Barnet Safeguarding Children Board

Making Safeguarding Everybody's Business

Annual Report 2012-2013

Contents

Foreword by Independent Chair

Welcome to the Annual Report of the Barnet Safeguarding Children Board.

On a personal level it has once again been a privilege to be the Independent Chair of the Barnet Safeguarding Children Board (BSCB) and to work with the representatives of the agencies that make up the BSCB. The most notable achievement in my view over the last year was the further recognition of the contribution that young people in Barnet have made to Safeguarding through Youth Shield. The detail of their work is outlined at page 51 of this report but the significance of that work and their ability to sustain it was reflected in their receiving the London Board's Safeguarding award for 2012 having been runners up in 2011.

The intention of the report is to outline the progress that has been made in the last year against the priorities that the Board set for itself, to identify work that needs to be carried out to improve safeguarding in Barnet and to assess the performance of the Local Authority and partners in delivering safeguarding outcomes for children young people and their families in Barnet.

In order to do that the Annual Report reflects the completion of a number of actions specific to the BSCB that were required by Ofsted following their last inspection in January 2012 and also a comprehensive assessment of the progress made in relation to the Board's own Work Programme.

As with the previous Annual Report each of the main agencies and partners to the Board has been asked to identify their own internal governance structures for safeguarding, their achievements over the last year in terms of impact for children and young people and their plans to further improve it over the next year. The Board continues to feel it important that agencies highlight their own individual contribution to overall safeguarding in Barnet so that it is possible for the wider public and the Board to make a judgement about the quality and quantity of the work being carried, out and more importantly how this translates into improving the lives of children and young people in Barnet. To that end each of the partners has been asked to highlight the positive outcomes for children and young people.

The Annual Report records a good deal of impressive work, jointly and individually, with the highlight being the work of Youth Shield being recognised through an award at the Annual London Safeguarding awards in December 2012 (and to which the Board has recently agreed to provide additional substantial funding), but there have been many other areas of positive work which are reflected within the Report.

Children's Services in Barnet offered themselves in late 2012, as a Munro Demonstrator pilot site which is intended to implement the recommendations of Professor Eileen Munro (who completed a report for Government into Child Protection and Safeguarding). A significant focus of that work has been around addressing neglect and related issues through early intervention and through the Board it has been possible to drive that agenda across the partnership. Whilst that work is still developing and being evaluated, the early signs are that it is effective and that the principles are shared by all the partner agencies. That focus on neglect has been adopted by the Board as a priority over the coming years because a number of case reviews that have been carried out over the last year have reflected major themes around neglect and the sharing of information. One of the existing priorities for the Board has been encouraging and supporting the creation of a Multi Agency Safeguarding Hub (MASH) where a range of partners can share information more quickly and appropriately at an early stage. The full implementation of the MASH from late July 2013 will go a large way to addressing many of the issues.

There are a number of other concerns which are likely to be major challenges over the next year which the Board will monitor and those are outlined in detail below;

Challenges facing the BSCB

- A key challenge will be the continued priority and capacity to deliver safeguarding at a time of budgetary restraint and organisational change across a range of partners, particularly the Local Authority, Probation, CAFCASS and Health. Despite efforts to protect children's services across the partnership, the threat of diminishing resources available to member agencies to safeguard children

and young people remains. This has been logged as a risk and will continue to be actively monitored by the Board. This is particularly significant given that the Ofsted proposals currently subject of consultation propose Ofsted will make a separate judgement in relation to the overall performance of the Board as well as Safeguarding across the partnership.

- Following the restructuring of Primary Care Trusts into Clinical Commissioning Groups (CCG's) on 1st April 2013, arrangements for the Safeguarding of children remain a priority for Barnet's Clinical Commissioning Group. The Director of Quality and Governance, Designated Nurse and Designated Doctor Safeguarding Children represent Barnet on the Safeguarding Children's Board. The CCG Clinical Director for Quality and Safety and, the CCG Children's Lead represent the CCG on the Health and Well Being Board. As yet NHS England representation on Safeguarding Boards has not been agreed.

- The community and voluntary sector has experienced a significant impact from the changes to allocation of grants and funding to grassroots services. There are real concerns that over the next year that may impact on their ability to work with children and families.

- Learning from review in Barnet has highlighted concerns regarding professionals' access to information about children and families with whom they work. The prevailing culture of caution in relation to information, driven by recent breaches of data protection, is viewed as a barrier to information sharing on the ground. The Board considers this to be a risk that potentially undermines good risk assessment practice. It is hoped that the implementation of the Multi Agency Safeguarding Hub (MASH) will improve safety in this regard. As part of the response to the most recent case review, it has been agreed that work will be carried out regarding access to the information systems.

- The continued independence of the Board and its role as a 'critical friend' is paramount. The position of the BSCB within the revised structure of Barnet should be monitored for impact in terms of any perceived dilution of that role or variance with the position outlined in Working Together 2013

- Ensuring that the lessons learned from local case reviews and case file; audits become embedded in local practice and improve the quality of the provision of services to children.

- Ensuring that the views of children and young people are taken into account in service planning and provision including setting priorities for staying safe.

- Continuity of key staff will continue to be an issue throughout the forthcoming year as we are about to lose the BSCB Manager

- The proposal to strengthen links with adult services through the appointment of a single Chair for both the Adults and Children's Boards will need to be implemented and should be reviewed to identify benefits and any associated risk.

Tim Beach
Independent Chair

Context:

Definition of Safeguarding: Safeguarding and Promoting the welfare of children is defined within the Working Together 2013 Guidance as

- Protecting children from maltreatment
- Preventing impairment of children's health or development

- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care: and
- Taking action to enable all children to have the best outcomes

The Children Act 2004 requires Local Authorities to establish Local Safeguarding Children Boards (LSCB) for their area as the key statutory mechanism for agreeing how organisations will co-operate to safeguard and promote the welfare of children.

Section 14 of the Children Act 2004 sets out the objectives of LSCBs, which are

a) 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; and

b) To ensure the effectiveness of what is done by each such person or body for those purposes

Working Together 2013, Chapter 3

This report is prepared in line with the statutory requirements outlined in Working Together to Safeguard Children 2013. The report will be submitted to the Chief Executive and Leader of the Council, The Mayor's Office for Policing and Crime, and the Chair of the health and wellbeing board. The report will also be submitted to the Children's Trust Board (CTB) and will be published as a document in the public domain.
The report forms part of the LSCB scrutiny function that should provide challenge in driving improvement.

The report should provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address them as well as other proposals for action. The report should include lessons from reviews undertaken within the reporting period. (Working Together 2013:3:17)

The document has been structured to a template which is recommended for national use. The intention is to both reflect progress made but also capture the priorities and areas which will need to be subject to additional focus over the coming year
This report will cover the extent to which the functions of the LSCB as set out in "Working Together 2013 "are being effectively discharged. The scope of the LSCB continues to be very broad and encompasses broader prevention as well as early intervention and child protection services: Within this framework, children at risk of harm will be a priority for consideration. The report will therefore include:

- The priorities of the Board: Why these areas have been identified as particular priorities and progress in relation to the priorities.
- Governance and Accountability of the Board: Effectiveness of the board and its sub groups.
- Monitoring & Evaluation/Quality Assurance Activity.
- Future challenges.

Summary of outcomes for the BSCB

Key activity and achievements of the Board itself over the last year include the following;

Ofsted Action Plan Update:

Barnet had a full inspection of its services in relation to safeguarding and looked after children in January 2012 and was judged to be good in all areas with the exception of quality of provision for safeguarding and looked after children services which were adequate.
An action plan was developed to address areas identified as a priority for improvement and the key area for the BSCB was as follows:

The BSCB to ensure that all schools adopt the correct safeguarding procedures by referring appropriate safeguarding concerns to either the LADO or children's social care before interviewing children in detail or undertaking any further investigative actions before a strategy discussion or meeting has been held

Action: In response to this, refreshed guidance was re issued to schools and the procedures were highlighted at relevant heads and safeguarding leads meetings. Schools have also been encouraged to take up training provided in relation to allegations management as well as safeguarding and child protection.
Additional training was also arranged with an input from the police Child Abuse Investigation Team (CAIT)

The LSCB was also identified as the lead for 3 additional issues, as below, that were raised in the Ofsted report, but which had not been included within the 15 recommendations and did not have a fixed time frame.

1. *Attendance at BSCB by all members is not consistent*
   Action: Attendance at the Board continues to be monitored and subject to discussion between the Chair, Board Manager and individual agencies as appropriate and overall has improved
2. *BSCB needs to strengthen its management oversight of the impact and quality of work undertaken on its behalf*
   Action: The change to the arrangements for the Executive Group have been effective in shaping the agenda for the main Board and providing additional detailed scrutiny to areas of focus such as case reviews and the examination of data
3. *Whilst the BSCB receive safeguarding performance information, scrutiny of this data is not robust and there is limited evidence that the board's oversight is having an impact in driving improvements*
   Action: The BSCB does receive performance information directly and work is ongoing to refine that information so that the Board can fulfil its strategic role whilst being alerted to issues of real concern or risk. This involves the development of an information dash board which indicates areas significant change or agreed priorities.

S11 Audit:

A focused audit for partner agencies to review compliance with the safeguarding duties contained in Section11 of the Children Act 2004 has been completed between March and May 2013. This report will be fully considered at the Performance and Quality Assurance Group and the Board and an action plan developed and monitored over the coming year. The returns for the S11Audit have generally been of a better quality in terms of the level of analysis and the detail of the supporting evidence provided by the agencies than has been the case previously. This reflected well in terms of the thought and effort which had gone into completing the Audit. The Audit highlighted a great deal of positive work but also a number of areas that will require planning and focus.

Key areas highlighted for focus by the report are as follows:

1. The monitoring of S11 requirements and maintaining standards in relation to commissioned services is a significant area of work for the BSCB, particularly the Performance sub group
2. Identified gaps in some services systems to capture the views of children and young people and how they contribute to service development, especially in relation to diversity policies
3. Induction training regarding safeguarding was not universal
4. Training in diversity appears to be a gap for some services
5. Agencies did not evidence impact of training in many cases and the training sub group will need to address this.
6. The Safer Recruitment Procedures standard had a number of elements which highlighted gaps in relation to assuring safer recruitment practice across commissioned services, training, knowledge and understanding of allegations management processes, support for staff and audit activity which will require follow up by the Performance sub group and monitoring by the Board.
7. The S11 audit also highlighted several areas for development in relation to the monitoring of attendance at meetings, demonstrating outcomes in terms of children and families and consultation with children and young people.

In the BSCB Annual Report from 20011/12, the Board identified the following priorities and below we assess our level of success in addressing them:

What we said	What we did
Quality Assurance, Challenge and Scrutiny To further develop scrutiny of BSCB in monitoring and evaluating the effectiveness of safeguarding activity across the partnership so that children and young people in Barnet are safe from abuse, neglect, violence and sexual exploitation	We have a strong basis to move forward as we have secured engagement of all key partners in our Performance and Quality Sub-group which is a well functioning group. Audit activity during the last year has included health, children's social care and other partners and work is in progress to agree an outcome based framework in line with Munro. Partners have played an active role in bringing their own QA processes to the scrutiny of the group. A S11 audit has been conducted based on an agreed London wide tool. This will be considered at the PQ group and the BSCB over the year.
Risk Assessment, Information Sharing and Partnership Work Seek to develop tools /Protocols to promote improved information sharing, risk assessment and partnership working, including support for development of MASH	The BSCB through its Professional Advisory Group piloted a multi-agency risk assessment tool designed to be used as an 'aide memoir' to support universal services in the identification of risk. This has also been used to good effect to review cases in supervision. Information sharing continues to be a priority and has emerged as an area of concern in our partnership reviews. This is now being reviewed in response to the

	learning from the SCIE review. Work has also progressed on the development of a Multi-Agency Safeguarding Hub – MASH which will begin in July 2013. A multi-agency steering group includes representation from the BSCB Independent Chair in order to provide oversight. A programme of training to support implementation has been developed by the London Safeguarding Children Board.
Young People at risk through peer violence and exploitation To focus on peer to peer violence including Gangs/Sexual Exploitation/ Anti Bullying/E safety	This remains a national and local priority and a reconvened task group led by Police colleagues will drive forward implementation of a coherent strategy based on the Pan London Multi-agency operating procedures**.** Training in sexual exploitation is being rolled out and the training programme also includes gangs training that features input from young people who have been gang affected. E safety training is also planned and a task group will update the BSCB e safety strategy. The work of Youth Shield has included training in peer support and will strengthen the contribution of young people in Barnet in providing peer support and education to promote healthy relationships
Early Intervention Promoting and evaluating a model of early help for children and families which reduces demand and cost (Munro)	Working Together 2013 sets out the importance of early help for children and the role of the LSCB in evaluating the impact of early help. Barnet has an early help offer that provides a coherent framework for family support. Many examples have been provided within the report below of how this can help families in practice, for example, through the therapeutic work in relation to domestic violence which has helped to improve safety for children. The Board will have an important role in monitoring the effectiveness of these arrangements
Learning and Development To strengthen the BSCB role in promoting learning and development across the partnership	As outlined in the report, BSCB has played an active role in promoting learning and development across the partnership. A number of reviews have already been conducted using the SCIE methodology and improvements made as a result of learning. Further reviews are in progress and the Board places a high priority on continuing to promote a culture of learning

Additional Outcomes

- Completion of 3 multi-agency case reviews using the Social Care Institute for Excellence (SCIE) model, which has identified important learning for all partners. This will be outlined in further detail later in the report.
- An audit to track the journey of a child from needing help to receiving help through a range of universal and targeted services
- Strengthened governance and accountability through the repositioning of the Executive Group which has oversight of policy, strategy and performance in respect of safeguarding children. The Executive is also responsible for establishing the BSCB budget and agreeing agency contributions which will be reviewed annually.
- Continued work with faith and cultural groups to increase safeguarding awareness in partnership with CommUNITY Barnet.

- Enhanced arrangements for quality assurance using a dashboard which is currently in development. This will be monitored via the Independently Chaired Performance and Quality Sub-Group.
- Continued involvement of children and young people through the work of 'Youth Shield' and an expanded remit to further drive their contribution
- A renewed focus on tackling sexual exploitation linking with arrangements to safeguard missing children. A group has been reconvened which will be led by representatives from the Met Police with the task of developing a coherent operational structure based on multi-agency Operating Procedures across London developed by the Met Police. Training has also been delivered which aims to build capacity and confidence in identifying and responding to concerns about CSE.
- Learning and development events including a conference on trafficking and sexual exploitation held with a neighbouring authority, Enfield.
- Maintaining a focus on Safeguarding in challenging financial climates and organisational change. The LSCB has managed to maintain funding from contributing partners at current levels.
- Continued engagement with schools to identify and respond to safeguarding and welfare issues and the involvement of schools in a self audit of their safeguarding responsibilities
- Promotion of the Strengthening Families approach to Child Protection Conferences which has been found to be an effective way of engaging families in bringing about improved safety for children.
- The pilot of support and consultation for staff working with families where personality disorder or challenging behaviour is a feature. This initiative was developed in response to learning from review which evidenced the impact on professionals and the risk of loss of focus on the child. Evaluation of the pilot has shown that this is a valued opportunity for consultation which has helped practitioners to manage some elements of casework more effectively, for example, a complex case initially referred to the Multi-Agency Group was able to be managed without the need to escalate which would have required more intensive resources.

Governance and Accountability Arrangements

The Board has an Independent Chair who formally reports to The Chief Executive, who, drawing on partners and where appropriate the Lead Member, holds the Chair to account for the effective working of the LSCB. The Independent Chair is a member of the Children's Trust Board where the work of the Board is tabled, including the annual report outlining the work of the BSCB which is also presented to the Overview and Scrutiny Committee. This ensures appropriate challenge where necessary.

The Lead member for Children's Services is a participant observer of the BSCB in accordance with the directive in Working Together 2013 and the Director of Children's Services a member of both the Executive and BSCB.

Barnet Safeguarding Children Board has recently seen a change in Lead Member and we are pleased to welcome Councillor Reuben Thompstone to this role. Councillor Thompstone replaces Councillor Andrew Harper whose contribution to the Board was greatly valued as a passionate and enthusiastic champion for children in Barnet.

The Board has continued to evolve structure and governance arrangements to ensure a sharper focus on scrutiny and monitoring. There is currently a two part structure with an Executive that meets in advance of the full Board meeting. Executive Members are responsible for policy, strategy and performance in respect of safeguarding children. They are also responsible for establishing the BSCB budget and agreeing agency contributions which are reviewed annually.

The role of the Executive has been further strengthened in the last year through a revised schedule of meetings to assure greater oversight of the BSCB agenda and maximise ownership of partnership working improvements.

The BSCB has established a large membership to include a wide range of partners, including Community (Lay) members and Youth Shield.

Attendance is actively monitored with gaps followed up and this is likely to be a continued challenge given the demands on partner agencies time and resources and overlapping structures that require some partners to service more than one LSCB. A breakdown of agency attendance is provided as an appendix and despite these challenges it is noted that attendance has improved significantly in the last year.

A further key development has been the work of the Joint Services Governance Group which has identified a number of opportunities for improved collaboration across Adults and Children's Services, including the appointment of a single Chair for both Boards, following the retirement of the current Chair of the Safeguarding Adults Board

The Board works to an agreed constitution and work plan and a number of sub groups are responsible for carrying out elements of the work programme and reporting back on progress at each Board meeting. This structure is also supported by a number of task and finish groups that are mandated to carry out specific pieces of work. Details of all of these groups are contained in Appendix 4.

BSCB Sub Groups:

There are currently four sub groups in addition to the Standing Serious Case Review (SCR) Panel and the Child Death Overview Panel (CDOP). These are as follows:

Performance and Quality Assurance Sub Group: The Performance and Quality Assurance Group (PQA), chaired by the Independent Chair, has a remit to scrutinise the performance of partners in relation to safeguarding activity and report back to the Board. The development of a coherent framework of multi-agency data has been led previously by work across London in relation to a Dataset Project.

Barnet actively participated in this work but unfortunately funding was no longer available to extend the project beyond the initial start up phase. This coincided with the need to review data so as to reflect Munro indicators and incorporate a multi-layered approach that captures the views of children and professionals as well as 'hard' performance data. The London Board and Chairs Forum have recently started work across London Boards to create a shared or comparable dataset and Barnet has supported this work.

The London Borough of Barnet data analysis team has provided input in reviewing the dataset and a revised framework is in development. The Board needs to continue to explore creative methods for capturing data from children and young people, drawing on work done by partners in this area, for example, patient experience data in health and the work of Youth Shield in the forthcoming year.

Partners are also being encouraged to report improved outcomes for children and young people and a number of examples have been provided from a range of services using a 'Positive Outcomes' proforma. This has enabled us to build an 'evidence bank' of the impact of our interventions which will give a picture of how measured activity has made a difference to the lives of children and families.

The PQA has also enabled partners to report on their own internal audit and monitoring processes. Health partners, Children's Social Care, Police and Probation have given informative presentations in this regard.

A further key vehicle of assessing multi-agency performance is the audit based on compliance with the requirements of S11 of the Children Act 2004.

