks to identify quality and quantity of single agency training as well as multi-agency training received across agencies), using a tendering process to commission trainers, employing clear contracts for internal and external trainers, course evaluations, and quality assurance of courses offered.
- A moderate review of the literature to research others' learning on linking training to practice and outcomes for children and young people was conducted.
- In order to explore further the link between training, practice and outcomes for children and young people, an Evaluation Pilot was carried out, to see whether other methods of evaluation might be preferable to, or might supplement, the current 'happy sheet' evaluation and quality assurance of courses.
- The purpose of the evaluation pilot was to evidence the impact of training on practice and on outcomes for children and families. Although the evaluation pilot did bring up some interesting data, the response rates were so low as to make an effective analysis of the data difficult.

Agencies attending multi-agency training



- 1059 (966 last year) applications were received throughout the year
- 818 (701 last year) of those attended the course, 182 did not attend and 59 cancelled- (17 courses were run throughout the year by external trainers)
- The agency with highest attendance is Children's Social Care with 196 applicants

Agency Attendance	2010-11	2011-12	2012-13
Adult's Social Care	0	0	1
Children's Social Care	124	184	196
Early Years	77	88	94
EWS/Ed Support	82	37	26
Health	120	101	153
Mental Health	26	25	24
Other	4	0	61
Police	7	7	5
Private	50	109	76
Probation	0	0	0
Schools	78	80	130
Voluntary	67	60	41
Youth Offending Service	8	6	6
Youth Service	10	5	5
Totals	653	702	818

Disabled children's policy and practice review group Chair - Head of service to children and young people of additional needs and disability

Remit: This group took recommendations from DCSF Guidance 2009 on Safeguarding Disabled children to provide its work plan and framework for the year.

The Disabled Children's Policy and Practice Review group became a formal subgroup to the LSCB in November 2012. The priorities for the group were:

- Domestic Violence and Disabled children,
- poor attendance at school masking CP issues for Disabled children,
- home educated Disabled children,
- Multi-agency audits, review of children who have SEN, at school action plus and one additional external service and on the threshold of CP.
- The effectiveness of Multi disciplinary team meetings in Special schools was reviewed.
- The impact of short breaks services on improving family's resilience was reviewed.
- Haringey's Threshold for continuum of need and intervention has been developed to include a more detailed definition of the threshold as it applies to Disabled children.
- Role of transport / escorts in safeguarding
- Lines of enquiry listed above has challenged professionals' practice in authorising absences, monitoring home education programmes; screening for DV etc
- Work informed development of new descriptors;
- Head teacher from Independent special school and who works with different LAs has shared practice with those LAs and applied lessons learned;
- Number of disabled CIC placed in residential schools has reduced and slowed the rate of disabled children requiring care;
- Further work underway as to how all services can maintain and share chronologies
- Special schools report that MDT meetings have demonstrated efficient and effective use of professional's time; improved working together and sharing of information; increased management of risk at school level; improved referrals enabling clear decisions to be made against thresholds.

The group also:

- Raised awareness of complexities involved in safeguarding disabled children across social care, education and health professionals;
- Detailed case reviews subject to evaluative and reflective multi agency discussions;

- Shared and tested Special school safeguarding policies to ensure fit for purpose;
- Gained clearer information from children during CP investigations and medicals using communication packs.

Participation of children and their families

- All permanent positions in the Additional Needs and Disability (AND) service involve parents of Disabled children and a youth panel of Disabled YP as part of our safer recruitment process.
- Regular meetings with parents / carers / providers including developing short breaks, personal budgets, transition, secondary transfer, starting school, preparing for changes in legislation. Attendance at all sessions has been from 60 – 100 parents on each occasion which has contributed to parents being well informed and there is evidence of how this has directly influenced decision making.
- Children within one of our Special schools are being consulted on the Threshold document regarding the descriptors of abuse for Disabled children.

Task groups

Child Sexual Exploitation Task group

- Child Sexual Exploitation (CSE) has been high profile nationally most notably due to cases in Oxford, Derby and Rochdale as well as the Children Commissioner's office review of CSE.
- Haringey set up a CSE group a year ago and have gone through a change of chair this year with the departure of the previous chair who had been leading on the work. Over the latter part of the year the group has re-established itself and has completed the multi-agency CSE protocol and will launch the protocol in the summer.
- A multi-agency themed audit was undertaken looking at the identification and response to CSE. The key findings were that CSE was identified appropriately and the initial response was appropriate. There was concern over the response from the agencies working with the families after the initial identification. As CSE awareness is raised future audits will take place to see if there is an improvement.
- Work is underway on mapping out the prevalence of CSE in the borough and what services are currently available. This will be captured in a report and made available to the board later in the year.

