



**Haringey  
Local Safeguarding Children Board**

**Annual Report  
April 2010 – March 2011**

## Chair's Introduction

It is pleasing that the progress made by the partners that collectively make up the Local Safeguarding Children Board (LSCB) was endorsed by external scrutiny this year. Nevertheless there is still a need for vigilance across all agencies. It is imperative that the routine things, such as communication with others and attention to detail, are done well.

This report outlines among other things a summary of serious case reviews undertaken. Such reviews provide the stark reality of people's lives and the impact that they have on children. To this end, effective early intervention is crucial and having the right mechanisms and resources in place is a key challenge for services in today's economic climate.

Violence has been a feature of the lives of some young people in parts of London, often with tragic consequences. The nature of crimes committed illustrates that for some there is a limited connection to what most would see as the norms of society; behavioural boundaries have been broken. Ensuring that parents have both timely support and advice where needed in the difficult process of bringing up children is key to ensuring that they – in sometimes very vulnerable circumstances – understand the importance of these boundaries and by the same token are better able to set them appropriately for their children.

There are huge challenges to be faced. The role of the LSCB continues to be central ensuring that agencies collaborate effectively in rising to these.

A handwritten signature in blue ink that reads 'G.M. Badwan'.

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## WHAT IS OUR BUSINESS?

Local Safeguarding Children Boards (LSCBs) came into existence as a legal requirement from 1<sup>st</sup> April 2006, under Section 13 of the Children Act 2004 and the Local Safeguarding Children Board Regulations 2006, with a broad remit to ensure that local work to safeguard and promote the welfare of children is well co-ordinated and effective.

Section 13 Children Act 2004 lists partner organisations who are required to be Board members – in addition to the local authority these include the police, the probation service, strategic health authorities and Primary Care Trusts, NHS Trusts, the Youth Offending Service, Connexions and CAF/CASS<sup>1</sup>. Section 10 of the Children Act imposes a duty to co-operate on these statutory organisations and section 11 a duty to conduct their daily business with due regard to the safeguarding and promotion of children's welfare – both duties are designed to enable different organisations to work more effectively together with the child as a common focus.

Haringey LSCB's current strategic focus reflects the need, given additional resonance after the death of Peter Connelly in August 2007, to ensure that multi-agency practice around the protection of children from harm is effective. This position was agreed by the Board in 2009 and is reviewed annually. It is defined as covering:

- The safety and welfare of all children on child protection plans and subject to child protection investigation;
- The safety and welfare of children with complex needs;
- The safety and welfare of children living with compromised care as a consequence of domestic violence, substance misuse, parental mental illness or learning disability, culturally influenced abuse, family breakdown, institutional dependency, serious youth violence, serial violence/anti-social behaviour or endemic criminality
- significant disabilities and/or chronic medical needs; or
- a combination of one or more of these factors

Full Terms of Reference and Board membership are attached as **Appendix 1**.

This approach was endorsed by Ofsted and the Care Quality Commission in the report following their joint inspection of safeguarding and looked after children services (February 2011).

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<sup>1</sup> The Children & Families Court Advisory and Support Service

*“Rightly, HSCB is maintaining a close strategic focus on key child protection processes and outcomes for children and young people whose focuses make them most vulnerable.....in the light of the continuing importance of child protection work and the increasing volume and complexity of cases coming to the attention of the partnership, this approach is entirely appropriate”. Haringey Inspection of Safeguarding & Looked After Children 2011; Ofsted & Care Quality Commission*

In 2010/11 the Board agreed to prioritise a series of objectives within its area of strategic focus, mainly as a result of local learning from serious case reviews but also to ensure compliance with statutory guidance around LSCB functioning. **The priorities** remain essentially the same in 2011/12 but the objectives have been slightly reframed to reflect desired outcomes more directly:

- 1. Children, young people and their families influence the work of the LSCB**
- 2. Strong governance and accountability arrangements are in place between the LSCB and other Partnership Boards so that everyone is clear about roles and responsibilities in relation to safeguarding children**
- 3. Our practice is underpinned by a common strategic approach to the management of risk at every threshold of intervention**
- 4. A co-ordinated strategic approach to address domestic violence is ensuring that fewer children and young people have to deal with its impact**
- 5. A coordinated approach to practice with young people missing – from care, home and/or school – is helping to keep those young people safer**
- 6. All our partner agencies have integrated safe recruitment processes and allegations of improper professional practice are investigated effectively**
- 7. The LSCB can demonstrate that it makes effective use of the learning that results from serious and other case reviews**

Over 2011/12 we will develop a forward plan for the sub-groups based on these and any additional priorities agreed by the Board. Part of this will involve a review of the number and function of each group and their membership.

This report also highlights a number of ongoing **challenges to LSCB and Trust partners** within each narrative section. These relate to one or more of the priority areas and are summarised below:

- Maintain a clear focus in context of organisational restructure and impact of reduced staff numbers, supported by the development of a partnership risk log;
- Continue to address the requirement to include lay members;
- Continue to ensure sufficient pooled funds to fulfil statutory duties;

- Improve the responsiveness of IT systems in order to generate more qualitative reporting and develop a clear mechanism for sharing outcomes of single agency audits;
- Ensure that childminders and early years providers are fully aware of their safeguarding responsibilities – this is highlighted because of consistently low levels of referrals from early years providers;
- Embed processes through which we can become better at understanding whether, how and why we are making a real difference.

## KEY ACHIEVEMENTS 2010/11

*Joint inspection 2011 assessed LSCB and partnership working as 'good' - providing strong focal point for improving and monitoring the quality of safeguarding services*

*Serious case review received overall judgement from Ofsted as "outstanding" – the first time in London and south of England*

*LSCB conference September 2010 – nationally recognised speaker on attachment/early intervention; bespoke MACIE training on risk*

**NEW** website ([www.haringeyslscb.org](http://www.haringeyslscb.org)) now a one-stop resource for professionals, families and children/young people

**NEW** multi-agency safeguarding induction training programme with an e-learning component – properly evaluated

**NEW** internally developed multi-agency training courses on child development & attachment and child neglect

*Key messages from serious case reviews integrated into every training course – single and multi-agency*

*Information sharing networks established for complex universal services (health operational group; education safeguarding fora) – with reporting line back to LSCB*

*An overarching statement of principles agreed between child and adult-focussed services – Think Parent*

*"Little Green Book" – pocket sized core child protection procedures to every practitioner*

*Involvement in 2 London pilot projects – QA Framework (outcome measures); SCIE model for SCRs*

## SECTION 1:

### EFFECTIVENESS OF THE LSCB – GOVERNANCE & ACCOUNTABILITY ARRANGEMENTS

#### Frequency of meetings

- 1.1 The LSCB met every 2 months between April 2010 and March 2011; 6 meetings in total.

#### Chairing & Leadership

- 1.2 All meetings were chaired effectively and independently by Graham Badman.
- 1.3 The Board voted for a new Vice-Chair in December when the Borough Commander left to take up a new post in Cyprus. Howard Jones, Director of Family Action and voluntary sector representative, was elected by majority vote. The post of Vice Chair is subject to review every 2 years.

#### Relationship with Children’s Trust

- 1.4 The LSCB Chair attends the Children’s Trust, chaired by the Lead Member Children & Young People’s Service. Although the status of the Trust has changed it continues to operate in Haringey. Responsibility for delivery of Haringey’s Safeguarding Plan sits with the Trust; the LSCB monitoring role providing challenge (see 2.4)

*“The very experienced chair of {Haringey LSCB} has established constructive and clear communication lines with the Director of Children’s services and the Lead Member.....This is ensuring a healthy level of challenge”.* Haringey Inspection of Safeguarding & Looked After Children 2011; Ofsted & Care Quality Commission

#### Engagement of partners

- 1.5 There is always a tension between the need to engage the right people and the optimum size for a meeting to be able to progress business. Haringey’s Board is now at the higher end of the national average<sup>2</sup> -with a total of 30 members.
- 1.6 Part of the reason for its size lies in the lack of an acute hospital in Haringey and the consequent need for representation from hospitals in two neighbouring boroughs. Adult-focused services are now well represented at the appropriate level through social care, mental health and substance misuse services.

<sup>2</sup> The Evaluation of Arrangements for Effective Operation of the New LSCBs in England 2010 (Research Report DFE-RR027)

- 1.7 Schools have been represented at both primary and secondary level for the first time this year.
- 1.8 Attendance is consistently good for a Board of this size, with an average for the year of 76%. This would have been higher but for a date clash in January with a local authority senior management meeting. There was 100% attendance by appropriate representatives from the key statutory agencies: children’s social care, community health services, and officers with designated health responsibility and the Police Child Abuse Investigation Team.
- 1.9 It has been a year in which key faces changed – a new Borough Commander, a new Deputy Director for Children & Families (social care), a new Borough Director for the Primary Care Trust and a new Director of Nursing for the Whittington Hospital. Despite the potential for this to be unsettling, attendance and engagement remained consistent.
- 1.10 A full schedule of attendance is at **Appendix 2**.

### Sub-Groups

- 1.11 The following sub-groups support the Board:

Group	Chair
Quality Assurance	Deputy Director Children & Families (CYPS)
<i>Remit</i>	<i>To monitor the effectiveness of multi-agency child protection work through data analysis and audit processes</i>
Training & Development	Head of Safeguarding Quality Assurance & Practice Development (CYPS)
<i>Remit</i>	<i>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</i>
Best Practice Delivery	Director of Operations Women, Children & Families, Whittington Health
<i>Remit</i>	<i>To turn the learning from serious and other forms of case review into effective operational practice</i>
Domestic Violence	Assistant Director Safeguarding Children (CYPS)
<i>Remit</i>	<i>A start and finish group straddling children’s and adult-focussed services to co-ordinate multi-agency practice in relation to domestic violence</i>
Serious Case Review	LSCB Independent Chair
<i>Remit</i>	<i>A standing group to consider whether or not cases meet the threshold for SCR and commission the author and</i>

	<i>Panel to take such reviews forward</i>
Policy Watchdog	Deputy Director Early Intervention & Prevention (CYPS)
<i>Remit</i>	<i>Meets as required to agree local response to national policy initiatives</i>
Child Death Overview Panel	Associate Director Public Health
<i>Remit</i>	<i>To review the circumstances surrounding all child deaths and make preventative recommendations where possible; to ensure a rapid response to any that are unexpected</i>
Health Leadership for Safeguarding Group	Borough Director (Haringey), North central sector
<i>Remit</i>	<i>To provide a strategic link to the LSCB across the health economy, ensuring the delivery of priorities in the Safeguarding Plan and quality assuring the health contribution to the multi-agency partnership</i>

- 1.12 Additional mechanisms are in place to support information flow from the Board to complex agency frameworks and back. The Health Leadership Group is supported by an operational group of staff drawn from all health settings; two Education Safeguarding Forums are in place for designated teachers – primary and secondary - and a safeguarding forum has more recently been introduced for children’s centres and early years settings.