The S11 audit recently completed has been presented to the PQA group and in turn the Board in the near future. Additional detail is outlined below within the report.

Training and Development Sub Group: The LSCB is responsible for the strategic overview of safeguarding training both by single agencies (to their own staff) and interagency training. The Training and Development sub group discharges this function in collaboration with the Children's Workforce Development Team to ensure that both single and multi-agency training is delivered to a consistently high standard and that a process exists for evaluating its effectiveness. Recent work has focused on the quality assurance role of the group and it has been agreed that the group will take an active role in reviewing course evaluations. Alongside this, the workforce development team will be introducing a system of impact analysis using follow up questionnaires.

Professional Advisory Sub Group: The Professional Advisory Group (PAG) includes members with direct operational knowledge and its function is to ensure that all policy and procedure is both appropriate and operable. It also oversees the work of a number of Task and Finish Groups which have a remit to develop policy or examine specific issues and report back to the PAG, and through that the LSCB, for example, in relation to sexual exploitation. During the last year the PAG developed a directory of professional guidance and resources which have been uploaded on the BSCB website. The group has also successfully piloted a Multi-Agency Risk Assessment tool for universal services. An E-Safety task group has been reconvened in order to review and update the E-Safety strategy on behalf of the PAG and has created it own action plan for work over the next year. There has also been work focusing on child sexual exploitation and the links with missing children that is also reflected upon within the report.

Cross-Generational Sub Group/ Joint Services Governance Group: This group operates as a cross service group responsible to both adults and children's safeguarding boards. The aim is to ensure that services collaborate as far as possible in promoting the safety and welfare of children and a holistic approach to working with families. The group has not been operational during the last year as this work

has been subject to review as part of the wider review of adults and children's joint governance arrangements which has identified areas for development in working across the interface.

Child Death Overview Panel: This panel is responsible for the specific functions relating to child death as outlined in Working Together 2013. Its purpose is to review all child deaths and identify any matters of concern in relation to any child death in Barnet and its work is covered in greater detail on page 26.

Standing Serious Case Review Sub Group: The Standing Serious Case Review Sub-Group (SCR) links to the Child Death Overview processes when a child has died or been seriously harmed and abuse or neglect is believed to be a factor. Independent Chair arrangements further enhance the capacity to exercise scrutiny and challenge. The serious case review sub-group has a wider remit in supporting learning from reviews and has carried out 2 case reviews using the SCIE systems methodology following an initial case review as part of a London pilot. This has identified learning and improvements in practice for a range of multi agency staff. A number of learning events have been held throughout the last year with further events to follows. The work of the group is outlined in greater detail on page 19.

Monitoring and Evaluation

The figures below reflect the current reporting period 2012/13 and cover children and young people within Barnet considered to be at the higher levels of risk.
Generally the statistics for Barnet in comparison with other London Boroughs are on the face of them reassuring in that the figures are relatively low when examined against population figures. However in 2011 as reported previously there were concerns at increasing numbers of children being placed on child protection plans which was greater than similar Boroughs. Some internal audit work was carried out by LBB and BSCB and whilst no single cause was clearly identified some focused work was carried out on monitoring those trends.
The figures below and the historic data in Appendix 1 reflect a more reassuring picture in that whilst 2012/13 saw a small rise in initial assessments, a significant rise in core assessments and a rise in Section 47 child protection investigations, the number of children on a child protection plan reduced significantly. Similarly the numbers of children being returned to a plan or remaining on a plan for over two years also reduced. The additional focus by Children's Services and partners in assessment and early intervention appears reflect better joined up planning and to have led to a reduction of children being subject to child protection plans without increasing the numbers of children having to be returned to plans at a later date.

Children's Social Care in 2012-13

277 children Subject to Initial Child Protection Conferences (inc Pre-births & Transfer-Ins)(2012/13)

311 Children in Care

229 children Subject of a Child Protection Plan (2012/13)

1,118 Children in Need (2012/13)

3,468 referrals
to Children's Social Care (2012/13)

86,809 children
aged 0-18

The Effectiveness of Safeguarding in Barnet:

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 difficult task facing an LSCB. The Annual Report is intended to reflect the most significant work that has gone on in the last year in Barnet that we judge to have had a real outcome in safeguarding children and families in Barnet.
Key outcomes are provided with some narrative throughout the report and within Appendix 3 from the agencies individually.

Much of the work is concerned with activity or output. It is not always easy to identify the outcome, or result of the actions we take but our aim is always to try and maintain a focus on actions that make a difference to a child or young person.
Partners have been helping the Board to build an 'evidence bank' of positive outcomes which demonstrate the effectiveness of interventions. Below are some of the examples which reflect the range and effectiveness of the safeguarding partnership within Barnet:

Children's Social Care Services worked with Targeted Youth and Housing to support a vulnerable young person in transition.
Positive outcome *The young person was helped to apply for and secure a place on the "Get Real Project" .The Get Real project offers shared accommodation and ongoing support to young people who show a commitment to education, training or employment. The scheme is aimed at breaking the culture of antisocial behavior, alcohol and drug abuse and welfare dependency that frequently exists among young people in temporary accommodation. The Young person is now thriving and is acting as a role model to other young people taking an active role in community projects aimed at encouraging young people from Black and Minority Ethnic Communities to engage in education and enterprise.*

Junior Role Model Army (Young People in Care) Film Production
The issues which the film highlighted were the following;

- *Children and young people having to move repeatedly until the right placement becomes available.*
- *Leaving family members*
- *Issues around trust*
- *Changing social worker*

The positive outcome *was that the children and young people's voices were heard, this was done by showing the film to the Lead member and Councillors from the Corporate Parenting Advisory Panel group. The film has been used for training with foster carers, designated teachers for looked after children and Educational Psychologists. It has been shown at a Social Care service study day, to ensure staff and professionals had the opportunity to hear the young people's journey through care. Having a film is an effective tool for raising awareness and understanding of issues with professionals across the Children's service (e.g. with colleagues in education).*

Norwood
Issues highlighted - History of allegations of physical and verbal abuse by the parents towards the children. Three separate concerns were raised historically. Parents denied this, and also said that they would never use physical chastisement as this is wrong. Social care closed the case accepting the parents and communities assertions that this was a malicious referral.

Child disclosed to school that the father was using physical chastisement. When parents were questioned over

this, father said that he did not know that this was inappropriate, and it was a cultural method that he was using, and now that it had been highlighted he would stop.

Complex cultural issues within the family.

Mother and one child has a learning disability, which seems to impact on ability of mother to take on board parenting advice. Mother becomes tearful.

Parents are refusing to get youngest child assessed by a paediatrician as there are concerns around developmental delay.

***Positive outcome** - Barnet allocated social worker did some excellent investigative work, taking into consideration the historical concerns and Norwood's Significant events record to help the assessment, and liaising with all professionals involved.*

Children's wellbeing is being monitored and services accessed to ensure that their needs are met.

Continuous monitoring of parents ability to meet the needs of these children, ensuring that concerns are not minimised.

Referral to CIN team.

Barnet, Enfield and Haringey Mental Health Trust
Issues highlighted - Current statutory guidance states that children under eighteen should not be admitted to adult ward. Although an assessment suite is not a ward, it is within a mental health unit and there was a lack of clarity in the statutory guidance about the use of assessment suites for children and young people under eighteen who were experiencing an acute mental health difficulty in the community.
At the same time as this local event, there was national recognition of the impact of the admission guidance for children and young people in these situations. Although highly unusual for a younger child it is an increasing problem for 16-17 year old young people.
Subsequently the organisation that monitors health providers, the Care Quality Commission, published revised guidance in the form of a briefing suggesting that there may be circumstances that it was in the child's interest to admit to an appropriate adult facility for a short period with oversight by a child psychiatrist to enable an assessment and the provision of an appropriate care setting to be organised. This will avoid children and young people waiting in inappropriate settings.

***Positive Outcome** - There is no indication that the child concerned suffered harm because of the delay in admission. There was good communication between the police, A&E, children's ward and the mental health Trust and during the delay the child was seen by a paediatrician. They were subsequently assessed in the assessment suite, seen by a psychiatrist and found a bed in a specialist out of borough mental health facility for those under twelve, early the following morning*

Barnet and Chase Farm Hospitals NHS Trust
Issues highlighted from several cases were Domestic violence ; allegations of physical and sexual abuse; maternal alcohol , learning difficulty and mental health issues ; maternal drug dependency issues in pregnancy ; neglect ; teenage alcohol issues; teenage pregnancy ; teenagers at risk of sexual exploitation ; vulnerabilities of looked after children; parental responsibility;

***Positive Outcome** - Seeking to ensure the safety of children at potential or actual risk of significant harm. Ages of children range from neonates to teenagers and the vulnerabilities are diverse, as highlighted above.*

Ensuring engagement of relevant agencies including local Social Care Early Intervention and Troubled Families Teams, Child and Adolescent Mental Health Team, local sexual health clinic, School Nurses and Special Educational Needs Coordinators, and on occasion Social Care professionals from outlying boroughs.

Solace Women's Aid
Issues highlighted - When a family first arrived at the refuge, child was observed to be quite rough in his play with other children. Due to the language barrier child found it difficult to communicate his wishes and feelings and would hit and push where he became frustrated and to get someone's attention.
Along with this frustration child's experience of relationships also taught him that violence was a part of communication with others.

Due to his rough play other children would shy away from playing with him. When child started school they also

flagged up concerns about child's ability to interact appropriately and to make friends
Child's mother was initially referred to Strengthening Families, who were running a parenting group in her native language. However, she decided that he did not feel safe attending this group as she was worried by attending a group with members of her community she might meet someone with a connection to her husband, whom she was fleeing.

***Positive Outcome** - Since coming to the refuge child has been able to access one to one play therapy and is now accessing this support within a group. The refuge has worked closely with school and they have been able to offer extra support, such as working with mother to look at supporting Child with his homework. In the refuge child and mother were supported to start using a star chart which mother says has helped greatly. Within play sessions held twice weekly in the refuge and in general day to day interactions staff supported the Child by mirroring positive interactions and praising where he played gently.*

Mother was referred to picking up the pieces – a parenting programme for mothers who have experienced domestic violence. An interpreter was provided for this group, enabling her to engage well and to contribute to the group. Mother was also referred to an ESOL class at the local children centre, especially aimed at mothers supporting bilingual children.

Through this support school have reported that child is calmer. Child is able to access breakfast club which has helped with his punctuality. He also attends twice weekly after school clubs – supporting him to build a network of friends.

The play therapist reported that following his one to one sessions child was better able to demonstrate his affection and interact with her by using gentler and more peaceful means. She continues to provide support through group play therapy.

Through accessing parenting classes and through one to one work with the FSW mother has been able to build her knowledge of the effects of DV on her child and how best she can support him.

Safeguarding Division
Issues highlighted:

- *Child being left unsupervised outside of the family home since the age of 4*
- *Allegations that the child had been physically chastised by parent*
- *Concerns re : children's clothes too small worn out or dirty*
- *Parents bereaved - Mother recently lost an unborn child and father lost his father*
- *Children hungry and packed lunch for school sparse*
- *Lack of stimulation in the home*
- *Mother finding it difficult supervising the children*
- *Family are from Afghanistan and children are allowed to play out unsupervised there , family thought this was alright*
- *Child struggling at school*
- *Child playing in an aggressive way*
- *Child being left outside unsupervised*
- *Parents depressed and living in crowded accommodation*
- *Child had behavioural issues at school*
- *Child was made the subject of a CP Plan under the category of neglect*

***Positive outcome** - The family have moved to a house in another area and the family have a garden*

- *The child has not been left unsupervised outside of the home and the parents understanding the risks of this*
- *The parents are interacting more with the child is making good progress at school and behaviour is good*
- *Parents are proud of the child's achievements at school*
- *The child seems happier is clean and well presented and has school dinners now*
- *both parents have engaged with professionals and are learning new ways of stimulating their children*
- *Children made subject of CIN Plans after 7 months*

Children's Social Care
Issues highlighted

- *Child wanted to return to a family he had previously been placed with by his mother under a Private Fostering arrangement. Child had been happy living with this family, however, sadly his mother had fallen out with this family and could not see that, if she was not in a position to care for him then it was in his best interests to*

return to somewhere he felt happy and was familiar with rather than foster carers who were strangers to him.

- *Some of the family circumstances of the proposed family that Child wished to return to, presented challenges for the assessing social workers. Despite this, a sensible and proportionate response to the issues of concern has been taken and the child's wishes to return have been taken seriously.*
- *Contact continues to be an issue as child does not wish to have contact with birth mother and siblings.*
- *DBS traces on adults in the household*

Positive Outcome

- *Returned to a placement that he was happy and comfortable in where his cultural, developmental and emotional needs are being met.*
- *Emotional health. Child is happy and feels content and supported in placement.*
- *Child is settled in school and is awaiting CAMHS input for further emotional support. The carers have been proactive at supporting this to happen.*
- *Child re-established since being in care, relationship with birth father – once monthly contact.*
- *Carer is supporting indirect letterbox contact with birth mother as an on-going process of re-introducing future contact.*

Central London Community Healthcare (CLCH)
Issues highlighted
This child was at risk largely due to her two older brothers having a long history of criminal activity. They were both involved in drugs and gang culture and were living in the family home where a series of threats had been made

Concerns regarding the mother's ability to protect her daughter from the activities of her two sons (who were both young adults).

Positive Outcome

- *Mother moved house into Barnet so she and her daughter were removed from the ganga culture that her sons were involved in.*
- *Referral to safer families' project*
- *Good engagement with professionals*
- *Mother maintained safe environment away from her sons*
- *One son was re-housed in a different part of the country with the help of probation service, whilst the other son is currently serving a prison sentence with a view to him being re-housed in a different area on his release.*
- *Concerns reduced sufficiently to enable the child to become subject to a CIN plan early this year.*

The Munro review identifies the LSCB as having a crucial role as the vehicle for scrutiny of safeguarding activity across the partnership. The Performance and Quality Assurance Sub-Group leads on this work and has responsibility for monitoring and evaluation through an agreed multi-agency programme of audit and review. Chair arrangements provide an opportunity for independence and challenge which has enabled the group to develop a strong basis with improved attendance and representation over the last year.

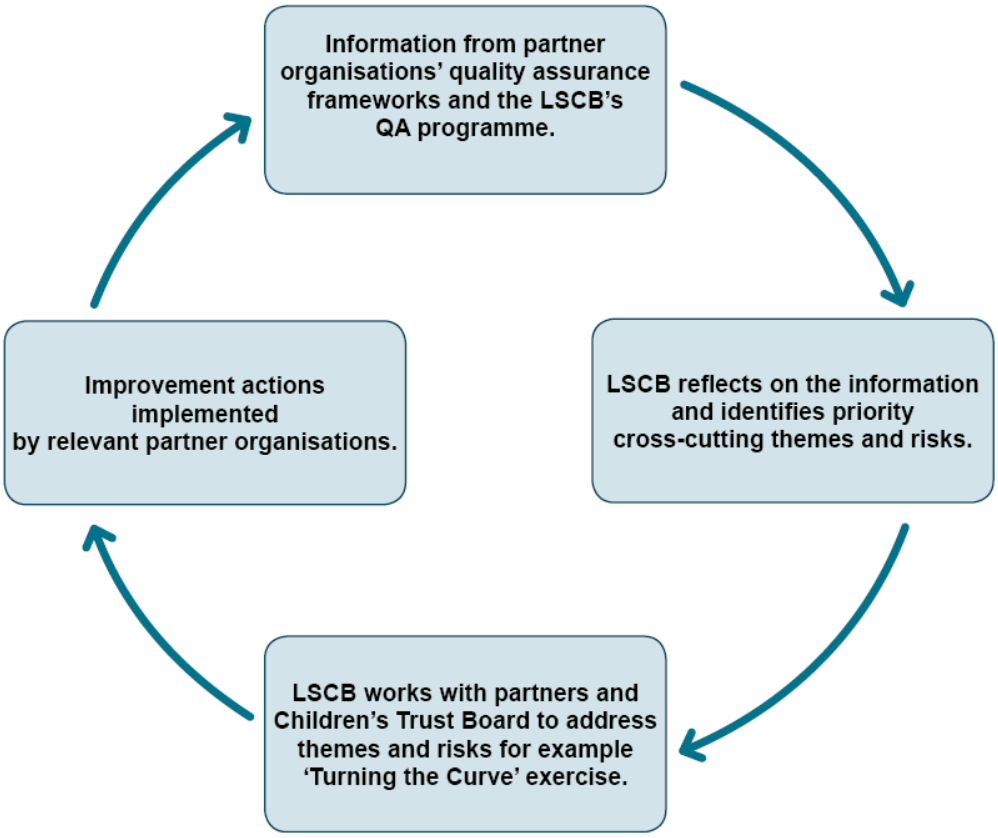
"LSCBs play an extremely valuable role and will remain uniquely positioned within the local accountability architecture to monitor how professionals and services are working together to safeguard and promote the welfare of children. They are also well placed to identify emerging problems through learning from practice and to oversee efforts to improve services in response".(Munro Chapter 4)

A review of partners Quality Assurance frameworks over the last year across a range of partners has provided assurance of robust processes within single agencies as well as across the partnership.
Barnet has continued to review partnership data across the range of outcomes for children. Interrogation of the dataset has highlighted several areas of note, such as the stabilising of referral rates to children's service, which had been appropriately flagged as an area of risk and subject to ongoing monitoring and levels of participation and General Practitioners in case conferences. The latter issue allowed focused

work with GPs to be carried out to assist their involvement in the provision of information appropriately in individual cases.

The Safeguarding dataset discussions need continued work at local and pan London level if the national and local performance indicators recommended by the Munro Review are to be adopted. This work has been accepted by the Board and Sub Group as part of their contribution to the Munro Action Plan being managed through Children's Services and as one of the four priority areas for the Board. This work including the development of feedback from service users and the workforce, will therefore assist in identifying the outcomes for children and families and remains work that needs to be completed.
Substantial work has gone into producing useful quantative data, but the progress in obtaining qualitative data from service users has been slower and is therefore a priority over the next year.

The Sub-Group has adapted the London Safeguarding Children Board Quality Assurance Framework for local use so that we have a comprehensive means of assessing how well we safeguard children in Barnet, based on key priority areas. This is based on recognised good practice. A diagrammatic representation of the process is shown below. It should be noted that there is current work in progress through the London Safeguarding Board to develop that framework and share it as widely as possible across London and Barnet has played its part in that work through the London Board and the Chair's Forum.



Audit Activity:

A number of audits have been undertaken in the last year including the following:

Journey of the Child: In line with the Munro report, a multi-agency audit group drawn from membership of the Professional Advisory Group piloted an audit intended to provide a picture of a child's journey from needing to receiving help through a range of universal and targeted services. An audit tool was developed which enables a qualitative judgement of practice outcomes in line with existing gradings used by Ofsted. This audit tool is structured to reflect the child's journey from early years to transition to adulthood. These stages of the child's journey broadly relate across to Barnet's current Children and Young People Plan 2013-2016 which was reviewed in late 2012.