Allegations against professionals – LADO

Key development work completed in 2012/13[5]

- Review of the thresholds for progressing referrals to strategy meeting stage – to ensure referrals receive the appropriate level of response.

- New workflow designed resulting in a process that is explicit to all

- The documentation and guidance has been reviewed and updated

- Development of confidential electronic recording system (on framework-i) for LADO referrals, improving recording and reporting capability significantly, resulting in following improvements operational from 1st April 2013:

    - service able to record and report in detail on all consultations and allegations which meet threshold

    - capture and reporting of all performance related data such as nature of referral, referring agency, setting of employment

    - capture and reporting of diversity data of alleged perpetrator(s) and alleged victim(s)

    - ability to compare and contrast data with allegations made within perpetrators own families or outside work

    - reporting of outcomes

    - reporting of length of time to resolve cases

- Development of system for recording and monitoring consultations.

- The LADO attends forums for Designated Teachers of primary and secondary schools and Children Centre meetings.

- The LADO action plan was updated in line with the last OFSTED recommendations and implemented.

Defined and communicated clear respective responsibilities of the referrer, HR and the LADO. This includes defining the criteria and boundaries in the process for a range of outcomes e.g. cases that meet the criteria for suspension.

Referrals that met threshold - There were 46 referrals to the LADO that met the threshold for involvement. This figure is broadly in line with our neighbouring boroughs.

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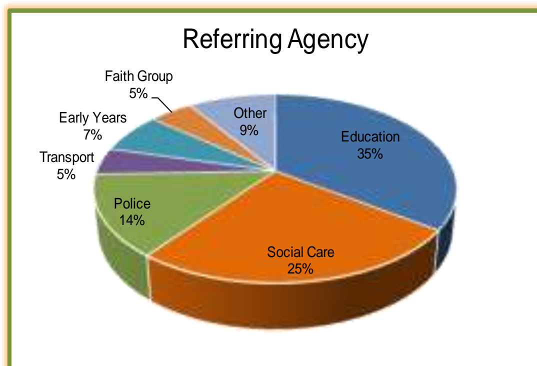
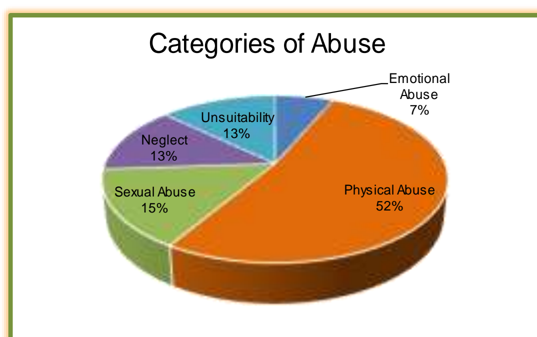
[5] *Reported activity is limited to quarter 3 and 4. Appointment of LADO and transfer of oversight of work to Head of Service for Safeguarding, Quality Assurance and Practice Development, made at the end of September 2012.*

The following charts illustrate the breakdown of referrals by referring agency and by categories of abuse



Referring Agencies - The large majority of contacts with the LADO came directly from the educational setting itself and account for 35% of referrals in total. The remaining educational referrals came via CYPS staff or the police after parents had approached them.



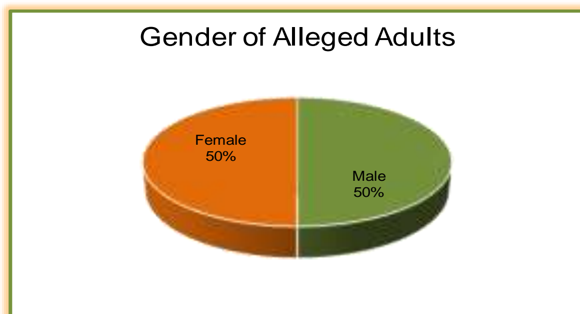
Categories of abuse - The largest category of allegations by type was physical abuse this primarily occurred in educational settings and accounted for 52% of allegations that met threshold and 59% of all allegations received.

- The majority of these allegations relate to teachers and support staff having trouble in managing challenging behaviour and the use of restraint regarded as being unlawful or contrary to guidance.

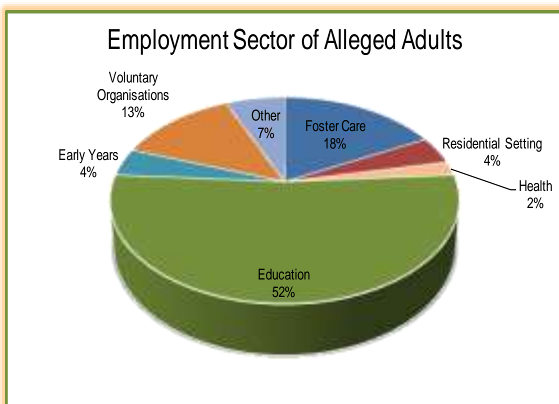
- In particular, the issue of appropriate restraint and personal protection by teachers when a child is out of control was a feature of a significant number of the allegations investigated. Analysis highlighted a positive correlation with a lack of understanding and interpretation, of the relevant legislation.