*"Can I please say how useful these forums have been as a platform for discussion"* feedback from a Designated Teacher for Child Protection, a Haringey Primary School

- 1.13 All sub-group Chairs are members of the main Board and Group membership and terms of reference are annually reviewed. Details of sub-groups and their membership can be found at **Appendix 3**.
- 1.14 An LSCB Executive comprises two leads from each of the key statutory agencies, together with the independent Chair, Vice Chair and Business Manager. It was created as a mechanism for driving the agenda of the Board at a time when so much of the business was concerned with the commissioning and completion of serious case reviews. Its terms of reference will be reviewed in 2011/12.
- 1.15 The officer support to the Board will decrease in 2011/12 with the end of government funding to support child death review processes. The Business Support Officer post ceased as of 1<sup>st</sup> April 2011. Business processes are being streamlined as much as possible in order to minimise the impact of this.

### **Governance: Challenges and Priorities for 2011/12**

- 1.16 Keeping focus in context of organisational restructure and impact of reduced staff numbers
- Development of partnership risk log
  - Sub-group review to take account of capacity of people to attend same number of meetings
- 1.17 Clarify interface between LSCB and Health & Wellbeing and other Partnership Boards in the context on ongoing structural change – generally - and specifically in relation to Domestic Violence.
- 1.18 Work with the local authority to address the requirement to include lay members

### **Pooled Budget**

- 1.19 The LSCB held two pooled budgets in 2010/11; one to support the bulk of the business and the other to house the final year of the ABG grant to support the embedding of statutory child death review processes. The financial year closed with a £24,000 underspend across both; the contingency identified at the beginning of the year to fund costs associated with an additional serious case review should one have been commissioned.
- 1.20 Although contributions are reviewed annually, contributions from the Metropolitan Police, the Probation Service and CAFCASS are centrally provided and there is little likelihood of increase unless it comes from central review. Health agencies together make a significant financial contribution and additional funding is received from Tottenham Hotspur Football Club. Two thirds of the funding for the Board – staffing, training and activities – is met by the Children & Young People’s Service.
- 1.21 A 30% increase in local base funding for 2011/12 was agreed by the LSCB in September 2010. A full budget breakdown is at **Appendix 4**.

### **Challenges/Priorities**

- 1.22 This has not changed. The Board must continue to ensure sufficient funding – both monetary and in kind - from a range of sources to enable it to fulfil its statutory duties, at a time when all partners are being seriously challenged to reduce the amount they spend. Fulfilment of those statutory duties in a way that takes full account of the strengthening of LSCB functions explicit in the Munro Review<sup>3</sup> is likely to present a challenge.

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<sup>3</sup> This Report is written in advance of the government response to the Munro Review so the extent of statutory compliance is not clear

## SECTION 2

### THE EFFECTIVENESS OF CHILD PROTECTION WORK

#### An outcomes-based approach

- 2.1 Making an informed judgement as to the quality of work to safeguard children and generating consistent activity to make improvements where they are needed is probably the most significant task facing an LSCB. Even for Haringey, with a narrower strategic focus than some deliberately targeted at the higher child protection threshold - the task is a huge one and, to have a complete picture, the lens has to take in aspects of practice that sit below the threshold level too.
- 2.2 The task of forming a judgement is helped to some degree by the inspection process and Haringey had both an unannounced inspection of frontline services and a full inspection of safeguarding and looked after children's services in 2010/11, the outcomes of which give a picture of organisational health at given points in time.
- 2.3 We know to what degree the services that we provide, both individually and collectively, are effective if we can tell whether or not they are making a difference to children's outcomes, how and why. This is not a simple thing to do in the context of the way quality assurance processes have been established in organisations over time, with a primary focus on measuring performance against nationally and locally set - largely quantifiable – indicators. In February 2011, Haringey LSCB joined the London pilot of the Local Government Improvement & Development Quality Assurance Framework and through its Quality Assurance and Domestic Violence sub-groups is developing an outcomes-based framework to measure the effectiveness of work around domestic violence.

#### Haringey Safeguarding Plan

- 2.4 The Safeguarding Plan was first developed as the JAR Action Plan in response to the government-ordered JAR inspection of November 2008. It has been through a number of 'refreshes' and continues to provide a framework for improvement to practice. Tasks resulting from recommendations of serious case reviews are integrated within the Safeguarding Plan in order not to have too many different plans circulating at any given time. In March 2011 the LSCB agreed to become a focal point for monitoring the Plan's delivery, arrangements for which will be set by the Executive in 2011/12.

#### Multi-agency audit process

- 2.5 Although multi-agency audits were undertaken within the report period it is fair to say that this has not to date been the result of an embedded multi-agency audit programme. Audits, when they have taken place, have

done so in response to a particular need at a given time. The outcome of those audits has led us to think about scrutinising the quality of case work in a slightly different way.

- 2.6 There is good reason for this more ad hoc approach when set against the audit activity that has been taking place in individual agencies – the people conducting single and multi-agency audits will largely be the same; they only have so much capacity in terms of time. That time is likely to be further consumed by the demands put upon them by the process of serious case review – and in Haringey this has been a major factor in the last two years. The audit process is further constrained by the lack of an audit tool that both works on a multi-agency basis and that is not too time consuming to use. One multi-agency audit used a tool that had been developed for use by social care and health professionals but which didn't really work beyond these; another piloted a London Safeguarding Children Board multi-agency audit tool that was almost as demanding of auditors' time as an individual management review might be.
- 2.7 As a first stage towards evidencing to what extent an LSCB knows about quality of practice within and between its member agencies we conducted a very short profiling exercise in 2010 to see how far processes for qualitative audits on safeguarding practice are embedded across the partnership.
- 2.8 Responses were received from all health partners including the mental health trust, from the police, CAFCASS, and the voluntary agency Family Action. All respondents have audit processes in place that address the quality of work to safeguard children. It was equally clear from the responses that there is not as yet a clear mechanism whereby their audit outcomes are routinely shared with the LSCB: **this is a priority business plan action.**
- 2.9 In all, three multi-agency audits were conducted in 2010, focussing on:
- Assessing and managing risk in relation to domestic violence (audit tool developed originally for children's social care and adapted for health);
  - The child protection conference process (bespoke audit tool from another borough);
  - Children in care (London SCB audit tool).
- 2.10 Only the audit looking at the child protection conferences justified the time spent on the exercise and resulted in useful learning around the conduct of strategy meetings and the construction of conference plans. The others both took overly long to complete, to the extent that, both times, only one case file was able to be audited in full. The balance between process and learning is therefore overly skewed towards process; the benefits relatively few. The priority for the coming year will be to

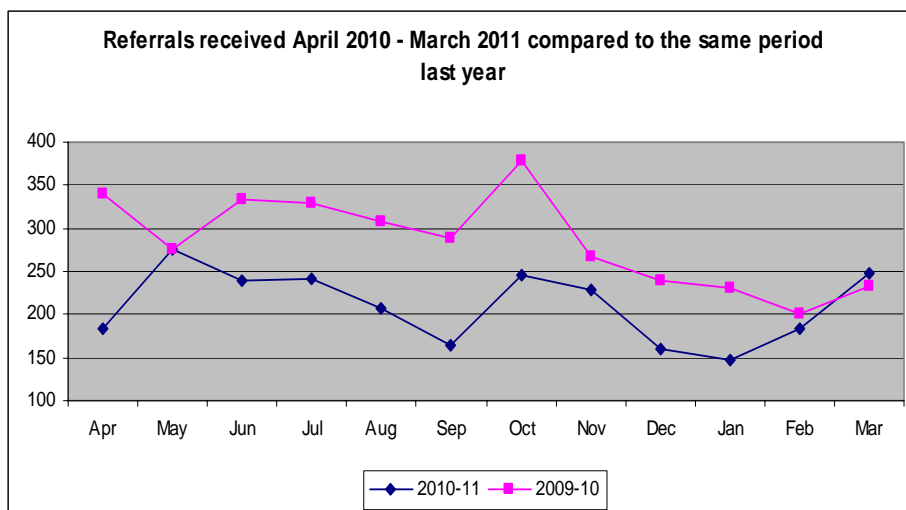
embed a system to feed outcomes of single agency audits back to the Board and develop further a model of multi-agency desk-top case review through the Best Practice Delivery Sub-Group. While the focus will still be on a single case, the process will involve more practitioners more directly so the benefits in terms of learning stand to be greater.

- 2.11 The Local Authority Designated Officer and police CAIT team have together developed an audit tool to help schools measure themselves against safeguarding criteria and support them in preparation for Ofsted inspections.

**THE DATA STORY**

**2.12 Volume and appropriateness of referrals coming into First Response**

All notifications of concern about children that are made to First Response, irrespective of where they come from, are known as ‘contacts’. A multi-agency co-located team comprising a permanent staff base of social workers, police and specialist health visitors screen these contacts to filter out which meet the threshold for further intervention – these positively screened contacts are what are then classed as referrals. In the period April 2010 to March 2011 a total of 2,526 referrals were received, compared with 3,423 for the same period last year. This does not necessarily mean that people are notifying less [there were 9,556 contacts or notifications over the same period] but it does indicate that they are being more appropriately screened and allocated. On average, this still means about 210 per month; in practice, numbers were highest in May, March, October and July. The conversion rate from referral to social work involvement via an initial assessment or child protection investigation was 83% - higher than previous end year outturns and comparator borough averages, and again, an indication that the thresholds for social work intervention are clear and appropriate.