The case selected was that of a young person who had experienced a number of services and following an initial scoping meeting in which services were identified, each provided a return which enabled the child's journey to be tracked over time. The case group met to analyse each of the reports and an overview report of key findings will be produced and reported to the PQ group. It is felt that this has generated valuable learning and the model will be used to audit cases at varying levels of need which will help inform knowledge and contribute to the improvement of multi agency planning. The audit reflected largely good work across the partnership with a complex case and required a significant commitment across the partnership.

S 11 Audit: As outlined in the earlier section of the report on Page 7, the S11 audit highlighted a number of areas that the Board and partners will need to focus upon. The move towards an increased commissioning role of the Local Authority and some partners for a significant number of services will mean that there is a concomitant responsibility to ensure that those services fully reflect all the necessary safeguarding commitments. Similarly the Action Plan will need to address some organisations not having robust mechanisms in place to seek and respond to the views of children and young people when planning services.

Schools Audit: A small sample of a range of schools under S175 Education Act 2002 where subject to audit in parallel with the S11 process. The results have been collated and reported to the Performance and Quality sub-group. The audit reflected that schools have appropriate safeguarding arrangements in place and compliance with training and Ofsted requirements.

Future Audit: Audit work around neglect and information sharing has been agreed for the coming year. Additional audit programme work will be informed by, learning from the SCIE reviews. The Section 11 and schools audit will also identify areas for development.

Joint Work: We have also explored the potential for peer audit with Enfield and had a useful cross borough review of data from Barnet and Chase Farm Hospital which illuminated difference in thresholds between boroughs. It is anticipated that the implementation of the MASH will have a positive impact on the consistency and response to initial reports of concern about a child.

A revised Children's Social Care Quality Assurance framework and audit programme has been agreed which will include a heightened role for Independent Reviewing Officers and Case Conference Chairs in scrutiny through identification of 'practice alerts'

Routine audits are now undertaken on an ongoing basis on children subject to Child Protection plans for 2 years or more and those re-registered'. This is to prevent 'drift' in those cases which can sometimes occur as a result of turnover of staff.

Following a successful pilot which the BSCB supported across the partnership the safeguarding division has implemented the 'Strengthening Families' approach to the conference process which has been found to be an effective way of engaging families in bringing about improved safety for children. In adopting the 'Strengthening Families' approach to Child Protection, and moving from a more traditional conference model, Barnet has aimed to create more effective partnerships between families and professionals. Barnet staff were invited to outline that work at a workshop at the London Board Safeguarding Conference in December 2012.

Professionals who have attended Child Protection Conferences are on the whole enthusiastic and supportive of the new approach. Feedback evidences that the structure is helpful and generally people have commented on the use of a visual tool for the headings.

There is generally positive feedback from families attending Child Protection Conferences. During the year 62 questionnaires have been completed.

The majority of the questionnaires reflected the fact that both families and professionals felt that the arrangements enabled them to better contribute to the process and produce more effective plans.

The London Borough of Barnet Cabinet and Overview and Scrutiny Committee receives annually an overall Safeguarding Report which covers both Adults and Children's Services. This document reflects the general picture of Safeguarding within Barnet across the Partnership.

Serious Case and other Reviews

The Standing Serious Case Review Group is chaired by an Independent Consultant Sally Trench and has a remit to promote wider learning from review

The panel has been responsible for ensuring action plans have been completed in respect of previous SCRs and these will continue to be monitored as required via the Performance and Quality Assurance sub-group.

Barnet has not been involved in a Serious Case Review for over 3 years.
However, a key area of activity during 2012/13 has been reviews carried out using the SCIE systems methodology .This is a collaborative approach, drawing on the contribution of the professionals involved, which explores the underlying conditions that affect professional decision making in the journey of a case.

Barnet is therefore well placed to fulfil the requirement of Working Together 2013 to adopt a systems approach to learning from review.

In relation to the initial review, BSCB has successfully delivered a series of learning events which have been attended by over 250 staff. The BSCB is actively implementing the findings of the review which have been collated into a composite thematic response from all the agencies involved.
2 further reviews have been conducted using this model and the reports are currently in the process of being finalised and agreed with SCIE and will be brought back to the group for consideration. Both cases featured children who had suffered neglect, albeit in very different circumstances. One case involved transfer from another area and has enabled both areas to share findings about professional practice.

The reviews have powerfully illuminated the challenges for professionals in the identification and management of neglect and have also highlighted failures in information sharing and the process to refer concerns. Central to the action plan agreed as a response to the second full case review is work to improve information exchange and, as is highlighted elsewhere within the report, the MASH and work supporting its introduction are seen as fundamental to addressing this particular challenge.

A further review looked at a case involving an unexplained injury to a very young baby and provided useful learning about inter agency practice across hospital , police and social care services and the application of parallel processes for child protection and allegations investigations.

The group has also discussed in detail the case of a teenager who died by hanging and had an overview of all the Health reports produced for the health SUI review process.

The case raised issues about communication with private health providers and their standards, as well as about support for a school where such an incident has occurred. Liaison with a neighbouring authority has enabled a review of the schools safeguarding practice to be carried out, following concerns expressed at the inquest.

Several members of the group have recently undertaken the SCIE Foundation training which will enable increased capacity for review using this model.

Two colleagues who completed the training are now acting as internal reviewers to assist an independent reviewer in conducting a further review. An initial meeting has agreed the scope of this review which will commence in September. The review will focus on a case involving both adults and children's services and will explore practice across the interface of services which will inform the joint services work in development.

The SCR group has functioned in line with Chapter 4 of Working Together 2013 which requires LSCBs to maintain a learning and improvement framework. This provides a timely opportunity to refresh the terms of reference and consider renaming the group to reflect its wider role in promulgating learning from review.

Managing Allegations against Adults working with Children

One of the prime responsibilities for the BSCB is to monitor allegations against professionals and a comprehensive report is prepared each year for the Board. The report outlines below a substantial increase in allegations being reported. The view of the Safeguarding staff is that this is linked to the high level of media attention to these issues which has in turn increased awareness and the level of alertness to these issues.

The allegations against staff arrangements continue to be supported by the Local Authority Designated Officer (LADO) and a full time Investigations Officer to complete case work tasks. In 2012 Barnet Social Care was inspected by Ofsted and a recommendation made that the LADO arrangements should be subject to review. A review took place in June 2012 and reported as follows.

The systems for managing allegations against people who work with children, or LADO arrangements, in Barnet, are effective, well-managed, and child-centred. They are compliant with all aspects of procedures contained within Working Together to Safeguard Children 2010, including Appendix 5,

(Procedures for managing allegations against people who work with children). There is a clear distinction between the roles of the LADO and the Investigations Officer, with the LADO making well-considered and thorough initial evaluations, and directing the work. She consistently reviews progress and makes a final evaluation, which identifies lessons to be learned from the case. Each case ends with a written outcome sent to the referrer which ensures clarity and a proper ending. The Investigations Officer role is one which is distinctive to Barnet. This role enables the service to offer more support to referring agencies and services, and also ensures expertise in the complex area of conducting investigations and involving children appropriately. In other councils, the LADO role is often an isolated one, but strength in Barnet is the distribution of responsibilities between the Divisional Manager, LADO, and Investigations Officer. This facilitates debate and a teasing-out of the issues, leading to better outcomes on individual cases, and on wider developments.

The recommendations to be made are minor. A strength of the service, as detailed within the body of the report, is that there is a proactive approach to learning lessons from casework involvement. This means that there is an inbuilt system of continuous improvement. Plans to strengthen the service further, through making direct contact with a wide range of Barnet organisations; and to publicise the service through a leaflet, will have a beneficial effect. Some stakeholders who provided feedback on the service also had ideas for developing the service further which should be considered.

It is clear that key senior managers in partner agencies and services in Barnet are aware of procedures and work well with the service. However, a challenge is to ensure that all employees working in a position of trust with children, and the general public, are also aware of safe working practices and how to report concerns. This of course is a challenge nationally, and not specific to Barnet. Plans to broaden the training workshops to groups of employees; to take a proactive approach to meeting Barnet organisations; and to dissemination of the publicity leaflet, will contribute to this goal. But it may be helpful to consider increasing of awareness as an overriding objective, and to undertake a range of actions which will help to meet it.

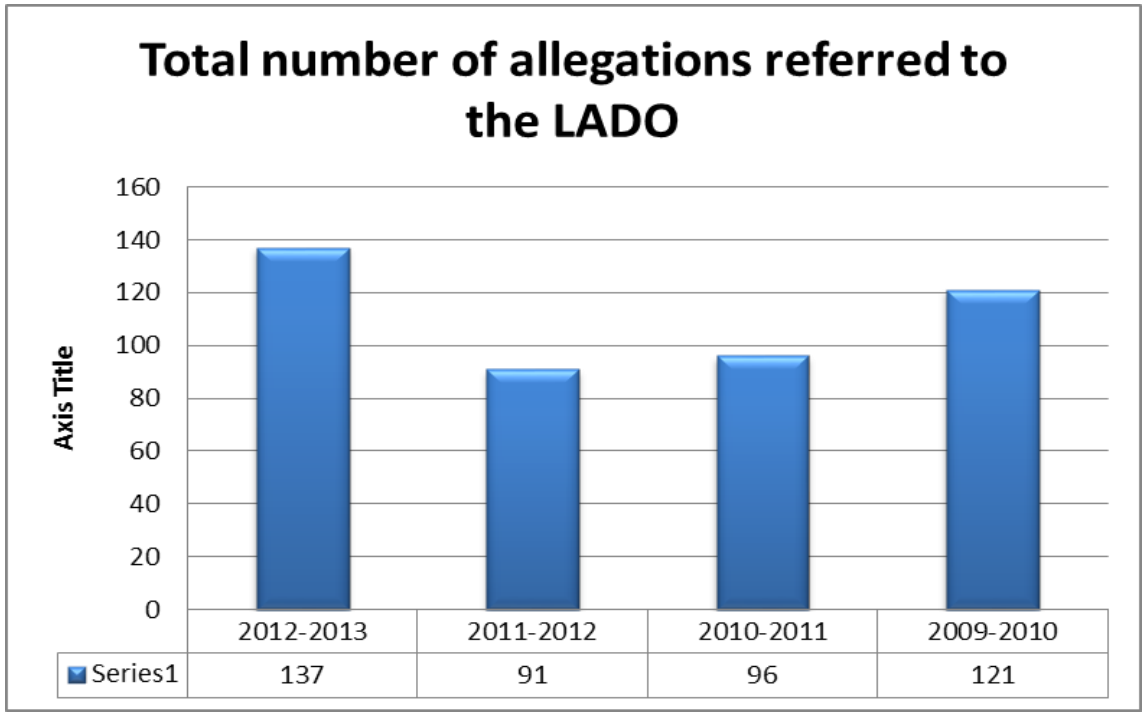
Since the review a leaflet has been completed detailing the LADO arrangements within Barnet and publicising the contact details for making a referral. There is now a dedicated LADO webpage on the Barnet Safeguarding Board website which includes the leaflet as well as other information regarding safer working and how to access training. This material has been publicised via the BSCB newsletter as well as directly to partner agencies for example within health, the voluntary sector and to head teachers and governors at breakfast and twilight briefings. All referrers are directed to this information. Training by the LADO is available to all multi agency partners 6 times per year and is well attended by a broad range of agencies. A leaflet designed by young people explaining the process to children will be available shortly.

Data below indicates there has been a rise in referrals to **137** the figures being **121** (2009/10) **96** (2010/11) and **91** (2011/12). There has been an increase in referrals from social care which may indicate greater awareness and a broadening of the sources of referrals. Physical contact continues to represent the biggest category of referrals, with the vast majority being of a minor nature and not requiring any statutory follow up. There has been an increase in referrals regarding sexual abuse, this may reflect a greater number of those working with children being arrested for downloading child abuse images as well as for historic sexual offences, the latter perhaps a reflection of the “Savile” effect. These referrals reflect a proportion of those requiring child protection and criminal investigations the remainder relating mainly to physical abuse allegations. In terms of timescales for completion of LADO input there has been an increase in those completed within 1 month and over 90% are completed within 3 months. Of those remaining more complex support is required to resolve the case with only a tiny minority remaining outstanding, in the main where there is a criminal trial underway or there has been a prolonged police investigation.

More detailed analysis will be available in the full LADO report which will be presented to the Board at a later date.

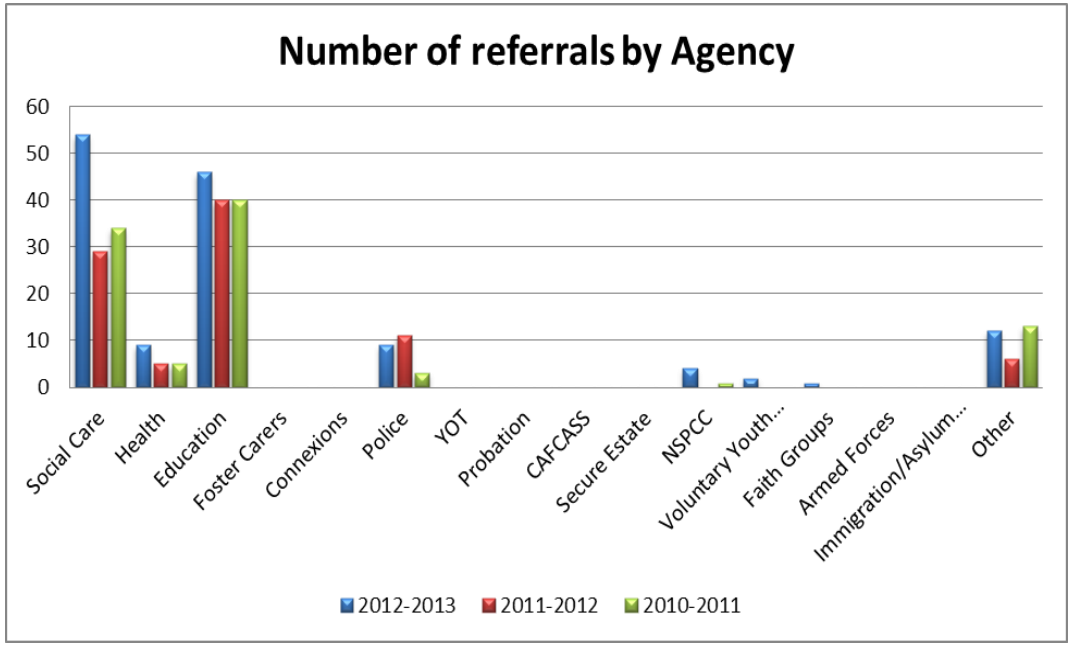
1. ***Total number of allegations referred to the Local Authority Designated Officer (LADO) from 1st April 2012 to 31st March 2013 in comparison to previous years:***

Total for 2012-2013:	**137**	Total for 2011-2012:	**91**	Total for 2010-2011:	**96**	Total for 2009-2010:	**121**



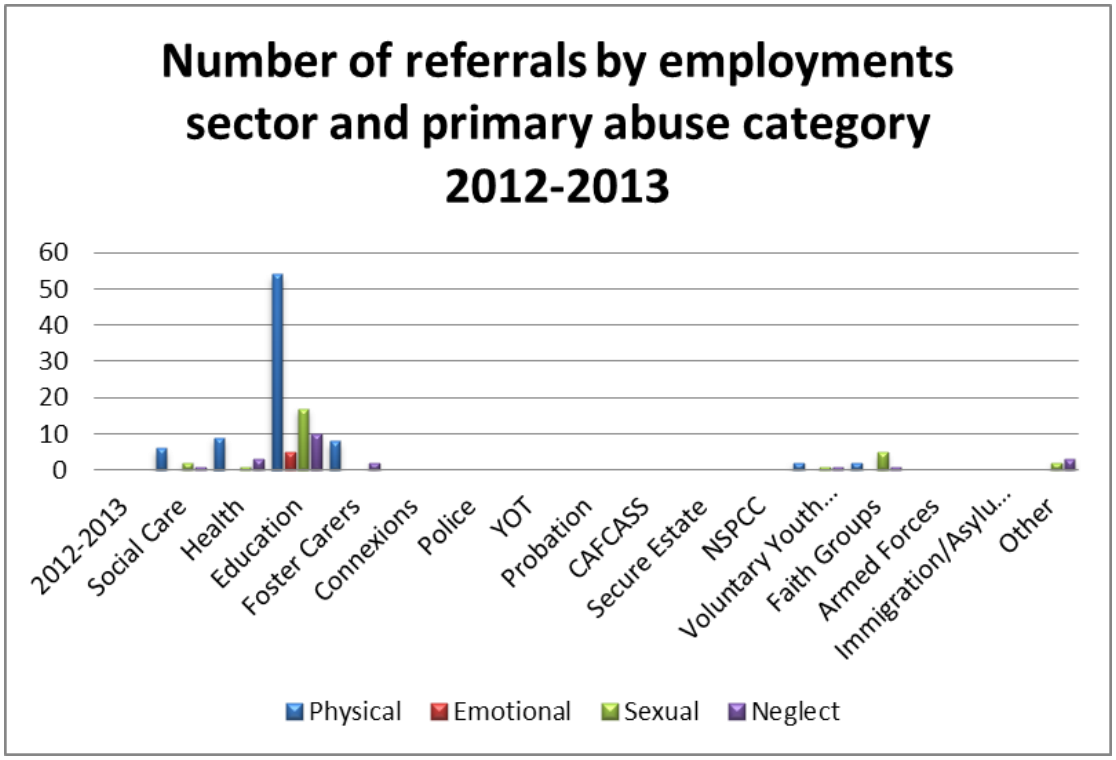
2. Number of referrals by agency for 2012-2013 in comparison with previous years:

Agency:	**2012-2013**	**2011-2012**	**2010-2011**
Social Care	54	29	34
Health	9	5	5
Education	46	40	40
Foster Carers	0	0	0
Connexions	0	0	0
Police	9	11	3
YOT	0	0	0
Probation	0	0	0
CAFCASS	0	0	0
Secure Estate	0	0	0
NSPCC	4	0	1
Voluntary Youth Organisations	2	0	0
Faith Groups	1	0	0
Armed Forces	0	0	0
Immigration/Asylum Services	0	0	0
Other	12	6	13
Total (should equal question 1)	**137**	**91**	**96**