- Although there was a predominance of allegations in relation to physical and sexual abuse, it was notable that the individual circumstances of the allegations varied significantly. This demonstrates the need for designated professionals and senior staff responsible for safeguarding to have an awareness of the range of situations in which children could be harmed and how what meets the threshold for intervention by the LADO.

Profile of adults that allegations have been made against



Of the 46 referrals to the LADO, there were an equal number of women and men referred.



The majority of referrals came from state schools, with only one by an Independent Academy. There are a low number of referrals from other sections, such as Early Years and children's residential provision. The lowest reported sector was Health. There have yet to be any referrals from Police[1].

Comparative Data

- The number of allegations (46) investigated in the year 2012/13 represents a considerable decrease from the 87 allegation deemed to have met the threshold in 2011/12. This reduction is a result of successful changes in application of the thresholds, LADO consultation and advice resulting in addressing issues through more appropriate channels such as HR procedures or through focused learning and development.

- During 2012/13, the largest numbers of allegations were made in respect of foster carers, the majority of these allegations subsequently being withdrawn or found to be unsubstantiated. The reduction in referrals that have been converted into investigations represents further improvement in the appropriate application of thresholds and focus on situations that meet the criteria for statutory intervention. Analysis of referrals since October 2012 that have led to investigation and those that did not meet the threshold has shown that the appropriate decisions have been made. Feedback from partner agencies including schools and children's centres indicate an increasingly high level of satisfaction and understanding of the process and thresholds.

Substantiation of Referrals

- In six months between October and March 2013, 56% of allegations taken to strategy meeting were substantiated (25% of these led to a criminal prosecution, with half of this number being convicted and other awaiting the outcome of the proceedings) and 25% of allegations were unsubstantiated of which one was found to be malicious.

- It should be noted that when an allegation is deemed to be unsubstantiated this does not necessarily equate to it being unfounded, but rather there is insufficient evidence to substantiate the allegation.

Community Partnership - Pamela Pemberton, HAVCO

- There are some 1000 Voluntary and Community Sector (VCS) organisations working in Haringey and a large proportion of them provide services to children, young people and their families.

- At the height of Haringey's Strategic Partnership (HSP) there had been organised engagement with voluntary sector partners operating in the children and young people's sector. Since the demise of the HSP the Local Children's Safeguarding Board has filled this gap by working closely with HAVCO late last year to ensure that voluntary sector providers are aware of their safeguarding responsibilities and to seek better ways of cross-working.

- The first important change that occurred is that HAVCO joined the LSCB in October 2012. Since this time the organisation, in conjunction with the LSCB and Children England, held two important events; the *Safeguarding Today Seminar* in December 2012 and *Core Standards Training* in March 2013. Approximately 90 VCS organisations in total, participated in these events.

- Through this engagement and support the VCS have: a) become more aware of how to access key resources to help them navigate their way through vetting and barring changes via the Safer Network website, b) consolidated a safeguarding priority list and c) developed two reports from the consultation and training as reference for future developments.

- Key partners need to maintain and build upon this momentum and the LCSB, Children England and HAVCO are currently looking at what we can put in place, given limited resources, to ensure that engagement between statutory leads and children and young people voluntary sector providers are held regularly, enabling the VCS to influence policy and service developments whilst developing and strengthening the VCS workforce to manage safeguarding issues effectively.

- Our ultimate goal is that ongoing engagement between partners improves and protects the lives of children, young people and their families living in the Borough.

Section Five – Local Safeguarding performance data

Quality assurance monitoring

In 2012/13 the LSCB has continued to challenge the performance of partner agencies to ensure the effectiveness of arrangements to keep children safe. This has been done by:
undertaking a multi-**partnership Section 11 audit on agencies' safeguarding** arrangements including on-site visits to confirm the evidence detailed in the self assessment returns. There is more detail later in this section.