**2.13 Where are the referrals coming from?**

The variety of referral sources makes a graphic presentation less easy to read, so it has more impact to list them in order of volume:

795 – police, probation prisons (31%)  
 417 – schools (17%)  
 203 – hospitals; mix of A&E, midwives, hospital consultants  
 144 – relatives, friends and neighbours  
 116 – primary care; GPs, London Ambulance Service  
 112 – housing  
 67 – health visitors  
 46 – adult mental health  
 44 – general public  
 40 – voluntary sector services  
 28 – nurseries, children’s centres  
 11 – other adult providers  
 0 – childminders

2.14 The volume of referrals has increased from GPs, housing and adult mental health staff and it is justifiable to see this as a consequence of the renewed emphasis on safeguarding children in these services, through training and involvement in serious case review. Numbers are lower than we might expect from nurseries and children’s centres and particularly low from child-minders, given the fact that under 5s are a well-researched high risk group. **Engaging this key group further is a business plan priority for 2011/12.**

**2.15 Allegations of professional abuse**

The safety of our workforce and how professional misconduct might impact upon the overall work to protect children is the job of the Local Authority Designated Officer (LADO) to investigate and annually report. Responding to an increase in volume of work associated with allegations against professionals the number of Local Authority Designated Officer (LADO) posts was increased from 1 to 1.5 in 2010. Given the length of time that investigations can take to conclude it is difficult to provide management information that matches allegations and outcomes within a given year but we do have enough information now to give more than a flavour of the rate of work coming from this direction, even though there is more work needed to ensure the accuracy of recording around ethnicity and children with disabilities:

- Overall numbers of allegations are increasing – which may be a result of increasing the profile of the LADO and the reach of training;
- More allegations are made about physical abuse than anything else;
- These include complex issues relating to the appropriate restraint of children in school settings;
- The highest number of allegations relate to primary school or foster settings;
- Allegations are made against more females than males, which probably reflects the employee gender balance;

- More very serious allegations are made against men;
- The majority of investigations are unsubstantiated

### 2.16 Numbers of children at highest threshold of need

Almost a third (29%) of referrals to First Response immediately met the highest threshold for intervention and became new child protection investigations. 203 initial child protection conferences were held over the year involving a total of 399 children; the conference rate a noticeable increase on previous years (177 in 09/10; 97 in 08/09). 83% of these children went on to become subjects of child protection plans; again, an indication that the threshold level was the largely the right one.

2.17 Perhaps unsurprisingly given this there was a parallel increase in the numbers of care proceedings initiated in the year – 243 compared with 186 the previous year.

2.18 More children and young people subject to child protection plans move into the Borough than move out. In the 12 months to March 2011, 39 children on plans moved in and 29 moved out. Housing benefit changes nationally are likely to increase the vulnerable family population still more so this is a pattern that is unlikely to change in the near future.

	Haringey 31/3/09 Rate per 10,000	Haringey 31/3/10 Rate per 10,000	Nat Avg 31/03/10	Haringey 31/3/09 Number	Haringey 31/3/10 Number	Haringey 31/03/11 Number
Children Subject to a CP Plan	36.5	60	35.5	179	294	322 (rate 66)

2.19 As the financial year closed a total of 322 children were subject to child protection plans. While numbers have risen year on year since 2009 this is not something that is peculiar to Haringey. The figures should also be viewed in terms of how they break down per 10,000 population and then matched against those of comparator boroughs before any kind of judgement as to 'high' or 'low' becomes meaningful. Figures are generally only available for the preceding year (below) but they do show that Haringey, Southwark and Lambeth are similar. Demographically, Lambeth is probably the closest match.

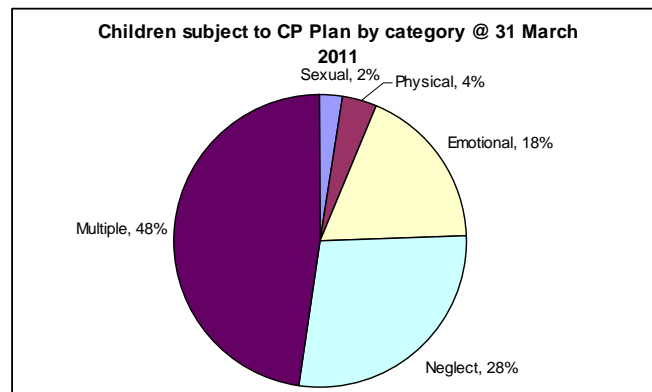
Children subject to a CP Plan @ 31/03/2010		
	Number	Rate per 10,000 population
National Average	N/A	39.5
SN Average	N/A	47.2
Croydon	346	43.1
Southwark	336	60.9

Lambeth	304	56.4
<b>Haringey</b>	<b>294</b>	<b>60</b>
Greenwich	278	52.3
Hammersmith and Fulham	235	74.9
Lewisham	203	34.7
Waltham Forest	170	31.3
Wandsworth	162	32.1
Islington	132	39.1

### 2.20 Disabled children on child protection plans

The number of disabled children on child protection plans has remained roughly similar for the last five years. In terms of proportion, it seems lower now (1.7%), because overall numbers are higher. Nevertheless it would seem too low to be a proper reflection of the particular vulnerability of this group and the Quality Assurance Sub-group is overseeing a piece of work to investigate. To date we have comparator data from one third of London authorities which tell a similar story, ie. the Haringey experience is mirrored elsewhere.

### 2.21 Nature of cases



The categories under which child protection plans are made and reported include one for multiple abuse. Haringey has more children on plans under this category than any of our statistical neighbours.

### 2.22 What conclusions can we draw from the data we have?

- Multi-agency work at the front door is effective – referrals that end up on a social worker’s desk for assessment are appropriate;
- Referrals are being made by a wider range of people than before; the impact of training and learning from SCRs is evident particularly in adult mental health and housing services;
- It is not clear why there are not more referrals from early years settings; we need to do more to unpick and address the reasons for this;
- The volume of work at the highest threshold for intervention has continued at the high level seen towards the end of the previous year while resources have remained the same;

- The right cases are being brought for multi-agency discussion at child protection conferences;
- ‘multiple abuse’ as a recorded category for a child protection plan is a broad acknowledgement of case complexity but clouds the identification of case specific ingredients. On the other hand, the primary reason for a child protection plan is not always an indicator of where the risk of further harm may come from, so the term ‘multiple’ may help keep professional thinking more open.

### **2.23 How effective is our work once children are subject to child protection plans?**

Or, are we making any difference? This is where the direct feedback from children, young people and family members is all important. Involvement in the Quality Assurance Framework pilot (see above, 2.3) will help this focus and ensuring effective mechanisms whereby that feedback can be routinely gathered and heard remains a key priority for the Board.

2.24 The LSCB did attempt to engage families whose children had been taken off child protection plans six months previously to find out what, for them, had made a difference. We used an independent voluntary agency – 4Children – to do the research and identified a sample of 22 families to approach. Only two took up the offer, so it is not really valid to draw general conclusions from what they said. Having said this, their common dislike and distrust of ‘punishing’ and ‘judgemental’ social work interventions chimes with the national research 4Children have done. The message seems to be that tough is OK and even preferable, as long as workers are open and honest.

2.25 We do know that:

- The timeliness of our assessment interventions is improving along with the overall quality of those assessments;
- The vast majority (98%) children on child protection plans had those plans reviewed in a timely fashion;
- The number of children who became subject to a child protection plan again having been on one before was very small – 9% - so the actions that the plans required of families and professionals would appear to have been effective. This can obviously shift over time but the percentage figure is in line with that of comparator boroughs;
- The vast majority of child protection plans cease within two years, meaning at least in theory that the tasks they contain have been completed with the right degree of impact.

## **SECTION 3                      SERIOUS CASE REVIEWS**

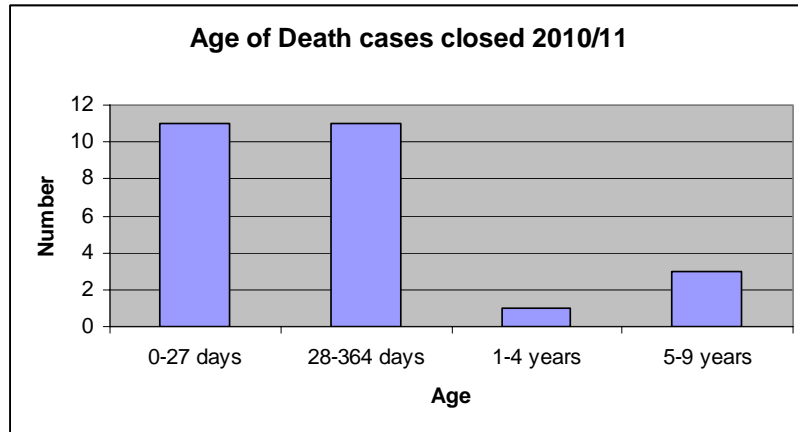
- 3.1 Any serious case review is also an opportunity to form a judgement as to the effectiveness of single and multi-agency working; generally because something has gone wrong. It is a formal process, conducted according to statutory guidelines and (for the period covered by this report) evaluated as to its content and process by Ofsted.
- 3.2 One serious case review was commissioned in February 2010 and completed at the end of November. It was triggered by a domestic violence homicide and although LSCB-led, was directly involving of the Adult Safeguarding Board.
- 3.3 Ofsted gave the review an overall judgement of 'outstanding'; the first time any such review has been so judged in London. The judgement is given on the quality of the content and on the process of review itself. Family members were involved in the review and their views were pivotal to the overall conclusions reached by the author and SCR Panel.
- 3.4 A wide range of agencies were involved in the case; wider than in the average review: five health agencies including mental health; children's social care; police; probation; a prison; courts; housing; voluntary agencies and a school. The learning is equally wide-ranging and reinforcing of the message that 'safeguarding is everyone's business' in different directions; changes have already been seen as a consequence and are beginning to be evidenced in attendance at training courses and in the source of referrals to First Response.
- 3.5 The recommendations made by the overview author and Panel have been integrated within Haringey's Safeguarding Plan for overview and monitoring. They contain many challenges, not least the task of working effectively with the complexity that is domestic violence. Governance arrangements within the strategic partnership will be reviewed as will the conduct and management of the Multi Agency Risk Assessment Conference (MARAC). Clarity around information-sharing will continue to be reinforced, as will the clues to the present contained in past records and the imperative on anyone doing an assessment to have a look at these wherever it is possible to do so, even if they pre-date what is accessible electronically.
- 3.6 Domestic violence accounts for, or is an ingredient in, a very large number of referrals to First Response. The precise figures are difficult to quantify quickly as data is known to be under-reported, but anecdotally we know this to be so. Getting to grips with the implications of this across the Partnership, as highlighted in this SCR, is one of the main challenges for the future and it is for this reason that the LSCB has agreed that domestic violence should be the focus of work on the Quality Assurance Framework pilot project over the next three years.