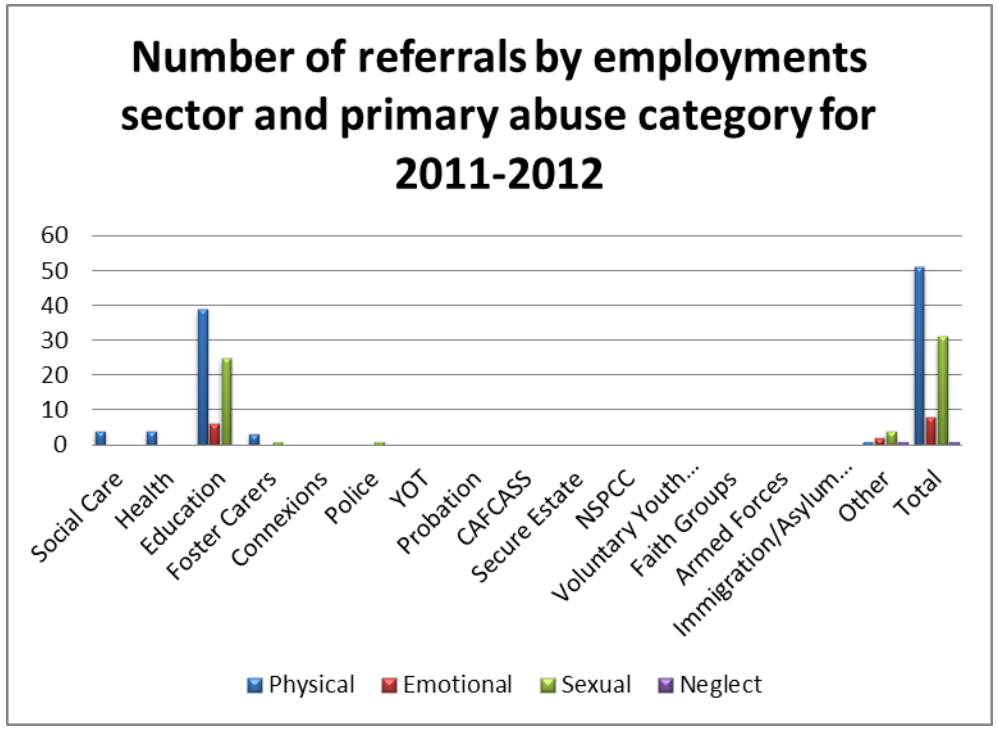


3. Number of referrals by employments sector and primary abuse category for 2012-2013 in comparison with previous years:

Agency:	Physical	Emotional	Sexual	Neglect	Total
2012-2013					
Social Care	6		2	1	9
Health	9		1	3	13
Education	54	5	17	10	86
Foster Carers	8			2	10
Connexions					
Police					
YOT					
Probation					
CAFCASS					
Secure Estate					
NSPCC					
Voluntary Youth Organisations	2		1	1	4
Faith Groups	2		5	1	8
Armed Forces					
Immigration/Asylum Services					
Other			2	3	5
Total	**81**	**5**	**28**	**21**	**135**

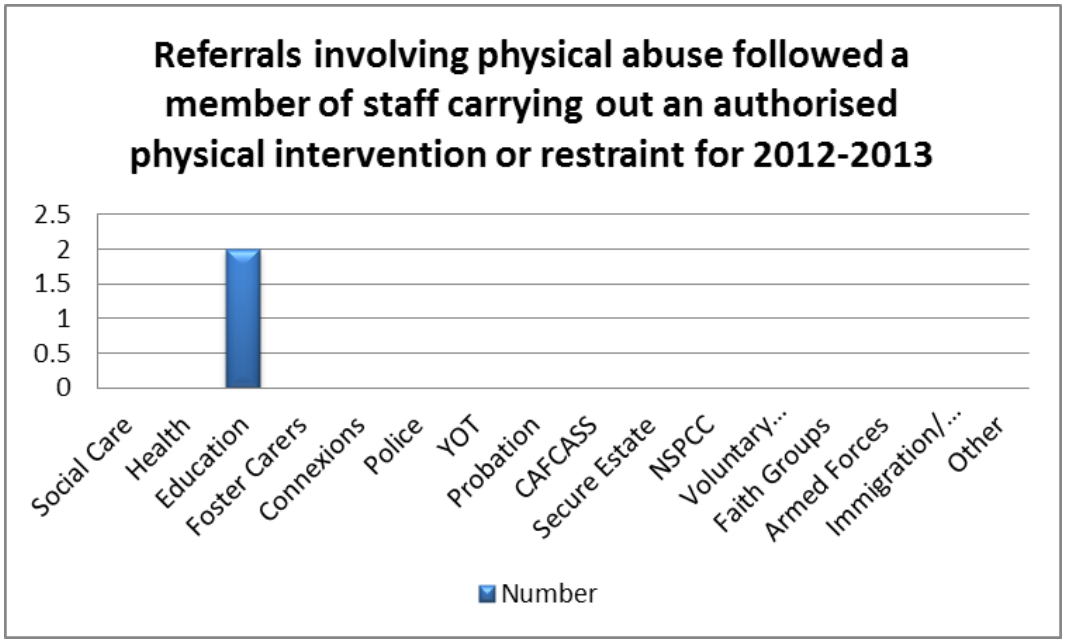


Agency:	Physical	Emotional	Sexual	Neglect	Total
2011-2012					
Social Care	4				4
Health	4				4
Education	39	6	25		70
Foster Carers	3		1		1
Connexions					
Police			1		1
YOT					
Probation					
CAFCASS					
Secure Estate					
NSPCC					
Voluntary Youth Organisations					
Faith Groups					
Armed Forces					
Immigration/Asylum Services					
Other	1	2	4	1	8
Total	**51**	**8**	**31**	**1**	**91**



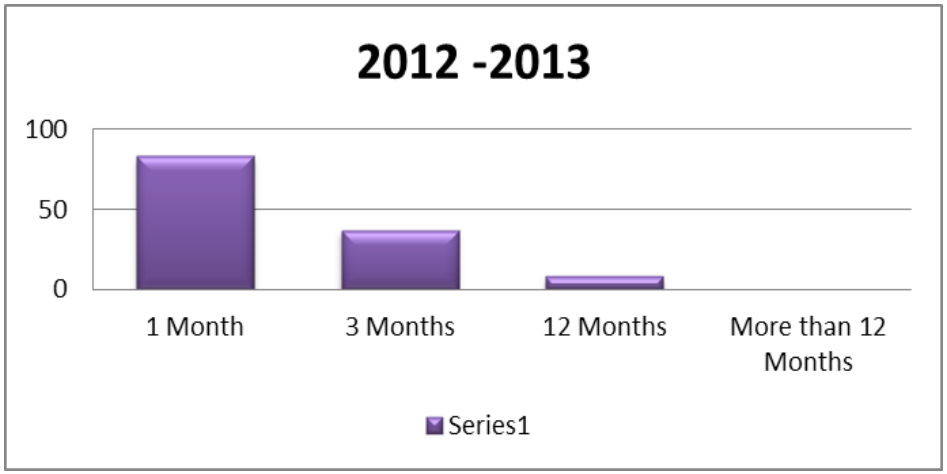
1. ***How many of the referrals involving physical abuse followed a member of staff carrying out an authorised physical intervention or restraint for 2012-2013?***

Agency:	Number
Social Care	
Health	
Education	**2**
Foster Carers	
Connexions	
Police	
YOT	
Probation	
CAFCASS	
Secure Estate	
NSPCC	
Voluntary Youth Organisations	
Faith Groups	
Armed Forces	
Immigration/Asylum Services	
Other	
Total (should be less than question 1)	**2**



2. At the point of conclusion, the number of referrals that were resolved within the following timeframe:

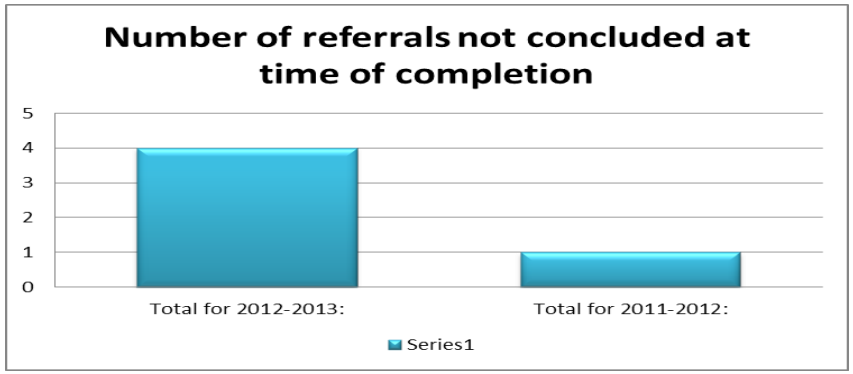
2012-2013	
1 Month	**83**
3 Months	**37**
12 Months	**8**
More than 12 Months	



2011-2012	
1 Month	**86**
3 Months	**39**
12 Months	**8**
More than 12 Months	

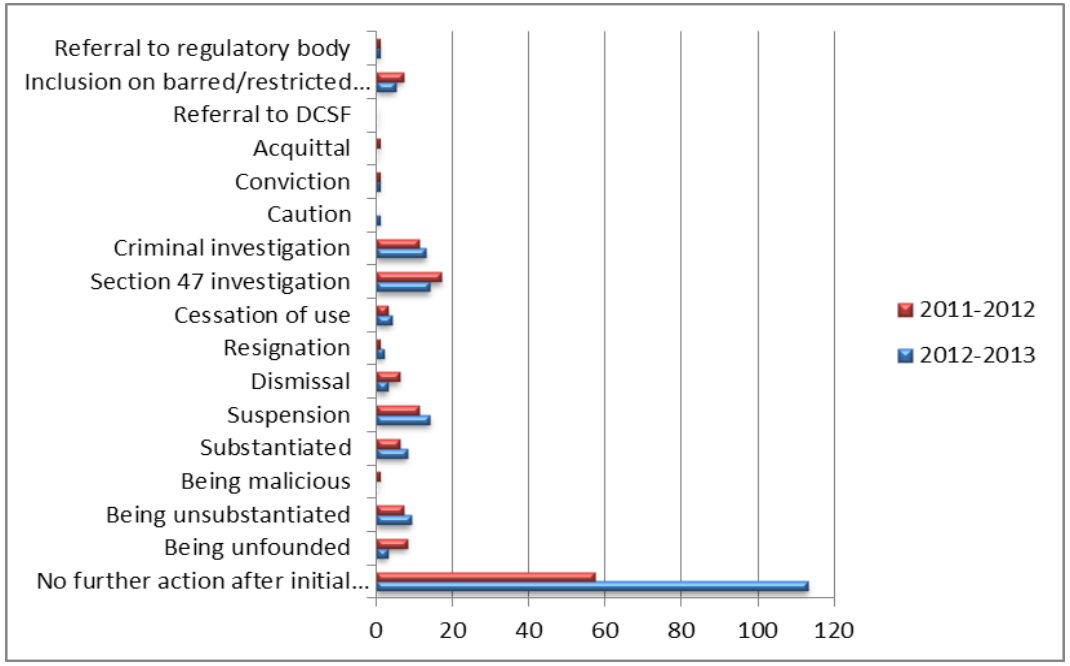
3. *Number of referrals not concluded at time of completion 2012-2013 in comparison with 2011-2012:*

Total for 2012-2013:	**4**
Total for 2011-2012:	**1**



4. *Number of concluded referrals that resulted in (for 2012-2013 in comparison with 2011-2012):*

	2012-2013	2011-2012
No further action after initial consideration	**113**	**57**
Being unfounded	**3**	**8**
Being unsubstantiated	**9**	**7**
Being malicious		**1**
Substantiated	**8**	**6**
Suspension	**14**	**11**
Dismissal	**3**	**6**
Resignation	**2**	**1**
Cessation of use	**4**	**3**
Section 47 investigation	**14**	**17**
Criminal investigation	**13**	**11**
Caution	**1**	
Conviction	**1**	**1**
Acquittal		**1**
Inclusion on barred/restricted employment list/Referral to DBS(ISA)	**5**	**7**
Referral to regulatory body	**1**	**1**



Measuring Performance and Progress in Other Policy Areas

The policy areas and priorities for BSCB have largely been reflected in the work of the Sub Groups and Task and Finish groups operating throughout the year, and the progress and performance is as outlined below;

Child Death Overview Panel:

Of the 28 cases reviewed during the period 1st April 2012 to March 31st 2013, 15 were female and 12 were male, one was recorded as 'blank'. They were aged in the range of 0 day to 15 years, with 53.6% of deaths occurring prior to the age of one.

- Of the cases 28 child death cases reviewed for this period 5 were categorised as a Perinatal/neonatal event, 14 were chromosomal, genetic and congenital anomalies, 2 due to malignancy, 1 due to infection, 1 due to a chronic medical condition, 2 due to suicide or deliberate self-inflicted harm, 2 sudden unexpected deaths and 1 acute medical or surgical condition.
- Ethnically, there was a higher prevalence of "white other" cases. However in 9 cases no ethnicity was recorded as they were recorded as 'blank' or 'unknown'.
- On analysis Golders Green and Burnt Oak wards appear to have highest number of child death cases.
- 8 of the 28 child deaths were categorised as preventable/potentially preventable with the remainder noted as not preventable.
- Currently there are 6 outstanding cases, with 6 'ready to be discussed' at the September CDOP meeting.
- Neonatal deaths – There were 6 of the 28 cases which were primarily due to congenital abnormalities, whether known or unknown and or due to extreme prematurity with some life limiting chronic underlying conditions
- Unexpected deaths – There were 12 of the 28 cases in this category. Primarily these cases were due to congenital abnormalities.
- Expected deaths – There were 16 of the 28 cases in this category and again these deaths were due primarily to congenital abnormality.
- Sudden Unexplained Death of an Infant (SUDIs) – There were 2 cases reviewed. One of the cases reviewed three key contributory factors to cot death were present. They were co-sleeping, alcohol and smoking. The issues identified were recognised by the panel as contributory factors to cot death.
- Suicide or deliberate self-inflicted harm – There were 2 cases reviewed. Each of the cases had issues identified, learning points and recommendations. In case one the issues identified were social networking, interface between private healthcare and statutory services. The learning points for this case were the consistent equitable support to all (professionals in schools and the children). Nationally it would be helpful review these deaths.
- In case two the issues identified were; communication between private care and NHS; access to record between GPs from children that are in boarding school; ambulance services and police need to follow the set protocol. The matter was referred to SCR however it did not meet the criteria. The learning point for this case is that the protocol for suicides is being developed. Recommendations made for this case were that the Chair of Barnet Safeguarding Children Board wrote to the Chair of Hertfordshire's Safeguarding Board regarding the management of bullying within the school setting.

Number of Deaths by Quarter (statistics reported by date of CDOP review 1st April 2012 – 31st March 2013)

Quarter	Number of Deaths
1st April 2012 – 30th June 2012	9
1st July 2012 – 30th Sept 2012	7 (one out of borough)
1st Oct 2012 – 31st Dec 2012	8
1st Jan 2013 – 31st Mar 2013	4 (one out of borough)
Total	**28**

Category of deaths reviewed 2012-13:

	Gender Breakdown							
	No.	%	Male	%	Female	%	Blank	%
Deliberately inflicted injury, abuse or neglect	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Suicide or deliberate self-inflicted harm	2	7.1%	0	0.0%	2	7.1%	0	0.0%
Trauma and other external factors	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Malignancy	2	7.1%	0	0.0%	2	7.1%	0	0.0%
Acute medical or surgical condition	1	3.6%	1	3.6%	0	0.0%	0	0.0%
Chronic medical condition	1	3.6%	0	0.0%	1	3.6%	0	0.0%
Chromosomal, genetic and congenital anomalies	14	50.0%	7	25.0%	6	21.4%	1	3.6%
Perinatal/neonatal event	5	17.9%	3	10.7%	2	7.1%	0	0.0%
Infection	1	3.6%	0	0.0%	1	3.6%	0	0.0%
Sudden unexpected, unexplained death	2	7.1%	1	3.6%	1	3.6%	0	0.0%
	28	**100.0%**	**12**	**42.9%**	**15**	**53.6%**	**1**	**3.6%**
	28							

Preventability of Death (of total deaths listed)

	No.	%
Preventable	5	17.9%
Potentially Preventable	3	10.7%
Not Preventable	20	71.4%
Inadequate Information	0	0.0%
	28	**100.0%**

Expected and Unexpected Deaths

	No.	%
Expected death: planned palliative care	3	10.7%
Expected death: other	10	35.7%
Unexpected death: Found dead/collapsed	2	7.1%
Unexpected death: Active withdrawal/cessation of treatment	2	7.1%
Unexpected death: Brain stem death	0	0.0%
Unexpected death: other	4	14.3%
(Blank – not stated)	7	25.0%
	28	**100.0%**

Key Outcomes:

- The current backlog of child death cases to be reviewed stands at 6. For the majority of these cases there appears to be a delay due to information that is still required from one or more agency.

- Coronial engagement at CDOP panel meetings remains a challenge. For the CDOP process to work well and for the aggregated findings from all child deaths in Barnet to feed into strategic planning in a timely way, engagement across Coronial service needs to improve significantly. Particularly as this also appears to be impacting on the transfer of the information required to support the Rapid Response and thus CDOP process. The issue has been raised in the past with the Coroner's Office and will need to be again.

- CDOP panel meetings for the last year have now reverted back to being held on a quarterly basis as the backlog of cases from the previous years (2008 – 2010) have all been reviewed.

- To improve the efficiency and timeliness of the Rapid Response process the designated Doctor for Child Death has set aside regular once weekly meetings to accommodate any unexplained child deaths that occur which would require activation of the Rapid Response process.

- Terms of Reference have been updated

- Clarity around resource (staff & finance) availability has impacted on the timeliness of implementing a robust process for communicating and engaging with families around the CDOP process. The process for informing parents about CDOP has now been implemented. Continued funding to support the CDOP process has been agreed.

- The number of child deaths remains small and as such it remains difficult to establish any clear trends or patterns.

Child Sexual Exploitation Task Group /Missing Children Sub Group:

This continues to be a high priority in Barnet and nationally with several high profile cases giving further impetus to the work of the Children's Commissioner's enquiry, now in its second year.
Work has focused in the last year on bringing together work streams linking sexual exploitation and missing children in recognition that they are one of the groups most vulnerable to sexual exploitation. A sexual exploitation and missing children task group has been reconvened to promote a more coherent approach to the management of risk in this area. The group will oversee the implementation of the Metropolitan Police Pan London Child Sexual Exploitation Operating Protocol created in conjunction with the NSPCC and recently piloted in two inner London Boroughs with the aim of establishing consistent

approaches to operational practice across Barnet. This work is regarded as fundamental to the work of the Barnet MASH.
Barnet has also been represented at a cross borough group convened by Enfield and a joint conference on sexual exploitation and trafficking was successfully held in Jan 2013

Following a review which identified the need for better assessment tools, a Protocol and Risk Assessment Tool for children missing from care or from home (Part 1 and Part 2) has been developed for multi-agency staff and carers in order to guide decision making in relation to assessing risk and defining action. It has been written with the assistance of Barnet Missing Persons Unit and Barnet Police Jigsaw Team and was piloted successfully with staff in residential homes before being issued.

Training has been commissioned and delivered to raise awareness and build capacity of staff to identify and work with children and young people to prevent sexual exploitation and reduce risk.