Safeguarding data

Long term trend	2009/10	2010/11	2011/12	2012/13
The Number of child contacts received	14,355	9,556	6,722	6,637
The number of referrals to children social care	3324	2658	2509	2045
The percentage of referrals to children social care going on to initial assessment	-	84%	99%	87%
Percentages of re-referrals within 12 months of the previous referral		19%	17%	15%

- There has been a small reduction in contacts and a significant reduction in referrals to children social care in 2012/13.
- There is a continued reduction in referrals to children social care
- The percentage of re-referrals continues to reduce

Long term trend	2009/10	2010/11	2011/12	2012/13
Percentage of initial **assessments for children's** social care carried out within 10 working days of referral	-	66%	71%	70%
Percentage of core **assessments for children's** social care that were carried out within 35 working days	47%	63%	66%	70%

Long term trend	2009/10	2010/11	2011/12	2012/13
Children subject to a child protection plan	294	320	284	275
Children becoming Subject to a child protection plan in the period		334	277	354
Children ceasing Subject to a child protection plan in the period		-308	-313	-363
Haringey Net Change		*26*	*-36*	*-9*

Long term trend	2009/10	2010/11	2011/12	2012/13
Children moving to Haringey on a child protection plan	-	-	11	25
Children moving out of Haringey on a child protection plan	-	-	-32	-27
Haringey Net Change	-	-	*-21*	*-2*

Long term trend	2009/10	2010/11	2011/12	2012/13
Child Protection Plans lasting 2 years or more	16.9%	5.8%	6.4%	7.0%
Percentage of children becoming the subject of Child Protection Plan for a second or subsequent time	-	9.0%	10.5%	4.8%
Percentage of child protection cases which were reviewed within required timescales	96%	98%	97%	95%

Long term trend	2009/10	2010/11	2011/12	2012/13
Child Protection Visits	-	92%	95%	94%
Children in Need Visits	-	69%	81%	85%

Long term trend	2009/10	2010/11	2011/12	2012/13
Care Proceedings Initiated– (No. of children)	-	243	137	117

Key headlines:

- There has been a reduction in contacts to Children Services over the past 12 months. This could be due to the efforts by the screening team to develop stronger relationships with referrers and providing clear advice around thresholds and information sharing.
- There has been a pro-active effort to have discussions with referrers to ensure that only those contacts that require statutory assessment are progressed and alternative strategies such as the use of CAF and the voluntary sector that do not meet the criteria.

- The low re-referral rate is an indicator that referrals to children social care and the work of the first response team is effective and resulting in low referral back into Children services
- The % of IA's completed in 10 days is below that of statistical neighbours. As of 2013/14 there will be the introduction of the single assessment, which will set targets of seeing a child within 10days.
- There has been an improvement in the completion of core assessments. Children services managers will need to be more focused in 2013/14 with the changes to a single assessment and management oversight to ensure targets on completion dates are met.
- There has been a 58% reduction of children with disabilities being subject to a CPP.
- There has been a decrease in the number of care proceedings initiated.

AUDITS, REVIEWS and EVALUATIONS

The partnership undertakes audits, reviews and evaluations throughout the year both multi-agency and single agency to provide assurance of the safeguarding practices and arrangements in Haringey and to improve single and multi-agency practices.

In the past year these include:

- 7 - Audits carried out by Barnet, Enfield and Haringey Mental Health Services
- 2 - Multi-agency carried out by LSCB
- 2 – Audits by the disabled children policy group
- 1 – Audit by health in respect to GPs
- 1 – Audit on core groups
- 1 – Audit by NMUH
- 1 – Audit on conference attendance by CYPS

An audit of Child Protection cases held in the safeguarding and support team was completed – identified issues of thresholds and effectiveness of CP plans. This team have actively looked at the findings. The audit also raised the issue on transfer between teams in Children social care and changes are taking place from April 2013 which involves the inclusion of the new social worker at the initial conference which allows CP plans to be progressed more quickly and less drift.

Child Protection Conference Pilot

An evaluation has taken place on the new child protection conference model which was piloted in Haringey Council in October 2011. The model was developed by the

Child Protection Chairs, who based it loosely on the Strengthening Families model of conferencing.

Section 11

- Section 11 (s11) of the Children Act 2004 places a statutory duty on key persons and bodies to make arrangements to ensure that, in discharging their functions, they have regard to the need to safeguard and promote the welfare of children and that the services they contract out to others are provided having regard to that need. Improving the way key people and bodies safeguard and promote the welfare of children is crucial to improving outcomes for children.

- *Working Together to Safeguard Children* (2010) requires Local Safeguarding Children Boards (LSCBs) to monitor the effectiveness of organisations' implementation of their duties under s11 of the Children Act 2004. The LSCB has a key role in achieving high standards in safeguarding and promoting welfare, not just through co-ordinating services but also through evaluation and continuous improvement. For example, by asking individual organisations to self-evaluate under an agreed framework of benchmarks or indicators and then sharing results with the Board.[6]

- This is the first s11 Audit commissioned by Haringey LSCB

- The key requirements from the statutory s11 guidance are as follows:

    - senior management commitment to the importance of safeguarding and promoting children's welfare;

    - a clear statement of the agency's responsibilities towards children, available for all staff;

    - a clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children;

    - service development that takes account of the need to safeguard and promote welfare and is informed, where appropriate, by the views of children and families;

    - staff training on safeguarding and promoting the welfare of children for all staff working with or (depending on the agency's primary functions) in contact with children and families;

    - safe recruitment procedures in place;

    - effective inter-agency working to safeguard and promote the welfare of children; and,

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[6] *Working Together to Safeguard Children (2010), 3.28*

- effective information sharing.