- 3.7 It is the intention of the Board, through its Best Practice Delivery sub-group, to integrate a process of multi-agency desk-top case review as a means of quality assurance and learning. The cases will be selected in terms of the degree to which they might qualify as a 'near miss' but also where there is learning to be had from good practice.
- 3.8 Haringey is one of seven London boroughs to be involved in a pilot of the Social Care Institute for Excellence (SCIE) model for conducting serious case reviews. The pilot began in January 2011 and will be reported in the annual report for 2011/12.

## **SECTION 4 CHILD DEATH OVERVIEW PANEL (CDOP) REPORT**

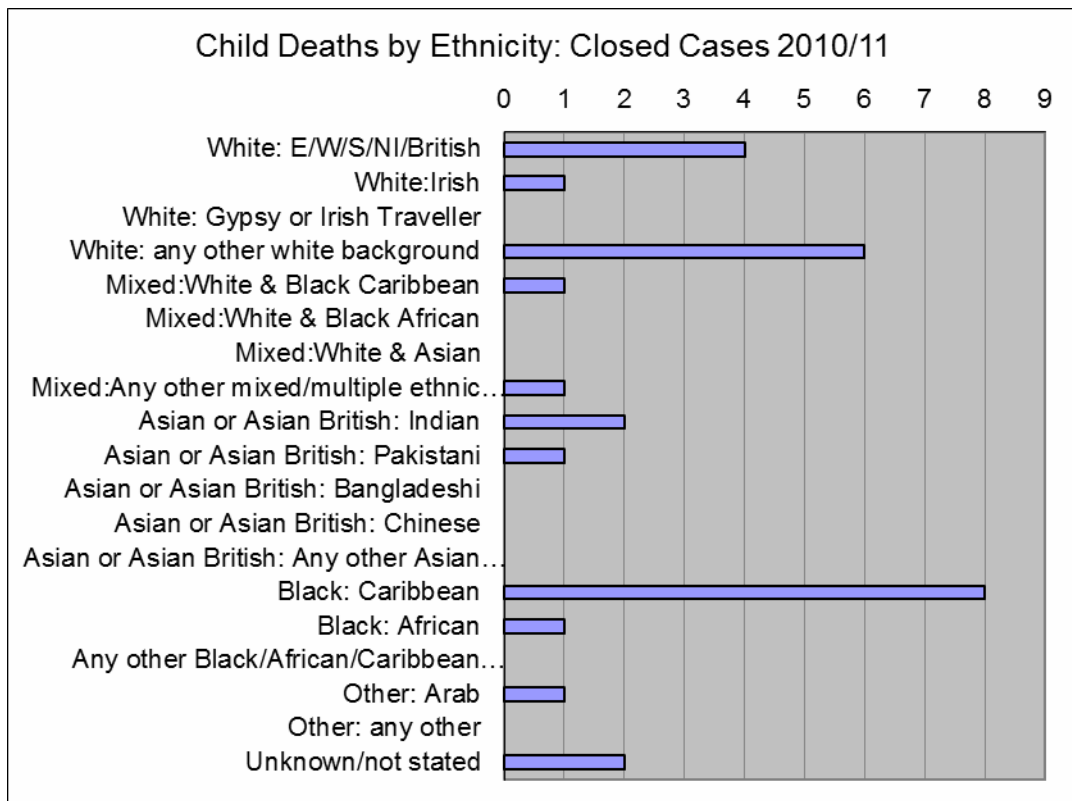
- 4.1 This report covers those deaths that the CDOP considered and closed between 1<sup>st</sup> April 2010 and 31<sup>st</sup> March 2011. Membership of the panel is included in the sub-group **Appendix 4**.
- 4.2 During the year, there were 4 panel meetings and, in addition, a number of smaller rapid response meetings relating to specific cases. These latter included one murder as well as a cot death.
- 4.3 Over the period in question, 34 deaths were notified, however most (29) of these were not closed to review as more information was required. This was mainly from hospitals, but there were also a number of inquests pending.
- 4.4 None of these children were looked after or subject to child protection plans or any legal orders and none resulted in a serious case review.
- 4.5 27 cases were closed (3 from 08/09; 19 from 09/10; 5 from 10/11). Of these 13 were directly related to prematurity (predominantly extreme prematurity), seven were genetic/chromosomal conditions, three infections (amongst which were one case of meningococcal septicaemia and one of myocarditis due to parvovirus), 2 malignancies (brain tumour and leukaemia), one trauma and one other acute death. The death due to trauma was a three year old who accidentally hanged himself in a curtain cord.
- 4.6 This was the only one case where there were felt to be any avoidable factors leading directly to the death. Following this death, all health visitors were informed of the potential hazards of curtain cords and asked to pass this on to parents. Children's centres were also informed.

4.7 17/27 (63%) deaths were in boys, following the expected pattern. The distribution of age at death is shown in Figure 1, with almost all deaths occurring in the first year of life. This follows the national pattern except that one would expect some deaths in the 10+ age group.



**Figure 1 Age at death**

4.8 Following the pattern in previous years, most deaths were not in white British children, but in ethnic minority groups (Figure 2).



**Figure 2 Deaths by ethnic origin**

4.9 Moves to combine experiences across the north sector's CDOPs were put on hold with the disruption caused by the NHS changes. We hope to revive this when things settle down.

#### 4.10 Summary findings

- There was only one death with an avoidable factor leading directly to the child's death. Messages from this have been promulgated.
- Ethnic minorities were over-represented.
- Male deaths predominated.
- Most deaths were in those under a year old and were related to perinatal events, especially prematurity.

#### 4.11 Challenges

- Delays in obtaining information means that closing cases in a timely fashion can be difficult. This does not delay sending out any advice arising from cases where it is felt to be appropriate.
- The uncertain future of the CEMACH process means that we may not receive as much maternal/neonatal information as before. We will encourage units to continue to use the forms, even if the overarching process ceases.
- Loss of administrative support has put an added burden on the rest of the team.
- Small numbers make detailed analysis on a yearly basis impossible. Next year, we will present an analysis of all deaths to date.
- It is often difficult to make any comments on the management of neonatal deaths, due to lack of detail. This is probably insoluble, short of going to all the relevant unit perinatal mortality meetings which would be impossible. Consideration is to be given to recruiting a neonatologist to the panel.

## SECTION 5 COMMUNICATIONS, TRAINING & WORKFORCE DEVELOPMENT

5.1 All organisations working with children and families have a responsibility under the Children Act 2004 to ensure that their staff are appropriately trained to recognise and respond to concerns that children may need support and protection. It is the responsibility of the LSCB to ensure that they do so and to attempt to evaluate the impact of what they do. Although there is no statutory requirement for LSCBs to deliver training, in Haringey there is a history of multi-agency training delivery through the LSCB and before it the Area Child Protection Committee (ACPC); the LSCB has agreed to retain this responsibility and keeps it under review.

## Annual Training Return 2009/10

- 5.2 The LSCB Training Strategy requires partners to make an annual training return equivalent to a needs analysis for their organisation. This also serves as a measure of compliance with the training element of any s.11 audit.<sup>4</sup>
- 5.3 The return for 2009/10 was essentially a ‘test-run’, designed as much to establish the extent to which agencies were able to respond as it was the content of the response. Neither children’s social care nor GOSH in Haringey were in a position to respond this time because of changes to staff responsible for holding training information – there was no-one there to do the work.
- 5.4 The data demonstrated that:
- All agencies are able to differentiate between staff whose jobs site them at different training levels and find the distinction useful
  - All agencies have provided safeguarding training at basic awareness level to the vast majority of their staff
  - All have identified safeguarding leads
  - Systems were less consistent when it came to organisational ability to track which of their staff attend multi-agency training and any evaluation of the impact of that training internally is therefore as inconsistent
  - Not all safeguarding leads have access to any supervision – particularly the case for designated child protection teachers

## Training Programme 2010/11

- 5.5 Although Haringey’s LSCB training courses run over an academic year, the data considered here relates to the financial year to be consistent with the rest of the report. The development of the standalone website over the year has enabled the introduction of a process of online application for training courses which is helping to streamline the task of course administration.
- 5.6 Haringey’s Safeguarding Plan required the introduction of a mandatory multi-agency induction course for all new starters. This was developed and phased in over the year and its evaluation (and that of the online e-learning course) is included in full at **Appendix 5**. We also ran a one day ‘Introduction to Child Protection’ course for the first time.
- 5.7 Also developed in response to learning from serious case review were courses on Child Development & Attachment, and on Child Neglect. A workshop on national research findings from serious case reviews was run termly. It is pleasing that these courses were all developed internally and particularly pleasing that the content of the Child Development &

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<sup>4</sup> Refers to s.11 Children Act 2004: duty to safeguard and promote welfare

Attachment course was positively quality assured by Professor Jane Barlow, University of Warwick.