Key Outcomes:

- Protocols and Risk Assessment tool launched for children missing from home and from care
- Reconvened multi-agency task group
- Sexual Exploitation training being rolled out to multi-agency staff to support identification and responses
- Cross borough collaboration and a Conference with L.B.Enfield attended by around 100 multi-agency staff
- Adoption of the Metropolitan Police Pan London Child Sexual Exploitation Operating Protocol by all partners at the BSCB

Practice Examples

- *Hospital staff were able to help safeguard a 15 year old girl, missing for several months after running away from foster care, and considered to be at risk of being forced to be a street-worker, who had absconded from the inpatient ward after admission following assault. A Regional Police Alert was put out, of which the teenager became aware, and she presented herself to a North London police station.*
- *Safeguarding of 15 year old girl, admitted for deliberate self-harm, who made allegations of sexual exploitation by gang members. In patient mental health placement found and referred to police and social care.*
- *Deliberate self-harm by a 13 year old girl in foster care, also considered to be vulnerable to possible sexual exploitation. Referred to CAMHS and close liaison with social care.*

Priorities for 2013-14

- Build the capacity of professionals to identify and support young people at risk of sexual exploitation, using the existing multi-agency framework.
- Review and work towards implementation of the Pan London Child Sexual Exploitation Operating Protocol
- Link with work of Youth Shield in developing peer support for healthy relationships

Safeguarding Across Faith and Cultural Groups:

The Faith and Cultural task group aims to establish and promote dialogue with a range of faith and other community groups that represent Barnet's diverse population. It operates as a cross cutting group that includes representation from adults services. CommUNITY Barnet has made a significant contribution to this agenda through its network of voluntary and community sector organisations. Through this umbrella organisation, a safeguarding advisor has established liaison with a range of community groups and has run safeguarding surgeries to offer advice and support, including training which is culturally accessible, for example, to a local Mosque.

Following the retirement of the previous Chair, this role has now been taken over by the Borough Commander Adrian Usher and membership of the group has expanded to include representation from the Britsom Somali network. A successful event was held in safeguarding month to explore safeguarding across different communities through themed case scenarios. The focus of the group will be faith groups. In particular the work that is currently being undertaken with the orthodox Jewish community. The group will also be focussing on faith groups where there has been no connection so far to partnership working.

Barnet has recently participated in a partnership review (involving a number of boroughs) which was commissioned following the death of a young person in Newham who was killed by family members in the belief of spirit possession.
The family had briefly lived in Barnet as one of a number of boroughs.
The focus of the review was to assess impact of local learning since January 2011 including progress in relation to the National Action Plan (NAP) which includes a particular focus on spirit possession. Although this was considered by the group as a consultation document, there is a need to review and consider local implementation of the action plan going forwards.
The review has enabled key areas for development to be identified which build on progress to date. This includes establishing liaison with local community and faith leaders to enable them to act as champions for safeguarding in their community. A learning event is planned later in the year for the 6 boroughs to disseminate learning and share good practice.

The group has also begun a mapping exercise to update information in the 'Faithbook' directory about local faith groups.

Key Outcomes:

- Contribution of members to events in safeguarding month
- Recruitment of new members and links with Somali community

Priorities for 2013-14

- Review national action plan to identify how it can be applied locally
- Consider and identify resources to take this work forward
- Continue to seek opportunities to work with faith leaders to enable them to become champions of safeguarding in their local communities
- Review literature, for example, through Project Violet, that may potentially be distributed to schools, health services and other universal services to ensure key messages on harmful cultural practices are effectively highlighted

Domestic Violence:

Domestic Violence (DV) continues to be a concern for many children and families in Barnet and a high proportion of families known to Children's Services are affected by domestic abuse at some level. The Children's Service restructuring has enabled closer alignment of this work through locating the Domestic Violence co-ordinator role within the safeguarding and quality assurance division.

A range of early intervention services are provided to families through the Safer Families Project in partnership with our Family Focus team and Solace, the contracted providers of DV support services. This includes therapeutic work for children and mothers affected by DV which aims to promote support and safety planning. In some cases this has enabled children to be stepped down from CP planning.
Within social care, there are three specialist DV workers who work with and support families affected by domestic violence who are deemed to be vulnerable and high risk.

The Multi Agency Risk Assessment Conference (MARAC) reviews and responds to high risk cases with the aim of reducing harm and makes a vital contribution to the protection of women and children. Regular MARAC training sessions continue to be delivered across the partnership, including to GPs to raise awareness and ensure the MARAC system is effective and high risk victims of domestic violence and their children are supported.

Barnet has recently agreed to move the response to DV so that it is placed within the wider Violence Against Women and Girls (VAWG) agenda in line with national and London policy. A strategy for 2013-16 has been developed which aims to coordinate services in Barnet in support of the wider safeguarding agenda. An action plan in development.

The recent Government change to the definition of DV to include young people is welcomed, as it will help raise awareness that young people experience domestic violence in their own intimate relationships as highlighted by the work of Youth Shield. This will mean that our safeguarding children systems in Barnet will need to be reviewed to ensure that are equipped to respond appropriately to younger victims.

As part of implementing the strategy for VAWG, BSCB will need to ensure strategic partnership responsibilities are clarified for responding to the strands which apply to children and young people, in particular

- Definition of DV
- Sexual abuse
- Sexual exploitation (including involvement in serious youth violence)
- Female genital mutilation

Key Outcomes:

- An early intervention project to support families (with children aged 0-11yrs) affected by domestic abuse including therapeutic work for children
- Specialist social workers to work with high risk DV cases involving children
- Provision of services for survivors, children and perpetrators by Solace Women's Aid

Practice Example

Child aged 5 and his mother resides in a Women's Refuge, having fled Domestic violence. When the family first arrived at the refuge Child was observed to be quite rough in his play with other children. He became frustrated by language barriers and Child's experience of relationships also taught him that violence was a part of communication with others. Due to his rough play other children would shy away from playing with him. When Child started school they also flagged up concerns about Child's ability to interact appropriately and to make friends. Mother admitted to finding it difficult to get Child to listen to instructions and best respond to Child's needs.

***Positive outcome**; Since coming to the refuge Child has been able to access one to one play therapy and is now accessing this support within a group. The play therapist reported that following his one to one sessions Child was better able to interact with her by using gentler and more peaceful means. Through accessing parenting classes and through one to one work with the family support worker mother has been able to build her knowledge of the effects of DV on her child and how best she can support him.*

Priorities for 2013-14

- Focus on domestic abuse in the context of young people's relationships.
- Ensure MASH arrangements extend to DV issues
- Contribute to implementation of VAWG as appropriate

Training Sub-Group:

The Training Sub Group is responsible for the strategic overview and quality assurance of safeguarding training, both by single agencies (to their own staff) and interagency training (where staff from several agencies train together).

The work of the group is driven by the requirements outlined in Working Together 2010, the Inter Collegiate Framework for health partners and the London Safeguarding Children Board 'Competence Matters' framework

As well as working in collaboration with the Barnet workforce development group, there is an active link with the London Safeguarding Board to promote a consistent approach.
Barnet has an excellent training programme and offers a wide range of courses that are generally well attended and positively evaluated across the partnership.

There has been active involvement in supporting the delivery of single agency training to a wide range of staff including GPs, health service clinicians, schools, faith and community groups, caretakers, and others.

Partner agencies have played a key role in contributing to some of this training and in particular colleagues from the Police Child Abuse Investigation Team and Children's Social Care have made a significant contribution to GP training that has been very well received.
Safeguarding sessions have also been provided for elected members as part of their development programme.

There will inevitably continue to be some pressures on resources and the possibility of cross service and cross borough collaboration in commissioning training should be explored as a way of maximising access to training.

The core safeguarding and child protection courses are over subscribed and BSCB provided funding for additional courses to meet demand in the last quarter. Courses have continued to be provided free of charge for Barnet agencies but this should be kept under review and the BSCB would endorse implementation of the penalty for non-attendance as a means of mitigating some of the cost.

Training Data:

The table below shows the number of courses and attendance broken down by agency, together with the %age that were quality assured. That feedback was overwhelming positive. The planning of the training is carried out annually and reflects the priorities of both the BSCB and the Children's Trust.
The recently reviewed Children's Trust Plan 2013/15 was deliberately planned following wide consultation to fit with a structure reflecting the Journey of the Child.

It should be noted that the chart refers to the workforce development/BSCB rolling programme and does not include specific or bespoke training which is shown separately. Take up of the on line programme by agency has also been included and identified gaps are being acted upon in planning training delivery. It should also be noted that some of our partners work across Boroughs and may therefore access training in neighbouring authorities. Some services such as Police and Probation provide their own training. It has been a matter of concern in Barnet and elsewhere in London that with the exception of specialist staff there is very limited take up of multi agency training by the police given their pivotal role in safeguarding. The concern has been raised locally and through the London Independent Chair's Forum with senior officers within the Metropolitan Police. It has been agreed that the Metropolitan Police will create additional training days to address the issue.

The recent S11 audit provides assurance that staff in all agencies are provided with safeguarding training. However, induction training appears to be less clear. An area requiring development is to demonstrate impact of training on practice and improved outcomes**.** There were also a number of returns which did not evidence training to enhance awareness of diversity issues, although training is available in this area as part of the multi-agency safeguarding training programme. Take up of Safer Recruitment Training also needs to be increased as not all managers had accessed this. These are all issues which will be followed up by the Training Sub Group

Description	11/12 outturn	12/13 outturn	Qtr 1 12/13	Qtr 2 12/13	Qtr 3 12/13	Qtr 4 12/13
Number of LSCB safeguarding children training courses provided in the past year	56	61	9	11	17	24
Agency attendance total						
Local Authority	259	351	31	46	108	166
Police	1	0	0	0	0	0
Health	154	132	35	13	21	63
Mental Health	38	77	2	10	15	50
Youth Sector		38	0	5	17	16
Voluntary	190	165	24	46	33	62
Private	181	164	23	23	33	85
Education	274	344	37	75	107	125
Probation	0	0	0	0	0	0
Service Users	0	0	0	0	0	0
Other	0	3	0	0	0	3
Online Safeguarding Introduction Training **Agency total**						
Local Authority	6	4	1	2	0	1
Police	0	0	0	0	0	0
Health	0	12	11	0	0	1
Mental Health	0	0	0	0	0	0
Voluntary	86	13	5	2	5	1
Private	71	102	18	26	22	36
Education	25	35	13	6	11	5
Probation	0	1	0	1	0	0
Service Users	0	0	0	0	0	0
Other	0	0	0	0	0	0
% of courses that were quality assured/evaluated/ audited	100%	100%	100%	100%	100%	100%

Other BSCB Events:

SCIE/DHR Learning Events Total Number 263

Agency	Number
Adults	30
Children's Service	105
Drugs/Alcohol Services	1
DV/community Safety	3
Early Years/Children's Centres	9
Fire Service	6
GPs/Hospital	7
Health (CLCH)	27
Housing	12
Mental Health	28
Police	3
Probation	9
Schools/Education	17
Voluntary/Independent	7

Sexual Exploitation and Trafficking Conference January 2013

Agency	Number
CAFCASS	2
Children's Service	8
Education/Schools	3
Health	21
Housing	1
Mental Health	1
Police	2
Probation	1

Personality Disorder Workshops October 2012 – February 2013

Agency	Oct	Dec	Jan	Feb	Total
Adults	0	0	3	3	6
CAFCASS	0	0	0	1	1
Children's Service	2	1	11	7	21
Domestic Violence Services	1	2	2	1	6
Early Intervention and Prevention	4	8	3	3	18
Health	2	5	3	2	12
Mental Health	1	0	0	0	1
Probation	1	2	1	1	5
Schools/Education	9	1	3	4	17
Vol Sector	0	0	1	1	2
Youth/YOS	0	0	5	3	8

Personality Disorder Consultation Slots

Agency	Number
CAMHS	1
Children's Service	2
Early Intervention and Prevention	3
Education/Schools	1
Health	1
Voluntary Sector	1

Priorities for 2013-14

- Implement quality assurance framework to demonstrate impact of training
- Encourage greater take up of the safer recruitment and safeguarding and diversity training
- Ensure learning events reflect messages from review.

Work of Youth Shield:

The Barnet Safeguarding Children Board (BSCB) is committed to ensuring that the views and experiences of children and young people play a key part in driving the agenda of the Board. Much work has been done in laying the groundwork to enable young people in Barnet to play an active role in the work of the BSCB. In order to support this process, the BSCB commissioned CommUNITY Barnet to consult with children and young people on the safeguarding agenda and this has helped to inform the work programme.

Youth Shield members have a standing invitation to the BSCB and report back regularly on their activity. At other times the Chair and Board Manager attend meetings with the young people.

The work of Youth Shield was recognised as an example of good practice through an award at the London Safeguarding Children Board in 2012 and the subsequent commendation at the full council meeting in Barnet.

Work carried out during 2012-13 has included giving young people a voice on health issues, for example, the CAMHS 3 year plan and designing a leaflet for young people regarding allegations.

Youth Shield members have also been involved in training to become peer facilitators in relation to healthy relationships and have piloted this in some of our youth provision.

Looking forward to the next year, as outlined in their section, Youth Shield have recently recruited new members and have put forward proposals for an expanded work plan that includes the roll out of healthy relationship peer to peer training and a mystery shopping exercise of different services. Youth Shield made a detailed Business Development Proposal to the BSCB for substantial funding and this was agreed.

Cross Generational Work:

This has been taken forward through the Joint Services Governance Group which has identified areas for increased collaboration including induction training and the appointment of a single Chair for both

Boards. The existing faith and cultural group is also cross cutting as there are common concerns linked to how we work with faith and cultural groups to promote safeguarding in all communities.

Barnet has also adopted the recommended national strategy for Young Carers and this is an issue highlighted by one of our case reviews during the last year.

A further significant area of progress is the implementation of protocols with Barnet, Enfield and Haringey Mental Health Trust and Children's Services. Following a successful launch in 2011, the protocols have been updated following a multi agency review in Jan 2013. Implementation of this protocol is being supported through a system of operational interface groups that enable complex cases or issues to be considered by social care and mental health service managers with a view to promoting collaboration in practice and resolving areas of professional difference. These are reported to be working very effectively in supporting work on the ground.

Practice Example

The Mental Health Trust has also developed systems in relation to young people who require emergency assessment and treatment following an incident in which a child became acutely ill and required inpatient treatment. There was a concern about the child being admitted to an adult facility and a lack of clarity in the existing guidance
***Positive outcome**; Agencies worked together to devise an agreed response to such situations in the future.*

Key Outcomes:

- Protocol between Children's Services and Adult Mental Health updated
- Interface meetings continuing to improve collaboration between services.
- Review of joint working through adults and children's services governance

Priorities for 2013-14:

- Joint Services Governance has identified areas for increased collaboration
- Young Carers strategy to be promoted

Communications Strategy

After a considerable period of planning and negotiation, and at times not a little frustration, we are delighted to report that BSCB now has its own independent website which includes sections for children, young people and families, professionals and members of the public. The website includes a directory of information for professionals which was developed by the Professional Advisory Group and provides a basis to further develop communications.
The website is regularly maintained by the BSCB Administrator and is a valuable resource to ensure key information is readily available.

The website also includes the BSCB newsletter which is produced after each meeting with the aim of providing a digest of the meeting and updates on new and emerging policy and guidance. Board members are asked to cascade the newsletter to front line staff. The Independent Chair carries out' spot checks' from time to time to assess awareness of the Board on the ground but ensuring information reaches a wide ranging audience remains a challenge
As part of the work to create the website all the existing guidance and policies and procedures were formally reviewed and a directory created on the website to increase the ease of access to professionals but also allow access to a wider public.

BSCB actively contributes to the annual November Safeguarding Month in Barnet which enables messages to reach a wider audience both within the council and externally.
There is also regular communication with schools through the School Circular and meetings with safeguarding leads and Heads.
We intend to further develop communication with young people through the work with Youth Shield who have designed an allegations leaflet for young people as part of their work during the last year.

Key Outcomes:

- Website now launched
- Improved awareness of the work of the BSCB including contribution to safeguarding month.
- Newsletter regularly circulated to front line staff.
- Participation by young people in developing accessible information.
- Review of policy and procedures and creation of an accessible directory

Priorities for 2013-14

- Continue to build and develop website
- Work with Youth Shield to develop accessible information for young people

Safeguarding Month

'Safeguarding is Everybody's Business':

November 2012 saw a repeat of the successful initiative safeguarding month at Barnet Council and, as part of this, a range of events took place to emphasise the message that safeguarding is everybody's responsibility. Safeguarding month has been a good opportunity to raise awareness about safeguarding and the challenge now is to keep up the momentum, building on best practice and ensuring that safeguarding issues are integrated into everyone's day to day work.

Key Outcomes:

- An informative presentation from the Lucy Faithfull Foundation regarding sexual abuse prevention. This was followed by the provision of free training sessions to a small number of Barnet Schools and Children's Centres. Further opportunities for this training to be delivered to a specific cultural group have recently been identified and will be explored via the Faith and Cultural Sub-Group.

- Wide range of events including express training sessions on how to spot and report a safeguarding concern to events about sexual exploitation of young people, trafficking, e safety and domestic violence.
- An event focused on faith and culture led by colleagues in the Somali Britsom organisation which included colleagues from both children's and adults services

Looking to the Future

The priorities for the BSCB remain similar to those of last year and reflect the Board's Work Plan 2012/14 agreed in 2012. Additional focus has been made on issues of neglect, child sexual exploitation and reviewing e safety policies.
In May 2013 the BSCB held a planning day with a focus on the learning from the SCIE Case Reviews which had been completed and reviewing our existing Work Plan priorities.
The consensus from the day taken in conjunction with significant feedback from multi agency "Learning Events", with frontline staff which had been carried out through the year resulted in an agreed focus on the priorities below and with a strong emphasis on the fundamental role that the MASH will play in continuing to develop both the culture and operational practice across the partnership in Barnet;

BSCB Priorities for 2013/14:

Quality Assurance, Challenge and Scrutiny:
To further develop scrutiny of BSCB in monitoring and evaluating the effectiveness of safeguarding activity across the partnership through a combination of S11 and multi-agency audit together with shared performance information, so that children & young people in Barnet are safe from abuse neglect, violence and sexual exploitation

Risk Assessment, Information Sharing and Partnership Work:
Seek to develop Tools/Protocols to promote improved information sharing, risk assessment and partnership working, including support for development of **MASH**

Young People at risk through peer violence and exploitation:
To focus on peer to peer violence including Gangs/Sexual exploitation/ Anti Bullying/e safety

Neglect/ Early Intervention:
Promoting and evaluating a model of early help for children and families which reduces demand and cost as part of the Munro Demonstrator pilot with a particular focus on issues of neglect.

Learning and Development:
To strengthen the BSCB role in promoting learning and development across the partnership.

Conclusion

This Report is intended to reflect the current state of safeguarding activity across Barnet, highlighting the level of work undertaken, outcomes and those areas which need additional focus. It is clear that a great deal of extremely positive work is either underway or has been completed.

On the whole it has been reflected in that the statistics above for Barnet, in comparison with other London Boroughs, are on the face of them reassuring. The figures are relatively low when examined against population figures. However in 2011 as reported there were concerns at increasing numbers of children being placed on child protection plans at a rate of increase that was greater than similar London Boroughs. Internal audit work was completed by LBB and BSCB, and whilst no single cause was clearly identified, some focused work was carried out on monitoring those trends.