- The Haringey LSCB s11 audit incorporates the standards for the areas of 'child protection' and 'safer staff and volunteers' with the addition of Ofsted standards for the effective functioning of an LSCB and in Section 12 of the audit, outstanding actions arising from Ofsted/CQC inspections in Haringey in early 2011. These relate almost entirely to Children's Social Services (CSC) only.

  - Adult Social Care – Haringey Council
  - Children's Social Care including Children with Disabilities Team– Haringey Council
  - Metropolitan Police - CAIT
  - Probation Service
  - North Middlesex University Hospital Trust
  - Whittington Health
  - Barnet, Enfield and Haringey Mental Health Trust
  - Haringey Housing (incorporating both Homes for Haringey and Community Housing) (H4H)

- Compliance with, and commitment to, the process was high across all agencies. Based on discussions at site visits it was evident to the Assessment Team that all agencies took their safeguarding responsibilities very seriously and saw the s11 audit process as a valuable opportunity to reflect on and improve standards. In this respect the process itself has a real value in raising awareness of what still needs to be done as well as highlighting where things are going well. The Assessment Team felt that this was particularly the case in those agencies where the primary focus of the work is providing services to adults – Probation, Housing and Adults Services, who all saw the audit as a vehicle for strengthening how they respond to the needs of children who may be at risk.

- Individual agency action plans will not be presented in this report. All agencies are responsible for monitoring their own action plans. Statutory agencies are also responsible for monitoring the action plans of commissioned agencies and ensuring that any areas of non- or part-compliance are addressed… Areas identified for improvement will be collated by agency and used as the basis for their action planning. The Board asked for progress reports from statutory agencies at the end of the year

Cross cutting themes

- These themes emerged as significant across a number of agencies but do not necessarily apply to all. Nevertheless they are issues which all agencies

need to keep consistently in mind when reviewing their arrangements under s11

- Processes for ratification of single agency policies and procedures by the LSCB need to be clarified and strengthened

- All agencies need to review and strengthen internal communication processes for making staff aware of policies and procedures and organisational and professional accountability frameworks. This is particularly the case in Adult focussed services for whom embedding staff awareness of safeguarding children is a priority action

- All agencies need to strengthen processes for disseminating learning and data in relation to safeguarding to staff

- All agencies need to strengthen arrangements for listening to children at a practice level

- All agencies need to strengthen arrangements for incorporating the views of children and families into service and business planning

- All agencies need to ensure that all staff are subject to a robust induction process

- All agencies need to ensure that all staff receive the appropriate level of supervision commensurate with their roles and responsibilities

- More opportunities should be afforded for staff and managers from all agencies to discuss issues of mutual concern and to share good practice

- Where sub-contractors are used to deliver services to children all agencies need to ensure that they are fully compliant with s11 standards

- Work needs to continue in strengthening the use of the Common Assessment Framework (CAF)

- All agencies need to strengthen their relationship with the Local Authority Designated Officer (LADO)

Inspections

- In January 2013, the LSCB were presented with the results of the Safeguarding Practice Peer Challenge (SPPC) pilot undertaken by the Local Government Association (LGA) and the Children's Improvement Board in November 2012. As a first step in responding to the recommendations presented to the LSCB, they have agreed to commission an independent reviewer to conduct structured interviews with key agencies and staff nominated by the board. The interviews are to determine practitioner's views on thresholds and early help as above and to confirm whether agencies are content that they have both the correct protocols and sufficient resources in place when concerns about children are escalating and urgent information

sharing is required. These views will be presented to the board along with the review of the application of thresholds and early help by social workers so that partners can determine whether any further action is needed.

- The findings of this review will be commented on in next year's report.

Learning from case reviews - Neglect

Neglect is the most common reason for children being on child protection plans.

- In April 2012 the LSCB made public a report of professional's involvement with a family where neglect was a concern. The report highlights the failings to identify and respond to Neglect. The SCR sub group agreed to pilot a systems methodology developed by the Social Care Institute for Excellence (SCIE).

- The review looked at the chronic neglect of a number of children – both boys and girls - who were removed from home by the police under powers of Police Protection and placed in local authority care at the end of April 2009. Both parents were arrested, charged and convicted and both have served custodial sentences. At the point that the children were taken into care they were known to a range of agencies and had been known to children's social care since 2002.