Number of courses per financial year	2009-2010	2010-2011	Attendance 2009-2010	Attendance 2010/11
Working Together	10	7	204	144
Managing & Assessing Risk	3	3	55	50
CP Thresholds: Analysis & Decision Making	2	3	36	31
Child Protection Conferences	3	3	52	59
Child Protection & Domestic Violence	3	3	60	59
Impact of Parental MH on Children	3	2	49	41
Safeguarding Disabled Children	1	1	14	19
Listening to Children	2	3	21	46
Engaging Reluctant Families	2	3	20	39
DV & Adolescents	1	2	15	33
Training for Trainers	2	3	18	13
Introduction to Child Protection	0	3	0	53
Child Development & Attachment	0	1	0	21
Child Neglect	0	1	0	20
SCR Workshop	0	3	0	27
<b>TOTALS</b>	<b>32</b>	<b>41</b>	<b>544</b>	<b>655</b>

- 5.8 As a consequence of the introduction of new courses we offered more multi-agency training options than in the previous year and trained a total of 655 staff (excluding numbers who attended the induction courses).
- 5.9 It is interesting to look at how this total breaks down in terms of different agency attendance (see below Figure 3). More social workers attended training and were particularly attracted to the new courses, showing that they are tapping into a need. Also popular to social workers were the courses on Listening to Children and Engaging Challenging Families.
- 5.10 Education Support and health attendance was well up on previous years throughout the course options, but particularly for courses on Child Protection Conferences. The huge rise in private agency attendance reflects an increase in the main from early years provision, private schools and children's homes.
- 5.11 It is important also not to make assumptions from apparent decreases – Housing training, for example, had been appropriately targeted the previous year so the numbers needing training this year were small. Police and the Probation Service receive safeguarding training centrally. The most significant gap in the context of learning from serious case review is the small number of adult social care staff across two years.

Agency Attendance	2009-2010	2010-2011	%
Adult's Social Care	5	0	=
Children's Social Care	75	124	+ 60 %
Connexions	11	9	=
Early Years	59	77	+ 6 %
EWS/ Ed Support	21	62	+ 295 %
Faith Groups	4	1	=
Family Support Services	21	20	=
Higher Education	4	1	=
Housing	17	1	- 94 %
Health	70	120	+ 58 %
Mental Health	36	26	- 28 %
Other	3	4	=
Police	5	7	=
Private	9	50	+ 555 %
Probation	3	0	=
Schools	96	78	- 19 %
Voluntary	74	66	- 11 %
Youth Offending Service	25	8	- 68 %
Youth Service	6	1	- 83 %
<b>TOTAL</b>	<b>544</b>	<b>655</b>	

**Figure 3**

**Evaluation of impact**

5.11 Developing mechanisms to sit alongside quality assurance activity whereby we can evaluate the impact that training has on practice both meaningfully and routinely remains a priority for the Board. Research and collation of findings has the potential to be quite an industry, however, at a time when resources need to be streamlined. The LSCB Training, Communication & Development sub-group is overseeing a pilot approach to evaluation on one of its new courses – Child Development & Attachment – anticipating that the impact of attending this is likely to be evident in the assessment process but also in the way that practitioners talk about children and their parents. Key to the success of the pilot is the engagement of first line managers, who will be asked for a view both before the course and six weeks after it has taken place.

**Annual Conference September 2010**

5.12 The LSCB conference is a day away from the desk for those who attend that ideally promotes reflection and gives an opportunity to do things slightly differently on return to the work place. The Board is keen to bring in nationally respected speakers. 100 conference attendees welcomed

Professor Jane Barlow from Warwick University and Research in Practice (whose research underpins much of the thinking around early intervention now evident in the Munro Review) and Professor Jonathan Crego from the Metropolitan Police. Professor Crego brought 100 laptops with him and an army of support staff to wire them up to a single point – for a bespoke “10,000 Volts” (10kv) exercise. The object: to enable people to engage with each other electronically at the same time and have an anonymous dialogue on a variety of organisational behaviour-related topics.

- 5.13 The findings usefully provided further evidence of the need for training to broaden the professional skill-base which the sub-group has responded to in ways evidenced above. A ‘reading group’ has been introduced for senior practitioners and Practice Managers in children’s social care, offering the opportunity for themed discussion around research papers. Topics covered to date include serious case reviews, domestic violence and working with fathers.

Four major themes emerged:

- **Serving people not systems:** together, comments reflected a view that successful interventions with children and families were not being helped by organisational tools and over-bureaucratised systems;
- **Professional competencies:** views were balanced between an acknowledgement of the skills of some and the need to improve the skill-base and confidence of others. Good supervision and training were valued.
- **Demands of the job:** within a clear recognition that complexity goes with the territory was a warning about how easy it is for demand to outweigh capacity to deliver;
- **Review and reflect:** most comments were about the insufficient priority given to reflection and review where practitioners are stretched to capacity.

*“We must recognise thinking time as work, time to read and reflect on research, or we will just continue to do the same”*

Interestingly, ‘partnership’ as a theme drew little response. Professor Crego highlights the low response rate here as unusual in a multi-agency audience and notes that its absence suggests comparative success.

#### **LSCB Website – [www.haringeyslscb.org](http://www.haringeyslscb.org)**

- 5.14 This was re-launched as a standalone site in September 2010 and is a one stop information resource for professionals, families and for children and young people. There is a specific section of the site for schools and early years settings.
- 5.15 Some of the statistical information around usage is shown below. We do know that usage has doubled on a month by month basis since the

website was re-launched and that the wide variety of pages viewed means that the LSCB profile in the community is higher than it was. Peaks in the year unsurprisingly reflect the interest in serious case reviews in general and the publication of the Peter Connelly Serious Case Review Overview Report in October. Increased use of the website to access training courses is also evident as is the time people spend looking at different policies and practice guidance.

#### **5.16 Summary of usage**

- **38,304** page views between April 2010 and March 2011
- Of these, 3,506 went to the serious case review page
- 2,513 went to the training pages
- 1,222 went to the Peter Connelly SCR
- 944 people downloaded the training brochure
- 728 viewed the 'making a referral' page

## APPENDIX ONE

# Haringey Local Safeguarding Children Board

## Terms of Reference

- 1 Purpose of the Local Safeguarding Children Board (LSCB)**

To ensure that partner agencies work together effectively to safeguard and promote the welfare of the most vulnerable children and young people in Haringey. To create a learning environment for staff at all levels within each agency, so that together we can generate the most positive outcomes for children.
  - 2 Mandate**

The LSCB takes its mandate from the Children Act 2004, the LSCB Regulations 2005 and from the statutory guidance contained in Chapters 3, 4, 7 and 8 of *Working Together to Safeguard Children, 2006*. It works alongside Haringey Children’s Trust, carries an independent authority through its chairing arrangements and has a statutory responsibility to challenge the Trust in relation to the effectiveness of its work to safeguard children.
  - 3 Objectives**

The LSCB’s core business is

    - a) to safeguard and promote the protection and welfare of the most vulnerable children in Haringey. These children might be:
      - Subject to child protection plans
      - Subject to child protection investigations
      - Living with a variety of factors that increase their risk of abuse, such as:
        - compromised care, as a consequence of domestic violence, substance misuse, parental mental illness or learning disability, culturally influenced abuse, family breakdown, institutional dependency, serial violence/anti-social behaviour or endemic criminality;
        - victim or perpetrator of serious youth violence
        - significant disabilities and/or chronic medical needs; or
        - a combination of one or more of these factors
    - b) To ensure that the broader safeguarding agenda in relation to the health, well-being and safety of children is progressing effectively
    - c) To contribute to, and work within, the framework established by the Haringey Children and Young People’s Plan
- 4 LSCB Executive Group**

The Executive Group is responsible for overseeing LSCB governance arrangements and driving forward the core business of the Board in relation to the statutory functions laid out in regulations. The Executive Group is chaired by the independent chair of the LSCB.
- 5 LSCB Subsidiary Groups**

5.1 The LSCB will direct and monitor work undertaken to achieve its objectives via the following subsidiary groups:

- Policy & Procedure Watchdog
- Communication, Training & Development sub-group
- Quality Assurance and Practice Review sub-group
- Best Practice Delivery sub-group
- Serious Case Review sub-group
- Child Death Overview Panel

5.2 Additional time-limited task groups can be commissioned that link to particular sub-groups in order to drive specific activities.

## 6 Functions

Haringey LSCB will:

- 6.1 Be constituted as required by S.13 of the Children Act 2004 and LSCB Regulations 2005 and will have appropriate representation from all relevant agencies, including those from the voluntary sector, at an appropriate level of seniority.
- 6.2 Ensure that local policies, procedures and protocols are up to date, consistent with legislation, Regulations and statutory guidance, and fully owned by all local agencies involved with the protection of children.
- 6.3 Actively address issues of diversity and equality and will take action to address any issues where necessary.
- 6.4 Put in place adequate resources to fulfil its responsibilities and objectives.
- 6.5 Put in place systems for monitoring the effectiveness of work to protect and safeguard children.
- 6.6 Challenge any partner agency or agencies that are failing to deliver on their duty to safeguard and promote the welfare of children under s.11 Children Act 2004.
- 6.7 Develop an annual business plan, including measurable objectives, relevant management information on child protection activity and progress against agreed strategic objectives.
- 6.8 Raise awareness within the wider community of the need to safeguard children and promote their welfare.
- 6.9 Address issues and, as far as possible, seek to establish common procedures and protocols, where boundaries with health and police are not co-terminus.

## 7 Information Sharing

- 7.1 Haringey LSCB will ensure that there are clear protocols between partner agencies about the sharing of information on children and young people and will ensure that these are properly utilised.

## 7 Knowledge, Skills and Training

Haringey LSCB will:

- 7.1 Develop a strategy for inter-agency training within wider partnership arrangements and the borough's workforce strategy.
- 7.2 Develop a strategy to ensure that the learning from any serious case review is embedded in single and multi-agency training.
- 7.3 Ensure that partner agencies make sufficient provision for the training of their own staff in basic child protection awareness, prior to undertaking inter-agency training.
- 7.4 Ensure that inter-agency child protection training is provided at appropriate levels of need for the staff of all partner agencies.
- 7.5 Ensure that staff have the necessary knowledge and skills to protect children in a manner that is sensitive to issues of race, religion, culture and disability.
- 7.6 Monitor and evaluate all training provided to inform the training strategy and identify any gaps.

## 8 Serious Case Reviews

Haringey LSCB will:

- 8.1 Develop clear criteria consistent with the statutory guidance on Serious Case Reviews.
- 8.2 Ensure that all Serious Case Review panels are independently chaired.
- 8.3 Conduct Serious Case Reviews in a manner that is sensitive to issues of race, culture, religion and disability.
- 8.4 Produce and monitor action plans arising from Case Reviews and evaluate the effectiveness of their implementation.
- 8.5 Ensure that the learning from Serious Case Reviews is widely disseminated.