The figures below and the historic data in Appendix 1 reflect a more reassuring picture in that whilst 2012/13 saw a small rise in initial assessments, a significant rise in core assessments and a rise in Section 47 child protection investigations, the number of children on a child protection plan reduced significantly. Similarly the numbers of children being returned to a plan or remaining on a plan for over two years also reduced. The additional focus by Children's Services and partners in assessment and early help reflects improved planning and appears to have led to a reduction of children being subject to child protection plans without increasing the numbers of children having to be returned to plans at a later date. That is a significant achievement and needs to be maintained.

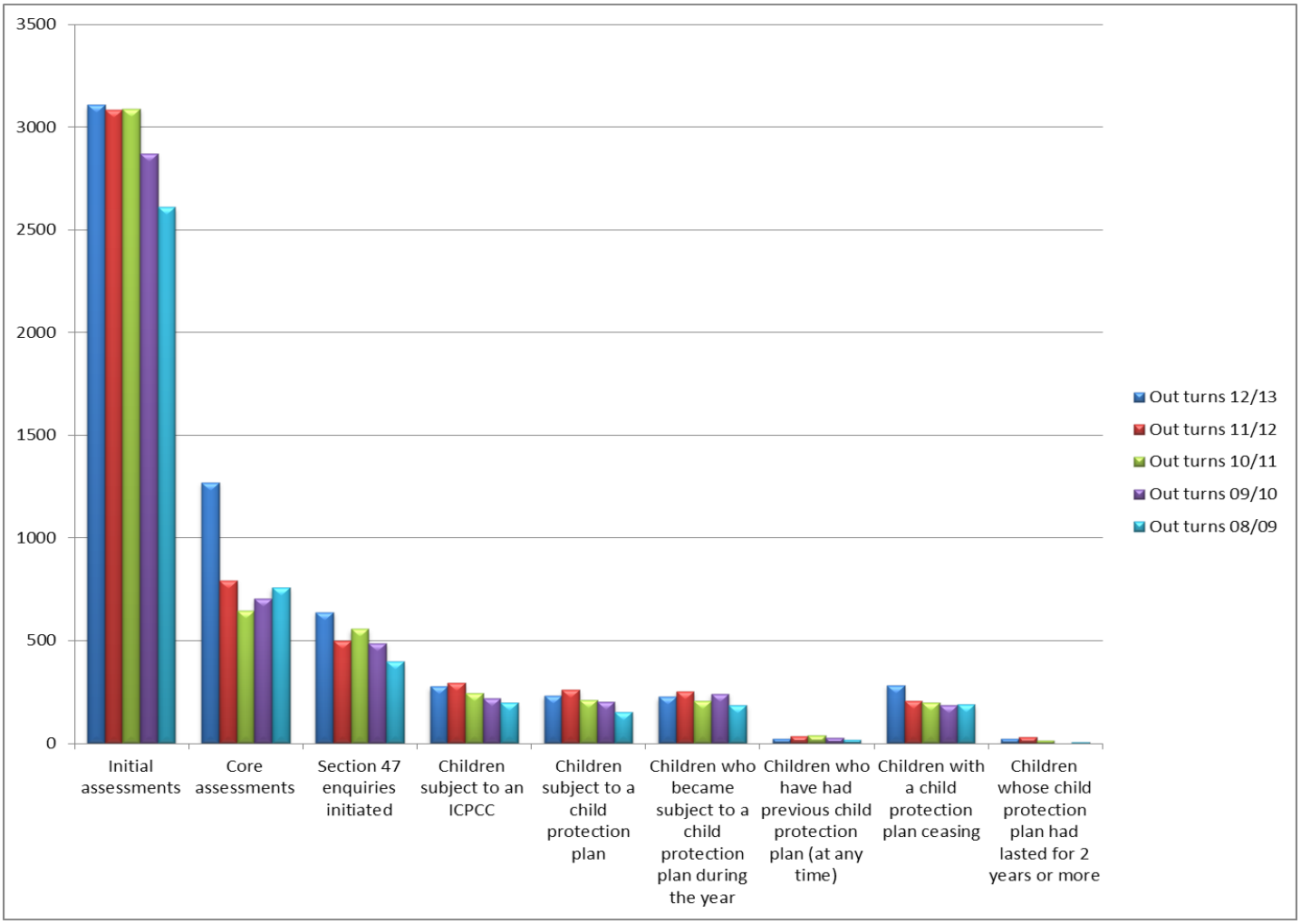
Other significant strands of work that are currently being carried out also reflect a determination to improve the quality of services to children, young people and their families.
In particular the work to embed the MASH structures will undoubtedly continue to improve information sharing arrangements and thereby assist in the integration of the early intervention and child protection processes to the benefit of children and young people. There is already good evidence of that work being effective across the partnership wider than just the local authority. Similarly the courage in taking up the challenge of being a Munro Demonstrator site has given a clear message that improvement and professionalization of social work in its widest sense is something which is desired in Barnet.
Finally the additional substantial funding that has been agreed to support Youth Shield will enable them to assist the Board in developing services that are built around the needs of vulnerable children and also to test the efficacy of the Board and individual agencies in delivering them over the next year.

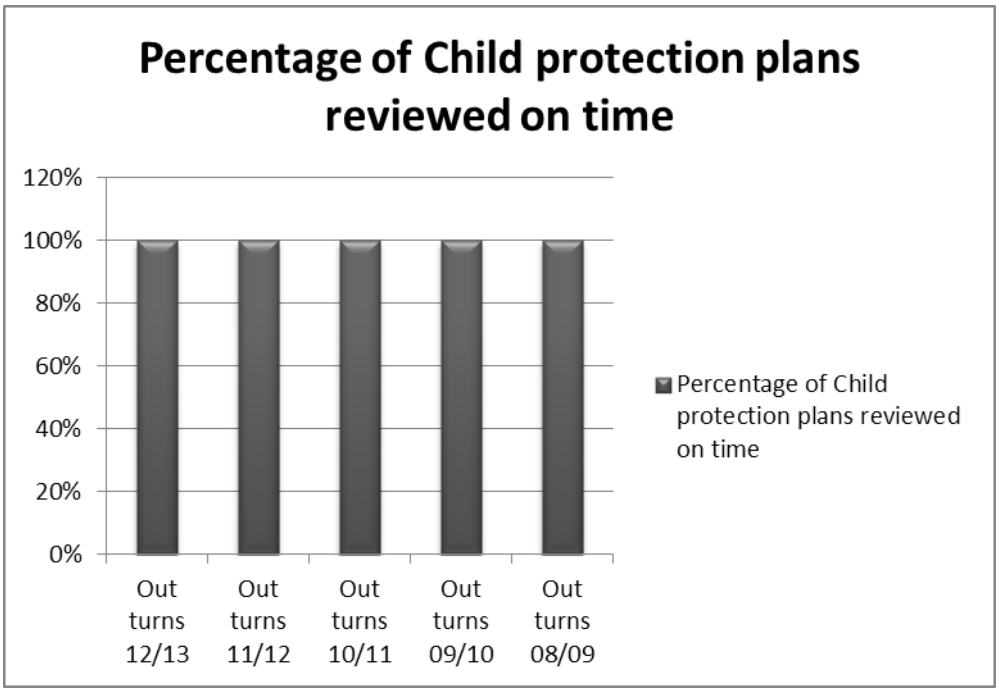
Authors:

Tim Beach: Independent Chair: tim.beach@barnet.gov.uk
Helen Elliott: BSCB Manager: Helen.elliott@barnet.gov.uk
Fiona Fernandes: BSCB Administrator: Fiona.fernandes@barnet.gov.uk
Partner Contributions as identified
Copies of the document can be obtained on request from the Board Administrator, Fiona Fernandes: Fiona.fernandes@barnet.gov.uk

July 2013

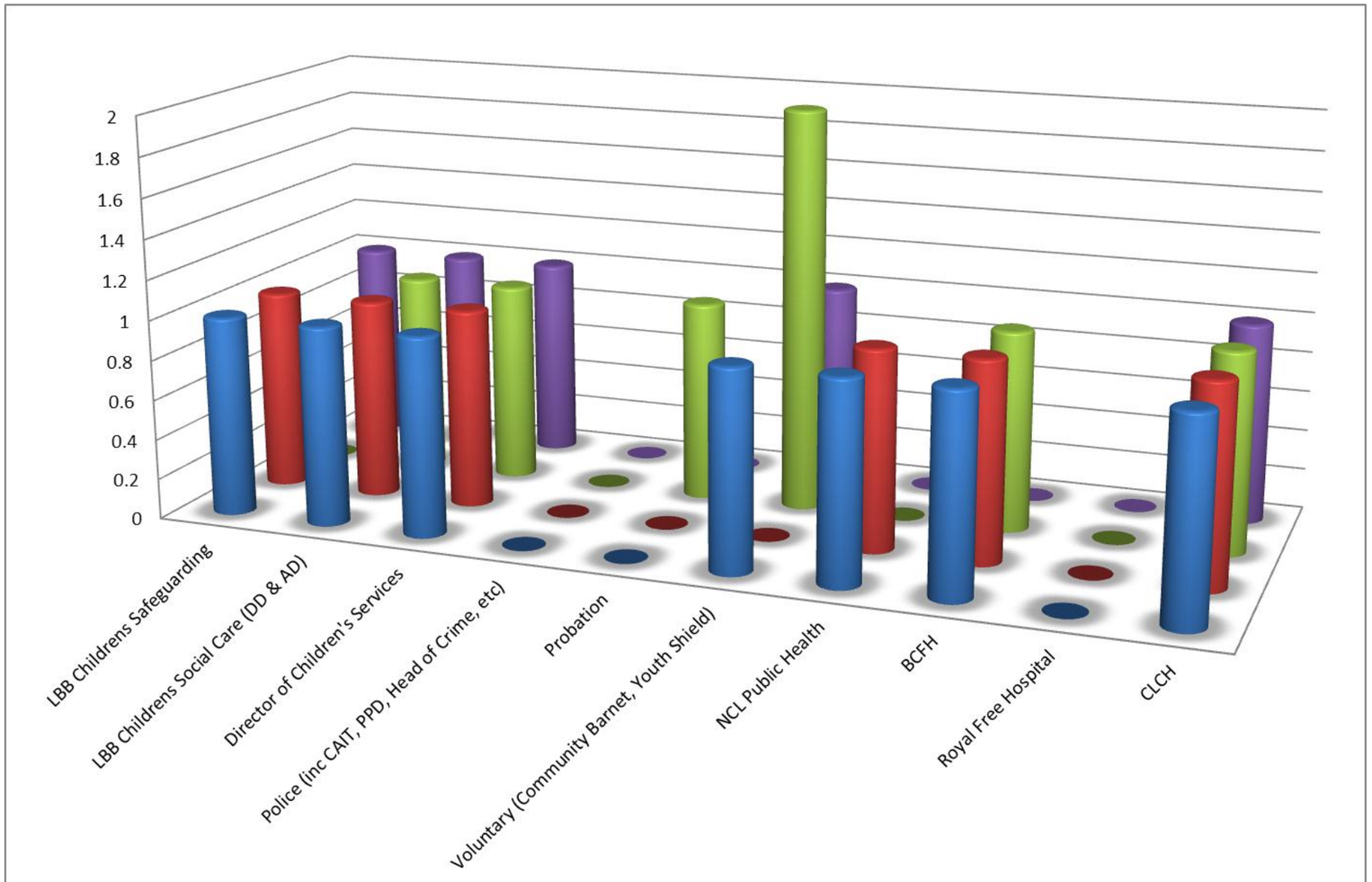
Appendix 1: Indicators for Barnet Safeguarding Children Board





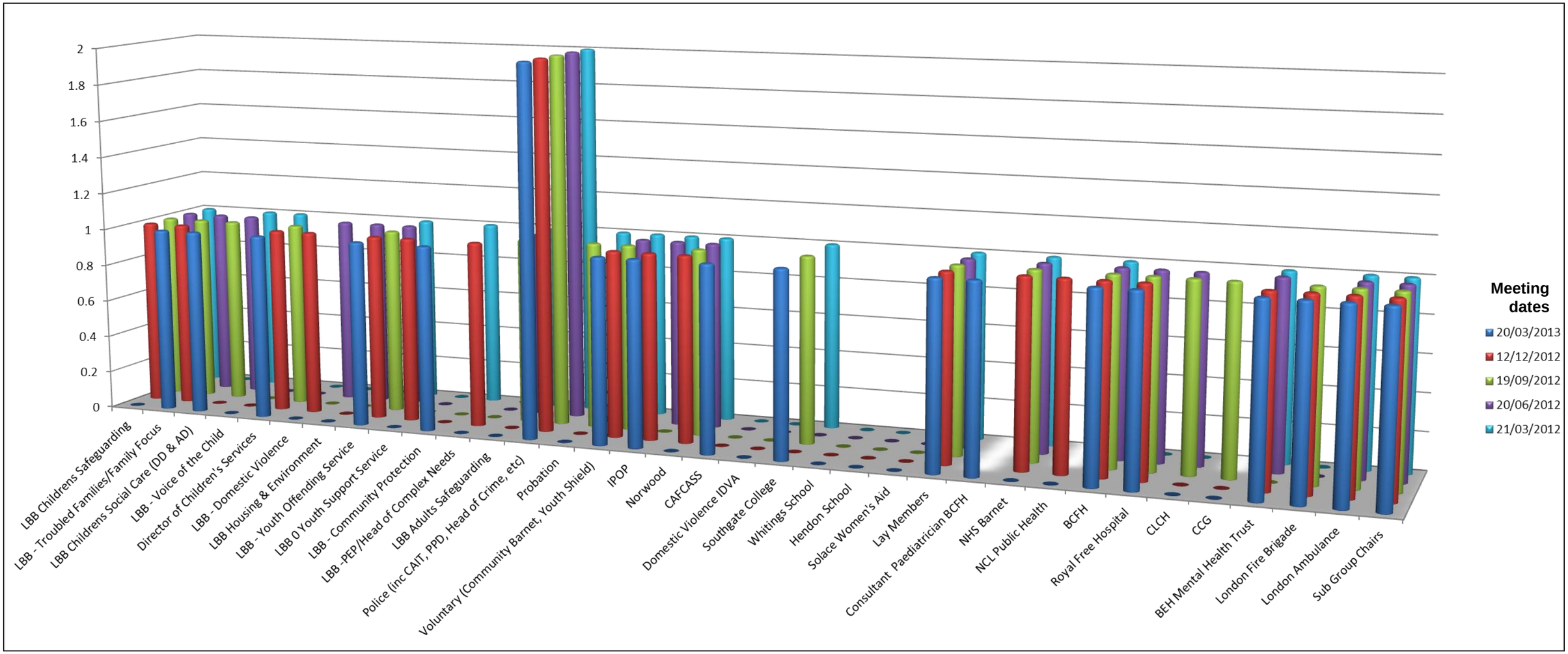
Appendix 2: Barnet Safeguarding Children Board Agency Attendance

Executive Board Meeting Attendance



	LBB Childrens Safeguarding	LBB Childrens Social Care (DD & AD)	Director of Children's Services	Police (inc CAIT, PPD, Head of Crime, etc)	Probation	Voluntary (Community Barnet, Youth Shield)	NCL Public Health	BCFH	Royal Free Hospital	CLCH
27/02/2013	1	1	1	0	0	1	1	1	0	1
28/11/2012	1	1	1	0	0	0	1	1	0	1
05/09/2012	0	1	1	0	1	2	0	1	0	1
13/06/2012	1	1	1	0	0	1	0	0	0	1

Board Meeting Attendance



Appendix 3: Barnet Safeguarding Children Board Agency Updates

Organisation: Children's Social Care

Internal arrangements for governance regarding safeguarding children at risk:

- In accordance with legislation and statutory guidance, local authorities have a duty to safeguard and promote the welfare of children in need living in their area.
- As part of ensuring effective partnership working, the local authority has a responsibility to ensure that arrangements are in place to promote cooperation with partners and others, as appropriate working with children in the local area.
- Children's social care carries out these duties working with other services and agencies both internal and external to the council.
- Children's Social Care works within the framework set out by the Barnet Safeguarding Children Board and adheres to the required policy and procedure, for example, the London Safeguarding Board procedures.
- The Chief Executive is the chief paid Officer of Barnet Council. The Director for People who is the Council's statutory Director of Children's Service reports directly to the Chief Executive. The Assistant Director for Children's Social Care is the Council's senior officer with day to day responsibility for safeguarding arrangement and children's social care and, reports to the Family Services Director who is accountable to the Director for People.
- The Council's organisation structure is available on the council website and shows the relationship between Children's Social Care and other services across the council. For more information on the functions within Children's Social Care, please see either the Children and Young People Plan or Barnet's Children's Service Plan both available through the internet.
- All social workers undertaking statutory functions in Children's Social Care hold a recognised qualification and are currently registered through General Social Care Council as required. From 31 July 2012, the registering body will be the Health Professions Council. All GSCC registered social workers will retain their registration.
- Social workers undertake regular training to maintain their registration.
- Children's Social Care is represented at the BSCB, Children's Trust Board, Health and Well Being Board, Domestic Abuse Strategic Board and other strategic groups relevant to promoting the welfare of children and young people.
- Safeguarding and promoting the welfare of children and young people is a strategic priority for the council. The performance of Children's Social Care is central to achieving the Council's objectives. Please see the Council's Corporate Plan.
- Within the Council, the Assistant Director for Children's Social Care attends the Assurance Meeting of the Strategic Commissioning Board which is chaired by the Chief Executive on a bi-monthly basis to report on safeguarding matters and risks related to children and young peoples. The Director for People is a member of the SCB. The Assistant Director is also a member of the Children's Service Senior Leadership team and other relevant teams within Children's Services.
- The AD CSC works with staff across Children's Social Care to continually improve outcomes for children and young people.
- The Governance of Children's Social Care is inspected by Ofsted as are many of its functions such as its fostering service, adoption service and children's homes.

Key outcomes and achievements for 2012/13

- Work has progressed on integrated safeguarding arrangements through the development of a Multi-Agency Safeguarding Hub – MASH. The MASH will begin in July 2013. The Independent Chair of the BSCB has provided oversight of the delivery arrangements through a steering group.
- Early Intervention for families to prevent their needs escalating to a point where statutory intervention is needed. This includes preventing admission into care, helping troubled families, and providing on-going support when children are no longer subject to child protection plans or return home.
- Implementation of a Strengthening Families model of Child protection Conferences
- Work has started on the development of a new single assessment to replace the current initial and core assessments and this is due to be implemented in March 2014.
- The implementation of the Family Justice Review and reduced timescales for Family Courts is underway
- Revision of the Quality Assurance Framework which includes a revised audit process. Increased scrutiny and oversight of children subject to CP plans and children in care by Child Protection Chairs and Independent Reviewing officers through practice alerts which will inform future workforce development.

Work Planned for 2013/14

- Making sure through Quality Assurance audits and performance management that our staff, are challenged and supported and learn the lessons from the review of serious cases and incidents.
- Assessments and interventions are of a high quality and plans are outcome focussed.
- All managers are confident and competent in the provision of good supervision, reflective decision making and service development.
- Ensure the views and experiences of children, young people and families inform practice and service development.