- The report provides a clear narrative of what a lack of understanding of the nature and causation and impact of Neglect can have on a child's emotional and physical development

> ***"..because without an understanding of the causation, manifestation and cumulative impact of chronic neglect, responses in the future will inevitably, be generally wanting" SCIE Learning Together, Haringey LSCB , Report of the Review of Family Z, 2012, p18***

- The systems approach requires the review team to learn how people saw things at the time and explore with them ways in which aspects of the context were influencing their work. This is known as the 'local rationality'. It requires those involved in a case to play a major part in the review in analysing how and why practice unfolded the way it did and highlighting the broader organisational context.

- There were limitations to the review; for example some staff had left the borough and the family were not involved and therefore their view on professional's involvement was not captured. However, using the methodology the review team identified eight underlying issues in 3 areas.

Management systems

1. The absence of a coherence between family support services and emergency response

2. Autocratic management style creates fear, paralyses thinking and prevents

constructive case work challenge

Long term work

3. Inadequate understanding of the causation and impact of neglect across agencies

leaves professional efforts misdirected

4. No shared culture of authoritative challenge amongst professionals allowing for the

exploration of disagreements

Tools

5. Design of work processes and procedures makes it difficult to respond *as effectively* to neglect as to incidents/injuries

6. Computer systems can make it difficult

Cognitive and emotional biases

7. Absence of systems to promote review of professional judgements

Family-professional interaction

8. No effective challenge to, or ability to work with, non-engaging families

Section Six Effectiveness of safeguarding in Haringey and Key recommendations

This report aims to reflect the current state of safeguarding activity across Haringey and some of the work that has gone on in the last year. Many areas of the work the LSCB and its partners conduct is concerned with activity or output. It is not always easy to identify the outcome, or the result of the actions we take but our aim is to try and maintain a focus on what is happening on the frontline for practitioners and the actions that make a difference to a child or young person. The board will continue to ask the questions on how well are children and young people helped, cared for and protected. This will sometimes involve making informed judgements about likely impact, for example, the effectiveness of training in helping professionals take action if they are concerned about a child. The Board has knowledge of many of the services that the partners offer around early help and child protection, both individually and collectively. In many areas the board can say that partnership working is good, for example: the MASH.

The board has collectively challenged and assured itself around the effectiveness of safeguarding in a number of areas over the year including:

- Ensuring that there were clear local arrangements in place for safeguarding in health whilst the NHS reforms of moving towards Clinical Commissioning Groups. There was recognition that potential risks associated with reforms would be mitigated in part due to the continuity of key professionals within the arrangements, as well as the establishment of the Health and Wellbeing Board to ensure services communicate with each other.

- A year on from the London Riots, receiving updates on agencies' response to the riots, which included the work of Troubled Families which is part of a wider programme of early intervention and prevention measures. The local authority had invested money toward Youth Services, which had produced a summer programme to ensure there were opportunities for children and young people in the borough to take part in positive activities. Residential provision over the summer period would also be introduced and there had also been a move toward a more targeted youth work offer which hoped to target 180 young people over the year.

- Whittington Health was asked to provide assurance around their safeguarding training provision, following a decision to withdrawal from the LSCB mandatory induction training programme. It was clarified that the proposal would impact on Level 1 & 2 staff but there would be no change to staff training at level 3 who would still access the LSCB programme. All Whittington health staff would also be signposted to the LSCB training programme and encouraged to access multi-agency courses to update their knowledge.

- Establishing the local picture of Home Education children and safeguarding. Data provided indicated:
    - 108 pupils are registered as home educated.
    - 13 are known to special needs.
    - 5 known to social care.
    - 5 known to traveller's team.
    - None are on a subject plan.

Overall the reviews and audits the board and partners have carried out reflect that there is good work across agencies but there are improvements and challenges to the delivery of services.

- The voice of the child is often still missing; more work is needed to capture how CYP feel they are safe as well as whether CYP know how to keep safe.
- The link between early help, thresholds and child protection needs developing to ensure professionals and the community understand.
- Agencies will need to share regularly their safeguarding audits to provide a clearer overview of safeguarding to be included in the LSCB annual report 2013/14
- single agency annual reports should be presented to the board
- Representatives attending the LSCB should improve the quality of dissemination within their organisations of lessons learned and relevant information
- All agencies should review the cross cutting themes as identified in the Section 11 audit
- The issue of CSE should be addressed within in the Children and Young People's Plan and considered in the JSNA

Key recommendations

- All senior officers should ensure that their service has had sight of the recommendations from the SCIE review and monitor any specific action plans for their service
- All senior officers should ensure their service reviews the S11 cross cutting themes to assure themselves their safeguarding standards are robust and fit for purpose.

How will we know whether we are achieving what we want?