## 9 Establishing and responding to the views of users

- 9.1 Haringey LSCB will develop different means by which to seek, and respond to, the wishes and views of children, young people, parents/carers on their experience of its work to safeguard and protect their children.

## 10 Responsibilities and Accountabilities

- 10.1 All statutory constituent agencies are responsible for contributing fully and effectively to the work of the LSCB.
- 10.2 The LSCB is accountable for its work to the main constituent agencies, whose agreement is required for all work which has implications for policy, planning and resource allocation.
- 10.3 The LSCB has a job description for each constituent agency representative, which clearly states that representative's relationship with the LSCB.
- 10.4 Constituent agencies have agreed procedures for considering reports from their LSCB representative and to identify any action necessary within the agency or the LSCB.
- 10.5 In order that Haringey LSCB can carry out its functions, constituent agencies will make available relevant management information as required.
- 10.6 Haringey LSCB will make appropriate arrangements to involve other agencies and professionals, as needed.
- 10.7 The work of the LSCB will be set out in a yearly Work Programme, covering the period 1 April to 31 March.

## 11 Membership

- |                                     |   |
|-------------------------------------|---|
| • Chair                             | Independent   |
| • Adult Social Care Services        | Assistant Director Safeguarding Adults  |
| • BEH Mental Health Trust           | Consultant Psychiatrist<br>CAMHS Assistant Director<br>AD Safeguarding  |
| • CAFCASS                           | Head of Safeguarding  |
| • Children & Young People's Service | Director, CYPS<br>Deputy Director Children & Families<br>Assistant Director, Safeguarding<br>Deputy Director Early Years & Prevention<br>Head of Education Welfare Service<br>Head of Safeguarding Quality Assurance & Practice Development |
| • Safer Communities/YOS             | Head of Safer Communities/Strategic Manager YOS<br>Manager, DAAT  |
| • Health agencies                   | Borough Director Haringey<br>Designated Nurse   |

- Housing
  - Legal Service
  - Metropolitan Police
  - Probation Service
  - Schools
  - Voluntary Sector
  - Lead Member for Children & Young People's Service
  - LSCB Officers
- Designated Doctor  
 Director of Operations Whittington Health  
 Director of Nursing North Middlesex Hospital  
 Head of Housing Support & Options  
 Assistant Head of Legal  
 Borough Commander  
 Detective Chief Inspector (CAIT North sector)  
 Detective Inspector (CAIT)  
 Assistant Chief Officer  
 Primary/Secondary representatives  
 Director, Family Action  
 Business Manager  
 Executive Officer (minutes)

Additional representation and advisors will be invited as agreed by the Chair.

## 12 Attendance

- 12.1 In order to be quorate two thirds of LSCB partners, or their delegated representatives, should be present.
- 12.2 Any member who does not attend nor delegate for three consecutive meetings, or is attending spasmodically, will be contacted by the Chair to review their membership.

## 13 Chair and Vice Chair Arrangements

- 13.1 The Chair of Haringey LSCB will be appointed in line with the guidance contained in *Working Together to Safeguard Children 2010*.
- 13.2 The Chair and Vice Chair should not be from the same agency, or the same type of agency.
- 13.3 The Chair is responsible for ensuring that a LSCB Business Plan, for the period April to March each year, is in place and is being implemented.
- 13.4 In a situation where there is a tied vote by LSCB members (including the Chair) on any matter, then the Chair has an extra deciding vote.
- 13.5 In the absence of the Chair, the Vice Chair will deputise in all duties above.
- 13.6 The positions of Chair and Vice Chair will be reviewed every two years.

## 14 Administrative Arrangements

- 14.1 The LSCB will be funded by LSCB partner agencies but managed through the Local Authority (Children's Service).
- 14.2 The LSCB will employ an officer to drive forward developmental work against its objectives in relation to structure and processes.
- 14.3 The LSCB will employ an officer to provide administrative support to LSCB and identified sub-group meetings.
- 14.3 The LSCB will employ an officer to administer the multi-agency training programme.
- 14.4 The LSCB will employ other officers as appropriate to enable it to fulfil its statutory functions.
- 14.5 Additional administrative support can be provided by partner agencies as resourcing 'in kind'.

**15 Funding Arrangements**

- 15.1 Where an LSCB member organisation provides funding this is committed into a pooled budget.
- 15.2 An annual review of the budget should include a request to each constituent agency to contribute to the funding of Haringey LSCB, with an explanation as to why funding is necessary.
- 15.3 The LSCB Annual Report should show any monies brought forward, income from each constituent agency, expenditure and balance, as well as a written summary in relation to budget matters.
- 15.4 The LSCB budget strategy should be annually reviewed, agreed and underpinned by contractual arrangements.

## APPENDIX 2: SCHEDULE OF ATTENDANCE AT LSCB MEETINGS 2010/11

AGENCY	REPRESENTATIVE (OR DELEGATE)	May 10	Jul 10	Sept 10	Nov 10	Jan11	Mar11	
<b>Chair</b>	Independent	✓	✓	✓	✓	✓	✓	
<b>Vice Chair</b>	Borough Commander (to Dec); Director Family Action (Jan+)	x	✓	✓	x	✓	✓	
<b>LSCB</b>	LSCB Business Manager	✓	✓	✓	✓	✓	✓	
<b>Local Authority</b>	Lead Member, CYP	✓	x	✓	✓	✓	✓	
Adult Social Care	Adult Safeguarding Manager/AD Safeguarding	x	✓	✓	✓	x	✓	
Children & YP Service	Director CYPS	✓	✓	✓	x	x	✓	
	Deputy Director Children & Families	✓	x	✓	✓	✓	✓	
	AD Safeguarding	✓	✓	✓	✓	✓	✓	
	Head of Children's Networks	✓	✓	✓	✓	x	✓	
	Head of Workforce Development Vulnerable Children	x	x	x	✓	✓	✓	
CYPS/Connexions	Head of Education Welfare Service	✓	✓	✓	✓	x	x	
Housing	Head of Housing Needs & Strategy	✓	✓	x	x	x	✓	
Legal	Principal Lawyer, CYPS	✓	x	✓	✓	✓	✓	
DAAT	Drug & Alcohol Partnership Manager	x	✓	✓	✓	x	✓	
<b>Health Services</b>	Director of Operations GOSH	✓	✓	✓	✓	✓	✓	
	Designated Doctor	✓	✓	✓	✓	✓	✓	
	Designated Nurse	x	✓	x	✓	✓	✓	
	Assistant Director, CAMHS	x	✓	x	✓	x	x	
	Consultant Psychiatrist, BEH-MHT	x	✓	✓	✓	✓	✓	
	AD Safeguarding BEH-MHT	✓	✓	✓	x	x	✓	
	Director of Nursing NMUH	✓	✓	x	✓	x	x	
	Deputy Chief Executive, TPCT	x	x	✓	✓	x	✓	
	Director of Nursing, Whittington Hospital	x	✓	✓	✓	✓	✓	
	Associate Director of Public Health		✓	✓	✓	x	x	
<b>Police</b>	Borough Commander (post = Vice Chair until Jan)	See above					✓	✓
	DCI - North Sector CAIT	✓	x	x	x	x	x	
	DI - Haringey CAIT	✓	✓	✓	✓	✓	✓	
<b>Probation</b>	Regional Manager	✓	x	✓	x	✓	✓	
<b>Schools - Primary</b>	Head Teacher representative		x	x	✓	✓	x	
<b>Schools - Secondary</b>	Designated CP Teacher representative	✓	x	x	✓	x	✓	
<b>YOS</b>	Strategic Manager	✓	✓	✓	x	✓	✓	
<b>CAFCASS</b>	Regional Director	x	✓	✓	✓	x	✓	
<b>Voluntary sector</b>	Director Family Action (Vice Chair from Jan)	✓	✓	x	✓	See above		

## APPENDIX 3: BOARD & SUB-GROUP MEMBERSHIP (as of May 2011)

### LSCB SUPPORT TEAM

<b>Business Manager</b>	Sarah Peel	020 8489 1472
<b>Training Officer</b>	Shauna McAllister	020 8489 1470
<b>Executive Officer (Training)</b>	Samantha Philips	020 8489 1470

### LOCAL SAFEGUARDING CHILDREN BOARD

<b>Chair</b>	Graham Badman (Independent)
<b>Vice Chair</b>	Howard Jones (Director of Service Family Action)
<b>Adult Social Care</b>	Lisa Redfern (Deputy Director Adult & Community Services)
<b>CAFCASS</b>	Elaine Redding (Regional Manager)
<b>Community Safety</b>	Marion Morris, Drug & Alcohol Partnership Manager
<b>Children &amp; Young People's Service</b>	Peter Lewis (Director CYPS) Jan Doust (Deputy Director Early Years & Prevention) Debbie Haith (Deputy Director, Children's Social Care) Marion Wheeler (AD Safeguarding CYPS) Rachel Oakley (Head of Safeguarding Quality Assurance & Practice Development) Terry O'Reirdan (Head of Education Welfare Service) Linda James (Strategic Manager YOS)
<b>Health Services</b>	Andrew Williams (Borough Director NHS North Central London (Haringey)) Jane Elias (Partnership Director of Operations, Whittington Health) David Elliman (Consultant Paediatrician/Des. Doctor for Child Protection and Child Death) Karen Baggaley (Designated Nurse, NHS North Central London (Haringey)) Shaun Collins (Assistant Director, CAMHS) Geoff Isaacs (Consultant Psychiatrist, BEH-MHT) Theresa Murphy (Director of Nursing, NMUH) Bronagh Scott (Director of Nursing, Whittington Hospital)
<b>Housing</b>	Denise Gandy (Head of Housing Support & Options)
<b>Legal Service</b>	Dorothy Simon (Assistant Head of Legal Service: Social Care)
<b>Police</b>	DCI Graham Grant (Police CAIT – North Sector)

DI Tony Kelly (Police CAIT - Haringey)

**Probation**

Kate Gilbert (ACO, Haringey)

**Voluntary Sector**

Howard Jones, (Director of Services Family Action)