Ann Graham
Assistant Director of Children's Service
Barnet Children's Service

Organisation: Barnet Borough Police

Internal arrangements for governance regarding safeguarding children at risk:

- The Metropolitan Police Service (MPS) has a specific policy and standard operating procedure for Safeguarding Children; awareness of which is delivered, through training, to all operational staff.
- We have centrally managed, dedicated Child Abuse Investigation Teams (CAIT) based at Borough level, with specialist knowledge and skills to investigate child abuse cases.
- Barnet Police has a Detective Chief Inspector lead for Public Protection matters, which incorporates Safeguarding. Along with a dedicated Detective Sergeant with responsibilities to provide a link between local police staff and the central CAIT unit, part of the role includes championing Safeguarding matters and learning.
- Existence of a Police Community Safety Unit (CSU) which is dedicated to the investigation of all hate, domestic violence and ensuring that matters relating to safeguarding children are referred to appropriate bodies e.g. Child Abuse Investigation Command.
- All CSU staff undertake a specific two-week course to be able to understand and effectively investigate the above crimes

- Representation on the Children's Safeguarding Board through attendance of senior police leaders, from the local Borough and the CAIT (minimum Detective Superintendent and Detective Inspector level).
- Daily Management meetings, chaired by a member of the Senior Leadership Team, where risk and harm for all crime is assessed and appropriate resources allocated. All matters involving children at risk/victims/perpetrators of crime are listed and reviewed at the daily meeting at local Borough level and CAIT unit.

Work undertaken and achievements in 2012/2013

- Implemented Phase 1 of a Multi-Agency Safeguarding Hub (MASH), to ensure a more dynamic and holistic approach to safeguarding victims.
- Worked with partners to implement a co-located Integrated Offender Management Unit, allowing a more joined up and speedy response to offender's risks and needs.
- Supported the multi-agency homicide review processes, designed to capture learning and improve our ability to prevent serious crimes of violence.
- Delivered two mentoring programmes with Barnet Education Business partnership and Friern Barnet School Blue Skies project.
- Continued to support Youth Shield.
- Fully supported the Troubled Families project.
- Undertaken Junior Citizens scheme for year 6 pupils approaching transition.
- With Partners introduced a new multi-agency 'operational approach' to Gangs to reduce youth violence, reduce opportunities/desire to join gangs and offer alternatives to gang involvement/lifestyle.

Work Planned for 2013/2014

- Implement a new local policing model ('go live' date 24/06/13), with the aim of improving performance, public satisfaction, and enhancing capability, particularly in respect to crimes of violence and risk.
- Implement the final phase of MASH; whereby the multi-agency team will be completely co-located, to ensure timely risk assessment and action in relation to vulnerable children across the partnership.
- Continue to provide information, support and resources into the Troubled Families project, to concentrate partnership resources on those families with the most complex needs across all agencies.
- CAIT developing a plan to increase staff to allow greater focus on risk/harm caused by sexual exploitation of children.
- Continue with a strong safer schools team concentrating on support and identification of threat, harm and risk. Running a 2013 Junior Citizens scheme.
- Undertake further mentoring programmes where police staff support Year 11 students at local schools.
- Continue to develop the newly formed multi-agency gangs approach
- Work with Youth Shield and other youth groups to improve confidence in police, including establishing which areas in the Borough young people do not feel safe and why.

Mark Strugnell
Detective Superintendent,
Neighbourhoods and Crime
Metropolitan Police Service
(Barnet Borough)

Organisation: Barnet Youth Offending Service

Internal arrangements for governance regarding safeguarding children at risk:

- The Youth Offending Service have a statutory responsibility to have regard for the welfare of children and young people in the Criminal Justice System; Safeguarding is therefore threaded through all areas of practice.
- Barnet YOS forms part of the Children's Service organisational structure. All YOS staff are required to update their Safeguarding training on a periodic basis which they access through the Barnet internal multi-agency Safeguarding programme.
- The YOS Management Board provides strategic oversight and direction, and coordinates the provision of youth justice services by the YOT and partner organisations, of which Social Care is a key partner.
- The YOS complies with safer recruitment policies and processes and all staff, including volunteers are CRB checked and these are periodically renewed. There are two GSCC registered, qualified Social Workers on the YOS staff team, one of whom is an Operational Team Manager holding delegated responsibility as the Safeguarding lead and the other is a Senior caseworker. The staff base also includes a designated Nurse, a Clinical Psychologist and there is a strong partnership with Drugs Counsellors and Psychiatrists through Barnet Young People's Drug and Alcohol Service.
- The Youth Justice Board assessment framework requires the Youth Offending Service to undertake assessments of vulnerability for all young people who receive YOS service. Vulnerability Management Plans are drawn up to identify how needs will be addressed. These assessments and plans are regularly reviewed.
- A corporate target for the YOS is to reduce the number of children and young people remanded or sentenced to custody, with resources dedicated to creating robust bail support programmes and community sentences.
- The Legal Aid, Sentencing and Punishment of Offenders Act 2012, received royal assent in May 2012 and became effective in the courts from December 2012. This has brought about some key significant sentencing changes which have an impact on the YOS' way of working, including the implementation of new Out of Court Disposals in April 2013 which removed the automatic escalation through the Youth Justice System. The Act has also for the first time, devolved its remand budget to each Local Authority and each young person remanded into custody is now considered a "Looked After Child"; potentially eligible for a leaving care service. Barnet Children's Service has created a multi-agency task group to ensure that the Local Authority has a shared understanding of the implications of this legislation. This group is responsible for identifying and implementing targeted approaches to minimise remand episodes and creating protocols around shared responsibilities and roles.
- As of April 2013, the Youth Justice Board has introduced a new set of National Standards that are less prescriptive and provide the YOS with the opportunity to implement a more flexible approach which promotes more direct, targeted work with young people. The emphasis is also on professional judgement and accountability for risk led decisions.
- The HMIP Inspection regime has been redesigned and the YOS are expected to undergo a multi-agency Full Joint Inspection between 2013/14. There is a significant focus on the experience of service users of agency involvement and outcomes for young people.
- The YOS are represented on the Children's Safeguarding Board and relevant sub-groups, the Children's Leadership Team and Safer Communities Partnership Board.
- Monthly multi-agency High Risk and Deter Panel meetings, at which Social Care is represented, address the needs of young people known to the YOS who are assessed as presenting a high risk of vulnerability. Vulnerability Management Plans are discussed and agreed with appropriate resources allocated.

- Assessments of victims of crime are conducted by the YOS Restorative Justice Co-ordinator. These victims are then supported and encouraged to engage with restorative interventions designed to repair the harm that has been caused by their offender.

Work undertaken and achievements in 2012/2013

- Significant progress has been made in relation to work identified in our HMIP Inspection Improvement Plan 2011/12 and key practice improvements are highlighted below:
- All YOS staff have undertaken refresher Safeguarding training relevant to their needs and role/responsibilities.
- Barnet YOS has been a key member of the sector led improvement project which comprises of 16 London YOS' and was brought together in order to develop an improved way of assessing and planning interventions. This has resulted in the new, streamlined Integrated Action Plan document which Barnet has implemented in full since December 2012.
- This initiative, together with the new National Standards for Youth Justice 2013, will allow the YOS to focus on delivering high quality interventions to young people in order to effectively reduce the involvement of children and young people in crime and anti-social behaviour; a strategic priority for 2013-16.
- There is a greater focus on more creative ways of working with and engaging young people and families and a Home Visits policy was re-launched in 2012; this ensures that young people are regularly visited in their homes, in the presence of a parent/guardian to facilitate an improved assessment of living arrangements and family circumstances.
- Barnet YOS has worked hard with the voluntary sector to increase and improve reparation projects throughout the Borough; all reparation staff are trained in Safeguarding and supported via consistent supervision. All new Referral Order volunteers have been trained in restorative approaches and the aim is to incorporate this way of working in future panels.
- Through the continued successful partnership with Barnet Police and Targeted Youth Support, we have successfully reduced the number of First Time Entrants to the Criminal Justice System by 21.9% in the last year through the use of a Triage model. This is an ambitious reduction rate to maintain, but the YOS is committed to continual reduction.
- There have been nominal reductions in the number of custodial sentences imposed in the last year and reoffending rate, which is in line with the national picture.
- The YOS have established links with partners to implement a co-located Integrated Offender Management Unit, allowing a more joined up and speedy response to offender's risks and needs.
- We have worked closely with Social Care colleagues to develop the MASH (multi-agency safeguarding hub) and have committed resources to the hub once this is implemented. All young people in Court will undergo a MASH screening process.
- A Family Support Practitioner from Troubled Families is now seconded to the YOS. This has helped to consolidate our partnership with Troubled Families joint agendas address and promote the welfare of children and young people through a systemic approach.
- YOS practitioners continue to contribute to Child Protection Plans through attendance at strategy meetings, Child Protection case conferences and other relevant multi-agency meetings. They also share Vulnerability Management Plans with Social Workers to ensure plans are joined up.
- YOS practitioners continue to work in close partnership with Social Care, Young People's Drug and Alcohol Service, CAMHS and Housing to ensure that targeted work is completed to safeguard young people and this work forms part of their Court Orders.
- Restorative Justice interventions with young victims of crime is a developing area of practice; the RJ co-ordinator has overseen successful RJ conferences resulting in verbal and written apologies to victims and victim information is now frequently represented at Initial Panel Meetings.

Work Planned for 2013/2014

- Our HMIP Inspection Improvement Plan review 2013-14 includes targets to revise our Quality Assurance process to make it shorter, more focused and facilitate professional accountability and to also include theme based audits on safeguarding practice; to produce timely and good quality assessments of vulnerability and have plans in place within National Standards which are specific about what will be done to safeguard the young person and make them less likely to reoffend and minimise the risk of them causing harm to others.
- We have set a team plan target to reduce the use of custody by 5% in 2013-14 and in order to achieve this, we will offer the Court robust alternative community sentences. This work will entail more creative use of our Intensive Supervision and Surveillance Programme and Bail Supervision and Support packages, working with the Remand Steering Group to develop the use of Remand Fostering placements and more robust RILAA (Remands into Local Authority Care) packages.
- In order to reduce the number of young people identified in the gang matrix, we will develop a joined up and co-ordinated approach to serious youth violence, including a joint Local Authority action plan and increase intervention input from Police and TYS.
- In order to further enhance our Education interventions with young people, we will develop the use of accredited programmes to facilitate progression with literacy and numeracy skills and with speech, language and communication difficulties to assist young people to achieve their potential.
- As part of support offered through the High Risk and Deter Panel, YOS Police Officers will undertake home visits for young people leaving custody, or who are deemed to be high risk of vulnerability or harm to others. Closer liaison and information sharing will be developed with Parenting workers, the intensive family focus team and social care managers to ensure that existing home visiting provision is captured in YOS case recording and contributing to assessments.
- Partnership working will be strengthened via the High Risk and Deter Panel, IOM, PPO, MAPPA and Gang Strategy group and this will facilitate improved intelligence sharing with the Police and other agencies.
- The Barnet Restorative Justice Co-ordinator is working towards developing the service Barnet offers to victims and in expanding the use of Restorative Justice between young people and their victims. We are aiming to contact 100% of victims and engage at least 20% in Restorative Justice interventions.
- TYS staff will be trained in Restorative Justice in order to address the needs of victims in intervention delivery for Out of Court Disposals.
- We will focus on quality, accurate assessments, targeted planning of interventions, the delivery of which, will meet, where possible, the learning style of the young person.
- Feedback from young people and parents to be collated and used to inform service improvements, facilitate accurate targeting and allocation of resources.
- Our team training plan for 2013-14 aims to enhance practitioner skills in engaging young people and families and affecting positive, sustainable changes. Mandatory courses for all staff due to take place include Speech, Language and Communication Needs, Working with Families using a Systemic Approach and Cognitive Behavioural Therapy.

Meeta Mahtani
Operational Team Manager
Barnet Youth Offending Service

Organisation: Central London Community Healthcare (CLCH)

Internal arrangements for governance regarding safeguarding children:

Summary - CLCH Key achievements:

1. **Development of a CLCH Safeguarding Adults Team:** CLCH has a commitment to link adults and children services to ensure transitions are managed and risk assessed. The development of a CLCH Safeguarding Adults team which and works closely with the CLCH Safeguarding Children's teams and CLCH Looked after Children teams supports the identification and assessment of issues related to the transition from children to adult services and also offers support and advice in cases where the parent is an adult at risk. This ensures CLCH health professionals in children and adults services are aware and contribute to child in need and child protection plans.
2. **CLCH has a workforce that is trained and supported by robust safeguarding supervision.** Safeguarding supervision in CLCH has been extended across allied health professionals and walk-in centres (quarterly reporting of compliance) and audited annually regarding compliance to CLCH policy and supervisee experience. Compliance with safeguarding children training at levels1 /2 /3 is published in the CLCH Safeguarding Declaration - CLCH external website. CLCH Declaration updated April 2013
3. **CLCH has a shared record and common understanding of risk and need:** CLCH in 2013 has implemented a version of Rio (electronic records) which is shared across the CLCH boroughs and links up children services. There is a robust system on flagging - placing an alert on records - where there are known vulnerabilities such as disability / Child in need plan / CP plan / domestic abuse incident. There is a common understanding of risk and vulnerability across CLCH children services with children and families assessed at a level of need 1 - 4 (CLCH Threshold of Need Procedure). This is recorded on Ri0 and reported on in CLCH quarterly reports.
4. **CLCH robust incident reporting:** all referrals to social care / police are recorded on CLCH internal incident report system DATIX. This would include all child deaths. This system assesses risk including action planning and is escalated to Board level. Deaths are reported to NHS England (London) and investigated as serious incidents (Si) parallel to the CDOP processes.
5. **CLCH contributes and participates in child protection processes.** CLCH achieved a high level of compliance with regard to attendance to child protection case conferences (reported on quarterly)
6. **CLCH HUB –** CLCH has dedicated safeguarding pages on the CLCH intranet – HUB so promoting ease of access to policies, procedures, training, updates and all matters relating to safeguarding.
7. **CLCH achieved 100% attendance at MARAC.** CLCH participates and contributes to the safety planning of high risk domestic abuse cases – this includes the sharing of information and 'flagging' of the Ri0 electronic record.
8. **CLCH has in place a Named Doctor -** interim arrangement. This was an action from the 2012 OFSTED inspection.

CLCH safeguarding priorities 2012/13

- **CLCH FGM** - CLCH had developed and delivered in house training to CLCH staff on FGM in 2012/ 2013 with additional sessions planned in 2013/ 14.
- **Response to national issues** - CLCH Safeguarding has considered the issues raised by the 'Savile Allegations' and reported on these to the CLCH Board.

Key multi-agency safeguarding lessons from 2012/13

1. **Management of the CLCH electronic record** - ensuring all family members are linked and information shared.

2. **Escalation of concerns / professional disagreement** - CLCH Safeguarding Procedure has been highlighted so that staff has greater clarity as to the process of the raising of concerns and professional disagreement within and external to CLCH.
3. **Management of allegations against staff -** CLCH Safeguarding Procedure has been highlighted so that staff has greater clarity as to the process of managing an allegation against a member of staff within CLCH and external in relation to the role of the LADO.

Monitoring and evaluation/quality assurance activity

1. Quarterly safeguarding adults and safeguarding children reports to CLCH Safeguarding Committee (SC). SC is chaired by Chief Nurse and Director of Governance Quality - with executive lead role at Board for safeguarding.
2. Annual report to CLCH Board
3. Annual Safeguarding declaration / statement on external website.
4. Audit of CLCH safeguarding supervision records / online supervisee feedback audit / safeguarding 'flagging' audit.

1. **CLCH Quality Account 2012/13.** CLCH has in place Patient Reported Experience Measures (PREMs) across services to ascertain the views of parents, young people and children. This is evidenced in the CLCH Quality Report.
2. **Looked After Children** - implementation of an experience measure / feedback from looked after children. This has been adapted to ensure younger children 5- 10 years are able to give feedback as well as older children and young people.
3. **Child Friendly complaints / compliments** project is being piloted in schools using an online web based feedback system.
4. **Staff feedback:** Staff engaging in safeguarding supervision has completed an online audit of the supervision process and their experience of being supervised. The results / outcomes have been reported back to both teams delivering supervision and staff receiving supervision.

CLCH Quarterly Safeguarding reports include:

i. numbers of children at each threshold of need 1-4
ii. numbers of children subject to plan and category
iii. numbers of child in need plans
iv. numbers of children with a disability subject to child protection plan.
v. numbers of police notification received by Borough
vi. numbers of referrals made to social care (also DATIX – incident reporting mechanism)

CLCH Partnerships

1. **Participation and understanding of the MASH.** CLCH has been actively involved in the development of the Barnet MASH. The Heath Representatives will be managed by the CLCH Safeguarding Team. CLCH staff have been made aware of the MASH – purpose and function through 1-1 supervision and staff updates at team meetings. CLCH Safeguarding professionals have been briefed at the 2013 CLCH Safeguarding Away Day. (April 2013).
2. **MARAC –** CLCH Safeguarding children and adult professionals attend the MARAC. CLCH records are 'flagged' to alert health professionals accessing the records that there is a high level concern relating to domestic abuse. The risks are known and shared across partner agencies.

CLCH Priorities for the 2013/14

Training – CLCH staff to be trained in safeguarding to a level appropriate to their role and responsibility and receive additional training on specific topics / subject areas as they emerge.

1. **FGM –** CLCH will ensure that staff are aware of the issues of FGM and responsibilities – 4 training sessions planned for 2013/14.
2. **Domestic Abuse -** CLCH has in place a programme of Domestic Violence Awareness training (Level 3)
3. **Internet safety –** CLCH to participate in the LSCB work on internet safety.

Supervision of CLCH staff – CLCH to engage in supervision compliant with CLCH policy.

1. Reported in relation to compliance %
2. Reported in relation to supervisee experience

Safer Workforce – CLCH adheres to safer recruitment policies and procedures (NHS Employers)

1. Reported on in Safeguarding Declaration
2. CLCH Safeguarding Procedures and Whistleblowing Policy give staff clear guidance on reporting concerns at work.

Engaging children and Young people – CLCH will continue to develop systems to ascertain the views, opinions and feelings of families, children and young people relating to the delivery of CLCH services.

Liz Royle
Head of Safeguarding

Organisation: NHS Barnet Clinical Commissioning Group CCG

Internal arrangements for governance regarding safeguarding children at risk:

On 1st April 2013 responsibility for children's safeguarding was handed over to Barnet Clinical Commissioning Group (CCG) from North Central Health commissioning cluster.

The CCG is currently responsible for the commissioning of services for children from both Acute and Community provision within Barnet i.e. Barnet Hospital services, Barnet, Enfield and Haringey Mental Health services, Royal Free Hospital services and CLCH.

Specialist services utilised by Barnet such as paediatric services at Great Ormond Street Hospital, tier 4 mental health services for Children and Young people and Primary care are now commissioned by NHS England (London), as are Primary Care Services.

NHS Barnet CCG has a General Practitioner who is the CCG board member for Quality and Risk who also chairs the CCG Quality and Risk Committee and in conjunction with the Director of Quality and Governance has responsibilities for Safeguarding across both adult and children's services.