The Board has discussed the need to become sharper at determining the impact of our work, and whether we are achieving our ambitions. We are reviewing our current performance indicators, with a view to improving the range and quality of performance data that we receive, and enabling us to know whether we are achieving our ambitions. Next year's report will capture the result of this work.

Section Seven Priorities for 2013- 2014

These priorities include priorities chosen as a result of local issues and demands and will be addressed over 2013-14 by the Board. They will be incorporated into work plans aimed at improving outcomes progressed through the Boards agenda, or addressed more specifically by either sub groups or task groups.

Priority one	Engaging children, young people and their families
Priority two	Strengthening governance and accountability arrangements between the LSCB and other partnership boards
Priority three	Monitoring the effectiveness of the MASH and Early Help intervention (new)
Priority four	Ensuring the link between schools and safeguarding
Priority five	The identification and response to children and young people at risk of child sexual exploitation including where there is gang and group violence (amended)
Priority six	Identification of missing, unknown or opted out young people (new)

Section Eight Business Plan 2013 – 2014

This business plan outlines the agreed priorities and actions to be undertaken by the Board and its partners to deliver this year's safeguarding priorities.

P1	Engaging children, young people and their families			
	Action	Lead group/person	By When	Evidence
	Develop/revise guidance on engaging CYP and their families	Best Practice	March 2014	Guidance tool will be available to detail best practice on ensuring the voice of the child and their families
	Develop a performance indicator around engaging with children and young people	Quality Assurance Sub group	December 2013	It will be embedded in the LSCB Dataset
	Undertake a survey of CYP voices around how safe they feel in their area?	LSCB	March 2014	A report to be presented to board end of year and evidence of CYP voices in future business planning
	All agencies to include in their end of year reports evidence of how they engaged with CYP and their families	All members	March 2014	Views will be in end of year reports
P2	**Strengthening governance and accountability arrangements between the LSCB and other partnership boards**			
	Action	Lead group/person	By When	Evidence
	Development of LSCB members packs to show clear roles/responsibilities	Business Manager	October 2013	All members will sign agreement stating they understand their respective roles/responsibilities on the board

	Review of the membership and role of the Executive sub group	LSCB chair	October 2013	Revised Terms of Reference will outline role and membership of group
	Recruitment of second Lay member	LSCB	December 2013	The board will have 2 lay members
P3	Monitoring the effectiveness of the MASH and Early Help intervention (new)			
	Action	Lead group/person	By When	Evidence
	Develop a performance indicator around early help provision	Quality Assurance sub group	March 2014	It will be embedded in the LSCB Dataset
	Review impact of MASH's first 12mths	Best Practice sub group	March 2014	LSCB will have an understanding on the strengths and challenges to MASH
	Review findings of peer review challenge response	LSCB	October 2013	LSCB will have an overview of partners perception of thresholds and early intervention
P4	Ensuring the link between schools and safeguarding			
	Action	Lead group/person	By When	Evidence
	Undertake audit of statutory duties and responsibilities for schools (under s157/175 Education act)	Quality Assurance sub group	March 2014	LSCB will be able to form a view on safeguarding practices in schools
P5	The identification and response to children and young people at risk of child sexual exploitation including where there is gang and group violence (amended)			
	Action	Lead group/person	By When	Evidence
	Launch the multi-agency CSE guidance	CSE task group	September 2013	Copy of guidance will be sent to all agencies
	Monitor the GAG strategy	LSCB	March 2014	Representative from GAG to attend board
	Review known prevalence of CSE and provisions in borough	CSE task group	December 2013	Report to be made available to the Board

	Develop a performance indicator around CSE and gangs	Quality assurance sub group	December 2013	It will be embedded in the LSCB Dataset
P6	Identification of missing, unknown or opted out young people (new)			
	Action	Lead group/person	By When	Evidence
	Review missing from home and care guidance	Best practice	December 2013	Ensure document is fit for purpose and includes pathways for early help
	Develop a performance indicator around missing from care and home	Quality Assurance	December 2013	It will be embedded in the LSCB Dataset