**Lead Member for CYP**

Cllr Lorna Reith

**CHILD DEATH OVERVIEW PANEL**

**Chair**

Susan Oti, Assistant Director, Public Health

**CYPS**

Sylvia Chew, Head of Service First Response

**Police**

Tony Kelly, Detective Inspector CAIT

**Coroner's Office**

Michelle Jones, Coroner's Officer

**Health Services**

Dr David Elliman, Designated Doctor for Child Death

Suzanne Dale, Child Death Co-ordinator

Jo Carroll, Named Nurse, Whittington Hospital

Chantal Palmer, Named Midwife North Middlesex Hospital

**LSCB**

Sarah Peel, LSCB Business Manager & Single Point of Contact for Child Death

**NUMBER OF MEETINGS IN PERIOD: 4**

**DOMESTIC VIOLENCE SUB-GROUP (est. September 2009)**

**Chair:**

Marion Wheeler, AD Safeguarding, CYPS

**CYPS**

Alison Botham, Chair, CAF Panel/Head of Network South

Sylvia Chew, HOS First Response

Brian Siani, Child Protection Advisor

Renata Bailey, Manager, Noel Park Children's Centre

Deirdre Cregan, DV Co-ordinator

Luciana Frederick, Service Manager Commissioning & Contracts

**Police**

DS Charles Nwachukwu, CSU

DS Ian Watson, CAIT

DS Sandy Hollands, Safer Neighbourhoods

**CPS**

Hywel Ebsworth

**Probation**

Karla Day, Senior Probation Officer

<b>YOS</b>	Andrea Crosby Joseph, Operations Manager
<b>Health Services</b>	Bridget Owen, Named Nurse Primary Care Teresa Murray, Senior Named Nurse Whittington Health Chantel Palmer, Named Midwife NMUH
<b>LBH Housing</b>	Denise Gandy, Head of Housing Support & Options
<b>Voluntary Sector</b>	Ben Jamal, DVIP Michele Stokes, Haringey Women's Forum

**NUMBER OF MEETINGS IN PERIOD: 6**

**WORK IN PROGRESS 2010/11**

- Oversight of 'Community Group Work' Project
- Oversight of Serious Case Review Family Q
- Development of practice guidance for universal and targeted settings around assessment and safety planning
- Involvement in strategic governance review

**POLICY WATCHDOG**

Chair	Jan Doust, Deputy Director Prevention & Early Intervention CYPs
CYPs	Marion Wheeler, AD Safeguarding
LBH Legal Service	Jacqui Longmore, Principal Lawyer
Health Services	Karen Baggaley, Designated Nurse Child Protection
LSCB	Sarah Peel, Business Manager

**NUMBER OF MEETINGS IN PERIOD: 4**

**OUTPUTS 2010/11**

- Barnet, Enfield & Haringey Mental Health Trust Safeguarding Protocol
- LSCB/SAB Statement of Principles: Safeguarding Capacity of Vulnerable Adults
- Complaints: LSCB Panel operating standards
- Substance Misuse Services Protocol: Safeguarding Children

**BEST PRACTICE DELIVERY GROUP**

Chair	Jane Elias, Director of Operations, Whittington Health
CYPs	Marion Wheeler, Assistant Director, Safeguarding

Iain Low, HOS Safeguarding & Support  
 Sylvia Chew, HOS First Response  
 Terry O'Reirdan, Head of Education Welfare  
 Dawn Green, Child Protection Adviser

**Health Services** Laura Hayman, Named Doctor Whittington Health  
 Karen Baggaley, Designated Nurse NHS North Central London (Haringey)  
 Bridget Owen, Named Nurse Primary Care NHS North Central London (Haringey)

**Police** DS Joe Derilo, Haringey CAIT

Other members invited as appropriate to discussion

**NUMBER OF MEETINGS IN PERIOD: 9**

**WORK IN PROGRESS 2010/11**

- Scrutiny of child protection conference processes
- Desk top review – near miss case

**QUALITY ASSURANCE SUB-GROUP**

**Chair** Debbie Haith, Deputy Director Children & Families

**CYPS** Marion Wheeler, AD Safeguarding  
 Iain Low, HOS Safeguarding & Support  
 Jeanette Brand, STM Disabled Children's Team  
 Debbie Cotterill, Performance Officer

**Police** Carole Tonks, Detective Sergeant CAIT  
 Aidan Gibson, DI Safer Communities

**Health Services** Karen Baggaley, Designated Nurse NHS North Central London (Haringey)  
 Teresa Murray, Senior Named Nurse Whittington Health  
 Graeme Walsh, Public Health Officer NHS North Central London (Haringey)

**Safer Communities** Jean Croot, Head of Safer Communities

**Voluntary sector** Belinda Christian, NSPCC

**LSCB** Sarah Peel, LSCB Business Manager

**NUMBER OF MEETINGS IN PERIOD: 8**

## **WORK IN PROGRESS 2010/11**

- Monitoring and development of multi-agency dataset
- Monitoring and development of Missing Children Action Plan
- Multi-agency audits
- Link to Disabled Children’s Policy & Practice Group

## **TRAINING & DEVELOPMENT SUB-GROUP**

<b>Chair</b>	Rachel Oakley, Head of Safeguarding QA & Practice Development
<b>LSCB</b>	Sarah Peel, Business Manager Shauna McAllister, Training Officer Samantha Phillips, Executive Officer – training programme
<b>CYPS</b>	Alison Botham, Integrated Working Manager Eleanor McConville, QA Consultant Youth Service
<b>LBH OD&amp;L</b>	Children’s Consultant
<b>Health Services</b>	Christina Keating, Named Nurse, NMUH Karen Baggaley, Designated Nurse Child Protection NHS North Central London (Haringey) Teresa Murray, Senior Named Nurse Whittington Health Bridget Owen, Named Nurse Primary Care NHS North Central London (Haringey) Jo Carroll, Named Nurse Whittington Hospital Norma Johnson, Lead Nurse Child Protection, BEH-MHT
<b>Middlesex University</b>	Diana Pillay - Module Leader for Child Protection
<b>Police</b>	DS Ian Watson – Police CAIT Inspector Tracey Franklin – Police BOCU
<b>Voluntary sector</b>	Olivia Darby, HAVCO

## **NUMBER OF MEETINGS IN PERIOD: 7**

## **OUTPUTS 2010/11**

- New training courses – induction, attachment, neglect
- Annual training return
- Ongoing QA of course content
- Reworking of 2 day ‘Working Together’ course
- Website relaunch

## HEALTH LEADERSHIP SAFEGUARDING GROUP

<b>Chair</b>	Andrew Williams, Borough Director
<b>Vice Chair</b>	Alison Pointu, Director of Quality and Safety
<b>NHS North Central London (Haringey)</b>	Sarah Parker, Head of Children’s Commissioning Karen Baggaley, Designated Nurse David Elliman, Designated Doctor for Child Protection Named GP (currently vacant)
<b>Whittington Health</b>	Jane Elias, Director of Operations Maggie Buckell, Director of Operations Women, Children and Families
<b>NMUH BEHMHT</b>	Theresa Murphy, Director of Nursing David Robinson, Director of Nursing
<b>LA Children &amp; Young People’s Service</b>	Debbie Haith, Deputy Director Children & Families

**NUMBER OF MEETINGS IN PERIOD: 9**

### OUTPUTS 2010/11

- Monitoring Implementation of Safeguarding Plan
- Monitoring and challenge of Safeguarding Assurance Indicators
- Reviewing and Improving Health input to the Child Protection Conference Process
- Reviewing Audit
- Dissemination of SCR learning
- Co-ordination of arrangements for and response to Inspections – Safeguarding Improvement Team ( NHS London) OfSted and CQC

## APPENDIX 4: 2010/11 REVENUE INCOME & EXPENDITURE

Fiscal Year 2010/11	
Revenue Expenditure	YDate Actual
<b>Employees</b>	
Salaries - Officer Staff	63,695
Training - Short External Courses	16,198
<b>Premises- related expenditure</b>	
Rents	12,048
<b>Transport-related expenditure</b>	0
<b>Supplies and Services</b>	
Catering	3,380
Printing Stationery & Office Expenses	121
Fees - Consultant	18,678
Fees - Interpreter & Translations	238
Fees - Project Management	9,505
IT Computer Services	250
Voluntary Organisation	350
<b>Total Expenditure</b>	<b>124,464</b>
<b>Revenue Income</b>	
<b>Partners contributions</b>	
JtFundInc - Health	-24,400
Joint Funding Income - Police	-10,000
Contrib Loc Str Part	-6,500
Reimbursements - Court Costs	-550
<b>Haringey contributions</b>	
Income - Internal Trade Education	-25,300
<b>Total income</b>	<b>-66,750</b>
<b>LSCB balance</b>	<b>57,714</b>
	YDate Actual
<b>Revenue Expenditure</b>	
<b>Employees</b>	
Salaries - Officer Staff	81,037
<b>Revenue Income</b>	
<b>Government Grants</b>	
Grant Income - Area Based Grant	-68,000
<b>Child Death Review balance</b>	<b>13,037</b>
<b>Variance</b>	<b>-24,948</b>

## Appendix 5 Annual Review of LSCB Multi-agency Safeguarding Induction

### April 2010 – April 2011

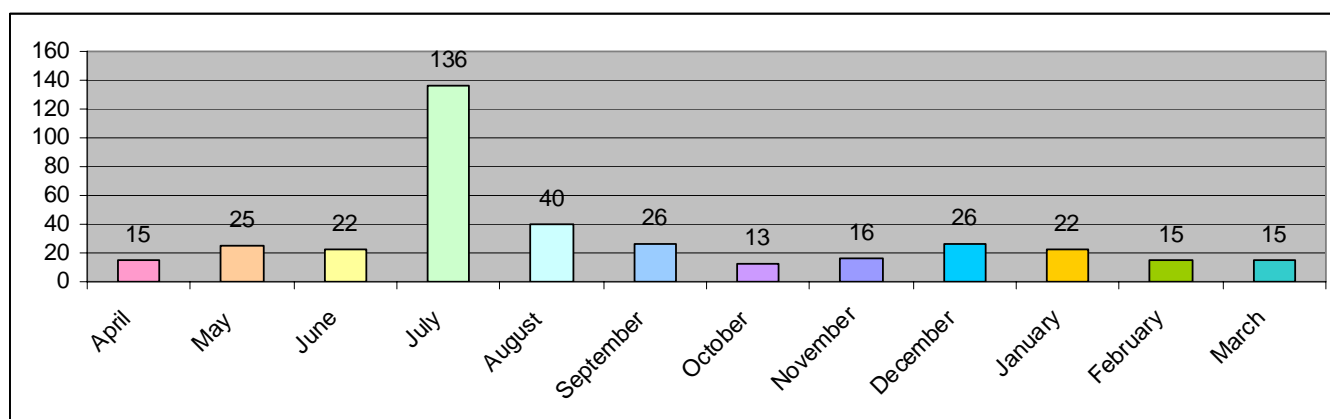
The Multi-agency Safeguarding Induction programme was developed for new employees across the Haringey partnership and was launched in stages between May and December 2010.

The induction is in two stages: e-Learning for all new employees; and a one-day training course for employees who have regular contact with young people, children and family members.

As of December 2010, the course was fully implemented across the Safeguarding Partnership. Overall, it has been very well received. Indeed, the success of the one-day Multi-agency Safeguarding Induction training session has been such that Haringey LSCB has extended the course to existing members of staff where it is referred to as the Introduction to Child Protection.

## E-Learning

### E-Learning Uptake by Month

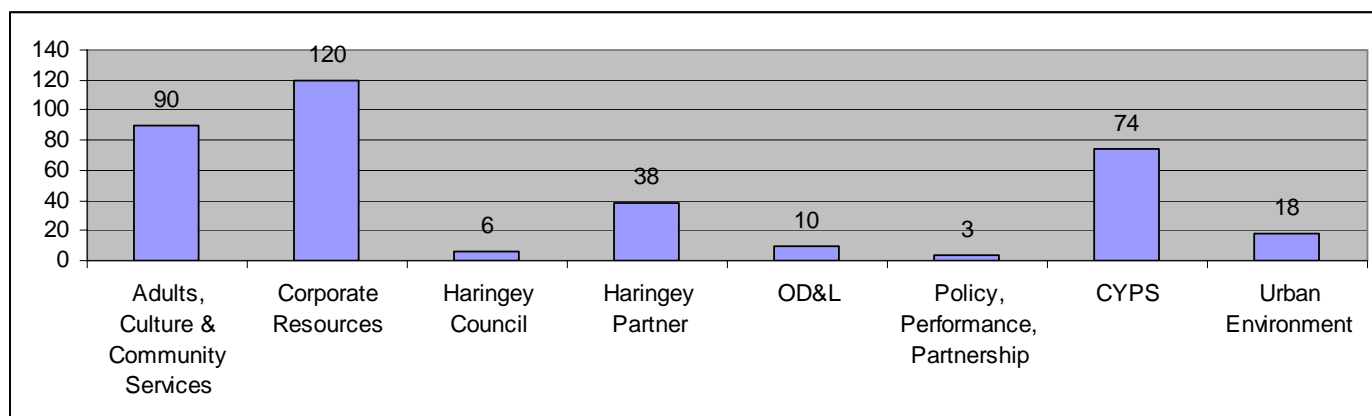


### A total of 371 staff received e-Learning training in 2010/11.

These figures include existing members of staff as well as new employees as the e-Learning course is open to all.

In July 2010, the Customer Services department within Corporate Resources enforced a policy whereby all of their existing staff had to complete the Introduction to Child Protection e-Learning course. This skews the figures for July and possibly August as well. Without Corporate Services, the July figures would be 42.

## E-Learning Uptake by Council Directorate/Agency



## One-day Training Course

Thirteen one-day induction courses took place in the course of the Multi-agency Safeguarding Induction programme's first year.

There has been a mean attendance of 14.8 per course, and a mean of 4.8 non-attendees per course. Due to current low hiring rates, numbers invited to the Multi-agency Safeguarding Induction one-day training have been significantly lower than originally forecast and five of the year's scheduled Induction training days were cancelled.

**Table 1: Attendance on One-Day Training Course**

Course Date	Numbers Attended	Agencies Represented	Non-attendance
21 April 2010	14	CYPS, Youth Services	0
28 May 2010	8	Youth Services, Adults, Children with Disabilities/CYPS, Voluntary Services	2
23 June 2010	19	CYPS, Youth Services, Early Years, Voluntary Services	9
25 June 2010	13	Children with Disabilities, CYPS, Voluntary Services, Youth Services, NHS in Haringey	8
29 July 2010	20	Youth Services, Customer Services, Early Years, CYPS, Children's Home	2
27 August 2010	8	Adults, Children's Home, Voluntary Services	9
29 September 2010	13	Early Years, NHS in Haringey, Adults, Voluntary Services	4
21 October 2010	12	Early Years, CYPS, NHS in Haringey, Voluntary Services	3

25 November 2010	19	Urban Environment, Early Years, CYPS, DASH, Voluntary Services	4
17 December 2010	14	CYPS, Legal, NHS Haringey, Schools, GOSH, Residential Care, Voluntary Services	6
21 January 2011	18	Probation, CYPS, GOSH, Voluntary Services, Early Years, Primary Care NHS, North Mid, School	5
18 February 2011	14	Schools, Schools support, NHS Haringey, CYPS, CAHMS, Red Gables, Voluntary Services, Residential Care	8
30 March 2011	21	NHS Haringey, CAHMS, Voluntary Services, Police, CYPS, Schools, Early Years	2
<b>Total</b>	<b>193</b>		<b>62</b>

## Trainers

The Induction one-day training course delivery began with the LSCB Training Officer as the sole trainer. *Outcomes of Interagency Training to Safeguard Children: Final report to the DCSF and the DoH (2010)* recommends that LSCBs not overly depend on one trainer for the delivery of their training as this can create a weakness in the service.

To remedy this, two new trainers (the Named Nurse for NHS in Haringey Primary Care, and the Local Authority Designated Officer (LADO) have both assisted in the delivery of the course in a co-training role. The LADO has also been used as a substitute for the LSCB Training Officer. Co-training, where possible, is valuable as it models working together and supports a multi-agency perspective.

## Agency Participation in Induction

The Multi-agency Safeguarding Induction Programme has been fully implemented across the partnership. It was rolled out in stages (the final stage in December 2010) to the following partner agencies:

- CYPS ^
- Housing ^
- Homes for Haringey \*
- Adults Services ^
- Youth Services ^
- All Other Council Staff ^
- NHS Haringey ^
- GPs, NHS Primary Care \*
- Early Years Settings \*
- Schools Settings \*
- Safer Schools Police & Community Support Officers & CAIT \*
- Probation \*
- GOSH Haringey ^
- Voluntary Sector \*

Most of these agencies' training and HR departments have coordinated systems set up with the LSCB for the notification of new employees (^).

Some agencies have not established systems but independently notify the LSCB as and when new employees begin work (\*).

## Exemptions

There are a few agencies who have decided to cover the Induction training material (though not the multi-agency experience of training) within their single agency Induction process. This decision was taken due to logistical difficulties of joining the induction proper because they are located out of borough or working across borough boundaries.

- North Middlesex University Hospital
- Whittington Hospital
- Barnet, Enfield & Haringey Mental Health Trust (BEHMHT)

Although logistically it is understandably difficult to include the BEHMHT in the Induction training, verbal feedback from Adults Social Workers who have attended the course is they would feel more comfortable if all BEHMHT staff attended the Induction training day because of the tendency of many adult mental health workers in health to focus only on the adults. Recent Serious Case Reviews across the country and locally also support this concern.

## Evaluations

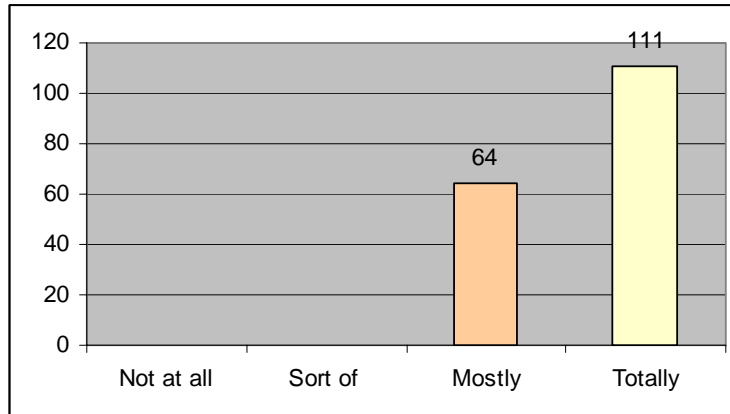
### e-Learning Evaluation Feedback

Three hundred and twenty (359) learners completed the e-Learning's evaluation feedback between April 2010 and March 2011. Overall, the feedback is extremely positive:

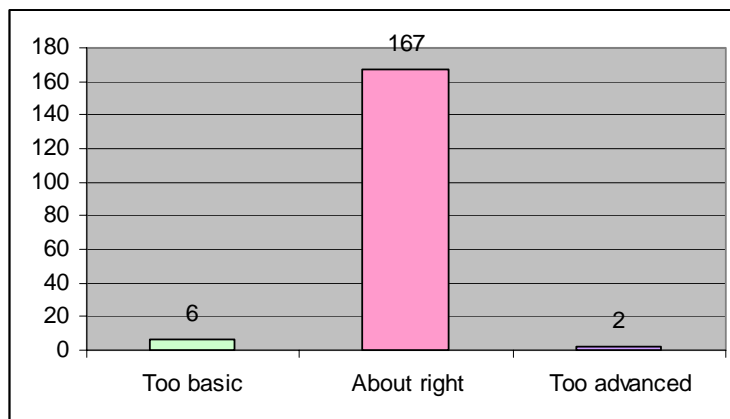
- Where 5 = 'Highly relevant and excellent' and 1 = Unsatisfactory:
  - The value of the course to learners' work was rated an average of **4.3**
  - The degree to which learning objectives were met was rated an average of **4.2**
- **93%** of learners thought the subject matter was sufficiently covered.
- **80%** of learners found it easy to make time for e-Learning.
- **98%** of learners would recommend the course.

## One-day Training Course Evaluation Feedback

Were the aims achieved?



The content of the course was...



The standard of the training was...