Appendix 1

LSCB current Membership	
Chair	Graham Badman (Independent)
CYPS	Libby Blake (Director CYPS) Marion Wheeler (AD of Safeguarding) Rachel Oakley (Head of Safeguarding, Quality Assurance & Practice Development) Linda James (Strategic Manager, YOS)
Police	DCI Graham Grant (CAIT- North Sector) DCI Victor Olissa (Borough Commander) DI Keith Paterson (CAIT – Haringey)
Probation	Andrew Blight (ACO Haringey)
Health Services	Jennie Williams (Director of Quality and Integrated Governance, NHS Haringey CCG) David Elliman (Designated Doctor for Child Protection and Child Death, NHS Haringey CCG) Karen Baggaley (Designated nurse for child Protection, NHS Haringey CCG) Geoff Isaac (Consultant Psychiatrist, BEH-MHT) Julie Thomas (Named GP, Haringey) Dee Hackett (Director of Operations, Whittington Health Shaun Colins (Assistant Director, BEH MHT/CAMHS) Susan Otiti (Assistant Director, Public Health)
Lead Member	Cllr Ann Waters, Lead Member for Children
Cafcass	Phyllis Dyer (Service Manager)
Voluntary Sector	Fitzroy Andrews (Chief Executive, HAVCO)
Housing	Denise Gandy (Head of Housing Support & Options)
Schools	Joan McVittie, Head Teacher Jane Flynn, Head Teacher)
Adults Safeguarding	Lisa Redfern (Deputy Director, Adult & Community Services)
Legal Services	Stephen Lawrence (Assistant Head of Legal Services: Social Care)
LSCB officers	Angela Bent, Business Manager Shauna McAllister, Training Officer Naomi Foreman, Executive Officer

Appendix 2

Attendance

Organisation	Job Title	Date of Meetings						% of attendance
		30/05/2012	18/07/2012	26/09/2012	28/11/2012	30/01/2013	27/03/2013	
Independent	Chair	√	√	√	√	√	√	100%
Independent	Independent	√	√	√	Apologies	Apologies	√	67%
LSCB	LSCB Business Manager	√	√	√	√	√	√	100%
Health	Designated Nurse for CP	√	√	Apologies	√	√	√	83%
Health	Consultant Paediatrician, Designated Doctor	√	√	Apologies	√	√	√	83%
Health	Named GP NHS London	√	√	√	√	√	√	100%
Health, NMUH	Director of Nursing NMUH	Apologies	Apologies	√	√	√	√	67%
Health, NCL London	Chief Officer	Apologies	√	√		√	Apologies	100%
Health, Whittington	Assistant Director, Universal and Safeguarding Children's Services	√	√	√	√	√	√	100%
LBH/NHS NCL	Drug and Alcohol Strategy Manager	√	√	√	Apologies	Apologies	Apologies	67%
BEH-MHT	Consultant Psychiatrist BEH-MHT	Apologies	√	√		Apologies	√	50%
BEH-MHT	Executive Director of Nursing Quality and Governance	√	Apologies	√	√	√	√	83%
CAMHS	Assistant Director	√	Apologies	Apologies	Apologies	Apologies		17%
CYPS	Assistant Director	Apologies	Apologies	√	√	√	√	67%
CYPS - Prevention and Early Years	Deputy Director, Prevention and Early Intervention	Apologies	Apologies	Apologies	Apologies	Apologies	Apologies	0%
CYPS	Deputy Director Children and Families	Apologies	Apologies	Apologies	Post deleted	Post deleted	Post deleted	0%
CYPS	Director of Children's Services	Apologies	Apologies	Apologies	√	√	Apologies	33%

CYPS	Head of Service	Apologies	√	√	√	√	√	83%
CYPS - Prevention and Early Years	Head of Integrated Working and Family Support			Apologies	√		√	33%
Adult and Community Services	Deputy Director	√	√	√	√		Apologies	67%
CAFCASS	Senior Service Manager	Apologies	√	√	√	Apologies	Apologies	50%
Police, Borough Commander	Borough Commander	Apologies	√	√		√	√	67%
Police, Haringey CAIT	DI, CAIT	√	√	√	√	√	Apologies	83%
Police, CAIT	DCI, CAIT	Apologies	Apologies	Apologies	√	Apologies	√	40%
Education		√	√	Left	vacant	vacant	vacant	100%
Public Health	Assistant Director	√	Apologies	√	√	Apologies	Apologies	50%
Housing	Head of Housing Support and Options	√	Apologies	√	√	Apologies	√	67%
Legal Services	Assistant Head of Legal	√	Apologies	√	√	√	Apologies	67%
Probation	Senior Probation Officer	√	Apologies	√	√	√	Apologies	67%
YOS	YOS Strategic Manager	Apologies	√	√	√	√	Apologies	67%
Voluntary	HAVCO	Apologies	Apologies	√	Apologies	√	√	50%
Lead Member	Councillor	√	Apologies	√	√	√	√	83%
Primary School	Head Teacher	vacant	vacant	vacant	√	√	√	100%
Secondary School	Head Teacher	vacant	vacant	vacant	Apologies	√	Apologies	33%
London Ambulance Service	Ambulance Operations Manager	vacant	vacant	vacant	vacant	√	√	100%
CYPS	Head of Service, Additional Needs and Disabilities	-	-	-	-	-	√	100%

Contacts

For more information about the work of Haringey Local Safeguarding Children Board, please contact the LSCB Team: 020 8489 1470 or email lscb@haringey.gov.uk