The CCG seeks assurance from its commissioned providers that they have arrangements in place to safeguard children under Section 11 Children Act 2004. Quarterly reporting regarding safeguarding children assurance from commissioned providers was developed within the NCL structure and is on-going within the new commissioning framework with the support of the CSU. Information is routinely collected through CQRG clinical quality and Risk Group meetings with providers. These reports will be monitored through the CCG Quality and Risk Committee. Safeguarding compliance is also part of the quality contract schedule within the contract framework agreed within the National framework with providers.

Internally NHS Barnet host a Safeguarding Children's Advisory group (SCHAG) which is attended by both its NHS providers, including The London Ambulance service, General Practice Out of Hours Services and also some independent providers within the borough.

The SCHAG group has both a governance and also a professional advisory and support function, and the group reports directly to the Quality and Risk Committee, which in turn reports to the CCG main board and the Local Children's Safeguarding Board. The Terms of Reference, for the SCHAG and also the forward plan is agreed annually.

Key Outcomes and Achievements in 2012 /2013:

In 2012/ 2013 health organisations in Barnet continued their role in ensuring that Barnet children were safeguarded both internally by ensuring that their arrangements were in line with CQC recommendations and also externally with their work with the Local Safeguarding Board.

Health services are represented and contribute to the multi-agency safeguarding agenda in Barnet.

Each health organisation provides a programme of safeguarding children training for their staff in addition to the multi-agency programme delivered by the local authority. This training is updated in line with findings from Serious Case Reviews/ SCIE reviews and other issues highlighted nationally.

Bespoke training was provided throughout 2012/ 2013 for Independent Health Contractors .This training was supported by colleagues in the Metropolitan Police and Barnet Social care as required. Since NHS England now commission primary care services the Designated Nurse for Barnet is a member of a work group to develop training for independent contractors to include General Practitioners, Dentists, Pharmacists and Optometrists.

Health agencies were actively involved in the Social Care Institute of Excellence reviews carried out in 2012/ 2013 and was represented in both the Review teams and the case teams and are in the process of ensuring that themes learned are disseminated to all staff.

The appointment of Director of Quality and Governance to the Barnet CCG Board has been made, and the post holder will represent the CCG at the Barnet LSCB executive board.

Resources for the Designated Doctor Safeguarding Children within Barnet were increased to enable the incumbent to engage more proactively with the safeguarding economy and become more involved in integrated work with other agencies. Monitoring of resources required to fulfil the role within the new commissioning framework is ongoing, particularly with regard to the proposal being made for NHS(London) to delegate responsibilities to the CCG Designated Professionals for Safeguarding Children and also with respect to recent Royal College of Paediatrics and Child Health advice for CCGS.

The CQC/Ofsted inspection of Safeguarding and Looked after Children Barnet in January 2012 resulted in an outcome of "good" for health across the board. The resulting action plan identified a need for a Designated Doctor for Looked after Children to support the role of the Health Looked after Children's team and the Primary Care practitioners currently providing Looked after Children Medical Assessment. Health has agreed provision of a full time Specialist health visitor to be part of the MASH process with Barnet.

Improvement of training statistics for Royal National Orthopaedic Hospital was achieved following regular support and supervision for its Named Nurse for Safeguarding Children from the Designated nurse for Safeguarding Children NHS Barnet CCG.

Work Planned for 2012/2013:

- Designated professionals will continue to support the CCG in their Safeguarding commissioning role.
- Role of Lead CCG GP for Safeguarding to be developed and supported
- Continue to work with cluster Designated Professionals to develop the strategic work programme for safeguarding children across the former NCL area.
- Ensuring that Safeguarding Children remains high on Barnet CCG Quality agenda.
- Ensuring that the local focus and partnership working relationship remains excellent...
- Clarifying the ongoing framework for Independent contractor training. The Designated Nurse is part of a work group at NHS England to develop some consistency in safeguarding training for independent contractors.
- Develop the roles of named safeguarding professionals within provider organisations
- Embedding learning from 2 ongoing SCIE review across health agencies in Barnet. 2013/14.
- Continue to work with providers to ensure that the health representation on the Multi-Agency Safeguarding Hub (MASH) is functioning appropriately and to support information sharing as required.
- Review Health visitor Liaison services at BCFH
- Develop the CCG capacity to recognise and manage safeguarding though its governance processes
- Ensure safeguarding is incorporated into the OD plan for the CCG
- Ensure all transitions issues are identified and supported by clear risk management plans

Vivienne Stimpson
Director of Quality and Governance
Barnet CCG

Organisation: Barnet, Enfield and Haringey Mental Health Trust

The Trust is a large NHS provider of integrated mental health and community health services. In Barnet this includes adult, child and adolescent mental health services and the Barnet Drugs Advisory Service.

The Executive Director of Nursing, Quality and Governance is the Trust's Executive lead for Safeguarding. There is an Assistant Director of Safeguarding Children and a matrix of a lead nurse, a Nurse Consultant, four Named Doctors and a safeguarding children champion (usually the manager) in each clinical team to help provide the training, support and supervision to over 3000 staff.

Key Outcomes and Achievements in 2012/2013:

There is a strong commitment to provide a wide range of preventative and responsive safeguarding children services throughout the Trust. The evidence from quality assurance activity indicates that this is being both achieved and evidenced across trust services. There has been a continued increase in the amount of safeguarding activity at a strategic, quality assurance and individual case level over the last three years.

Key Achievements
The development of the Trust's Domestic Violence and Abuse Protocol.
Active engagement in the strategic and operational Multi-Agency Safeguarding Hub (MASH) development in Haringey, Barnet and Enfield.
Joint quarterly meeting with Children's Services Social Care in each borough to encourage building of relationships and discuss arising interagency safeguarding issues at an early stage.
The publication of the multi-agency protocol "Safeguarding Children where there are concerns of Parental Mental Health" Fact sheet in March 2013. A training morning around the interface between Mental Health services and Social Care, when dealing with adults with mental health problems was held in Barnet and attended by 101 staff from children's services and mental health the Trust.
The level of attendance at level one and two safeguarding children mandatory training is above the 80% standard.
The Trust has contributed to multi-agency case reviews held under the provisions of statutory guidance. This includes three Domestic Homicide Reviews (Barnet, Enfield and Hertfordshire); three Serious Case Reviews (two in Haringey and one in Brent); three Social Care Institute of Excellence (SCIE) Reviews in Barnet and two multi-agency case reviews in Enfield.
The Trust's Forensic Services have been commissioned by Barnet LSCB to provide training and consultation to LSCB partner agencies in working with parents who have a personality disorder. These are now well established and feedback is very positive.
Increased the number of referrals to Children's Social Care in each borough (total 128) and increased the number of children that Trust staff are recorded as involved with safeguarding (total 744) from the previous year's. This helps to indicate an awareness of safeguarding issues amongst Trust staff.
Our work in providing specialist advice about the assessment and management of stalking cases nationally continues to develop.
Barnet CAMHS have developed a new protocol for emergency management of 16-17 year olds presenting at Barnet Hospital with mental health problems, which includes recommendation for joint assessments with Social Care.
Taken part in routine in-depth case audits with Enfield and Barnet LSCBs.
CAMHS-Social Care consultation workshops, clinic or advice sessions have been further developed and are held in Barnet and Haringey and Enfield.
Our Complex Care Teams offer systemic couple and family treatment when staff have concerns regarding child safeguarding or domestic violence and their intersection with parenting
The Trust's Forensic Services have been commissioned by Barnet LSCB to provide training and consultation to LSCB partner agencies in working with parents who have a personality disorder. These are now well established and feedback is very positive.
Completed action plans in respect of all the case reviews excepting the three Serious Case Reviews where the reviews themselves are not yet completed.

Work planned for 2013-2014:
The Trust aims for 2013-14 support its commitment to safeguarding children and includes:

- Providing consistently high quality services to patients, delivered with kindness and compassion.
- Developing stronger collaborative partnerships.
- Developing our staff to work more effectively and flexibly, in line with patients' needs.

The Trust's safeguarding children and young people priorities include:

The development of practice in responding effectively to Domestic Violence and Abuse.

Achieve at least 80% of eligible staff having attended appropriate level three safeguarding children training through continued improvement in attendance and recording of attendance at in-house training and Local Safeguarding Children Board Training.

The development of a child protection leaflet for children and young people.

The development of a leaflet for parents and carers to support them in accessing local resources to support parenting.

Ensuring that there is adequate specialist safeguarding resource within the Trust.

The Trust's safeguarding children work plan will guide the achievement of these priorities and is outlined in the Trust's Safeguarding Children and Young People Annual Report.

Deborah Perriment
Assistant Director – Safeguarding Children
BEH Mental Health Trust

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

Organisation: Royal Free London NHS Foundation Trust

Internal arrangements for governance regarding safeguarding children:
The Royal Free London NHS Foundation Trust has all the required safeguarding professionals in post: Named Nurse, Named Midwife and Named Doctor. We also have dedicated administrative support and a safeguarding children training facilitator.

Internal governance is provided to the Trust Board by the Director of Nursing who is the Board lead for Safeguarding. The Safeguarding Children committee meets two monthly. The Trusts Board lead for safeguarding and the designate nurses for Barnet and Camden are members. The safeguarding committee reports into the Clinical Governance and Risk Committee which is chaired by the Medical Director and reports to the Trust Board.

The Trust undertook an annual section 11 audit to ensure that arrangements are in place to safeguard children.

The requirement to ensure Safeguarding people who use services from abuse Outcome 7 NHS Provider Compliance Assessment is reviewed quarterly. The most recent CQC unannounced inspection in October 2012 judged the trust to be compliant with outcome 7.

In January 2013 we responded to the Director of Quality and Safety NCL following the Saville allegations that our safeguarding procedures, policies, structures, staffing and reporting are assured and robust.

The Trust Board receive a bi-annual safeguarding Children report. This report provides a summary of work and activity undertaken by the safeguarding Children's team including progress with annual work plan, progress with any action plans, details of any incidents, training and development updates, audit outcomes, case conference attendance, supervision and safeguarding activity data.

The Trust Board also seek assurance through external inspection.

The named professionals provide governance through internal multi-disciplinary meetings, through audit of the management of every child who is admitted and has a diagnosis of child maltreatment and through supervision.

The Royal Free London NHS Foundation Trust was inspected in February and December 2012 by the CQC as part of the joint inspection with Ofsted. On both occasions health services were rated as 'good'

The Director of nursing is a member of Barnet Safeguarding Children Board. The named nurse is a member of the Professional Advisory sub- group and the training facilitator is a member of the Training Sub- group

Key Outcomes and Achievements in 2012:
The main focus of the safeguarding team's work has been concentrated on the Emergency Department to further embed the lessons learnt from two Serious Incidents. These SI's were reported externally. Both were fully investigated and both have had action plans which are now closed off.

As a result of this process we have:

- Developed new paediatric multidisciplinary documentation for the ED
- Strengthened participation at our weekly ED meeting to include Adult mental health and plastic surgery
- Reviewing all safeguarding cases at the weekly ED meeting to ensure safe processes and safe children
- Using the weekly ED meeting for teaching and learning
- Producing a weekly written summary of the ED meeting that is distributed to all senior staff that contains details of non-compliance, good practice and attendees - to enable feedback to relevant teams and to maintain training records
- Audit compliance with ED processes relating to safeguarding
- All new ED nursing staff as part of their orientation have specific tuition in ED safeguarding processes
- New teaching programme for ED Doctors provided by a member of the safeguarding team

Other outcomes and Achievements 2012:

Training and Development

We continue to review our mandatory & statutory training programme in line with guidance and recommendations. We continue to be active members of the training sub-groups for both Barnet & Camden safeguarding Children Board sub-group.

The figures at the end of May 2013 are level 1 100% level 2 72% level 3 90%. There is an action plan in place to address the shortfall in level 2.

Our level 3 programme consistently gets excellent evaluation. In the level 3 monthly updates we are able to be flexible in relation to both local and national drivers. We provided training that reflected lessons learnt from the SI's. We have also provided training and have further sessions planned to raise awareness of sexual exploitation following recent national guidance and as requested by NCL.

Inspection

Camden was invited by Ofsted to join their Pilot Multi-Agency Inspection. This new Inspection process has been devised following the recommendations made in the Munro Review of Child Protection taking in account the effectiveness of the contributions of all local services, including health, education, police, probation and the justice system. The CQC was the partner agency to inspect the Health providers. The inspection, which took place in December 2012 concluded an all-round finding of 'good' across the partnership.

Some of the positive points raised in relation to the health providers were:

- Multi-agency work contributing to the safety of unborn children at risk of abuse is outstanding,
- A culture of learning, support and mutual challenge is evident in and across all child protection services,
- The protection of children is given high priority by health service leaders and senior managers with suitable arrangements in place to deliver core responsibilities.
- The high priority to safeguarding children is demonstrated through the named and designated child protection lead roles working across health agencies.
  The key areas across Health providers which required improvement were

- Improve the process to notify primary care staff of children's attendance at the accident and emergency departments so that information is consistently shared in a timely way

RFH- *The acute Trusts and primary care have met with the designate staff to ensure this happens. The current position for RFH is that we share information consistently within agreed timescales*

- Ensure health practitioners routinely receive regular structured safeguarding supervision

RFH- *We have reviewed our supervision processes. Dr Ben Lloyd has a more formal structure for providing and recording supervision to consultant colleagues. Supervision data is recorded monthly*

- Ensure that key professionals attend children in need and child protection meetings as a matter of course and that written reports are routinely submitted by all relevant agencies

RFH- this is part of the monthly data collected. Currently we only record attendance and reports submitted to child protection case conferences. We are not able to robustly collect data for children in need

- Develop an overarching strategy across the partnership for tackling child sexual exploitation

RFH- *The Named professionals to contribute to this ongoing work. Sexual exploitation is included in both level 2 & 3 safeguarding training*

Think Family

The previous Ofsted/ CQC inspection in February 2012 highlighted that all agencies needed to embed the "Think Family" message across all areas. Think family requires staff in all areas to consider the family and their wider family. The Staff in the Emergency department are highlighting concerns where adults attending for their own Health needs have children. This is reflected in the referral figures to social services and the cases discussed at the weekly ED safeguarding meeting. The "Think Family" approach is to be rolled out on two adult wards as a pilot.

Supervision

Currently the Assurance metrics only contain details of the number of staff who have received formal recorded supervision. This does not reflect the great numbers of staff who receive ad-hoc supervision from the named professionals via the phone or face to face. Nor does it reflect the many staff who receive safeguarding children supervision by attending the weekly multi-disciplinary team meetings which are held in all the paediatric areas, the Emergency Department and in midwifery.

The named professionals are working with colleagues from other Acute Trusts and the designate professionals to look at how to capture this information in a way that would be useful. This information is necessary to provide assurance to the Board that staff are receiving supervision and also to enable the named professionals to target the supervision appropriately.

Work Planned for 2013/2014:

On-going work plan

- Use the flagging system to support further audit programmes
- Develop mechanisms to capture data about formal, non-formal or ad hoc supervision that are meaningful to external scrutiny
- Implement systems that support audit of supervision and promote service improvement
- Improve governance of case conference attendance and reports
- Develop more robust process to ensure that all referrals are copied to the named nurse
- Respond to assurance requests from the CCG's

Deborah Sanders
Royal Free Hospital

Positively welcoming Actively respectful Clearly communicating Visibly reassuring

Royal Free London NHS
NHS Foundation Trust

Organisation: Lay Advisers Report

This is our 3rd year sitting on the Barnet Safeguarding Children Board as Lay Members.
This has been a year which has seen much development in many areas and we have found it a privilege to sit on the Board, to listen to the thoroughly professional, caring and detailed reports of the various groups and to partake in the ensuing discussions.

We would like in particular to draw attention to the SCIE review and the auditing developments, with the significant and sensitive procedures evolving for retrospecting individual cases. Other issues which have emerged as important to us as lay members this year are the discussions on sexual exploitation and trafficking, the consultation on internet safety for young people and their families with its recommendations, the fantastic contribution by youth shield members on 'hot spot safety' and of course their award from the London Safeguarding Children Board. And finally of course, the launch of the website with its accessibility, wealth of information for young people, parents and carers, professional and the extensive links for information for all.

There are also areas around which we have concerns as lay members and residents of the Borough of Barnet, in particular the effects that outsourcing aspects council work may have on the provisions for safeguarding, along with any cuts in services connected with children and their safety. We hope and trust that as lay members who are not involved in the day to day work of professionals across the agencies, we can reflect back our observations on practice as affected by these changes.

We are delighted to be part of a Board that has been highlighted as one which has good methods for involving lay members and would like to thank the Chair and Administrators for ensuring that we can continue to feel as involved and valued as part of the on-going work.

We look forward to the coming year and further opportunities to utilise our skills

Naomi Burgess and Maxine Zeltser
Lay Members to the Board

Organisation: Community Barnet &Youth Shield

Community Barnet

Community Barnet's Head of Children's Services sits on the Barnet Safeguarding Children's Board as a representative of the voluntary sector within the borough. We also, with the support of a safeguarding officer, attend relevant sub groups. This participation allows us not only to contribute to discussions but also to inform the board / the sector of the findings / rising trends etc. Allowing us make the relevant changes in training / support so that we are enabled to make a positive contribution to help keep the children of Barnet safer.

Being part of the board facilitates the free flow of information between statutory partners and the voluntary sector. It also allows for the VS to be represented at SCIE reviews and other pertinent overviews, where learning is a vital part in moving forward in the protection and safeguarding of all children within the borough.

Our aims are clear - to continue to support the work of the BSCB and represent the sector accordingly.

We also support/facilitate Youth Shield through our participation officer. We will continue to work with the YSB to allow it to grow and therefore offer a wider service / level of support to children and young people of the borough.

Youth Shield

Youth Shield members have a standing invitation to the BSCB and report back regularly on their activity. At other times the Chair and Board Manager attend meetings with the young people.

The Barnet Safeguarding Children Board (BSCB) is committed to ensuring that the views and experiences of children and young people play a key part in driving the agenda of the Board. Much work has been done in laying the groundwork to enable young people in Barnet to play an active role in the work of the BSCB. In order to support this process, the BSCB commissioned CommUNITY Barnet to consult with children and young people on the safeguarding agenda.

Key Outcomes and Achievements 2012/2013:

- Recruited new members to Youth Shield who represent: Barnet Young Carers and Siblings, LGBT young people's group: Rainbow Head, GRT community, local schools and young volunteers
- Represented young people on Barnet LINk, giving young people a voice on health issues
- Sat on interview panels
- Attended a full council meeting
- Completed an Allegations Leaflet for young people
- CAMHS subgroup contributed to new 3 year CAMHS plan
- Winners of London Safeguarding Children Awards 2012 from the London Safeguarding Children Board. Our work was recognised as an example of best practice.
- Provision of a Workshop available to all London Boroughs to spread our good practice which was well attended

Healthy Relationships peer to peer training

Context:
We did a survey for young people in Barnet (Barnet Young People's Safeguarding Consultation 2011). 60% said they do not receive enough relationships education in schools. 15.8% said they had been grabbed, pushed or shoved by a boy or girl they were going out with and 69.5% thought that domestic violence exists in teenage relationships.
16-24 year olds are most likely to experience abuse from someone they know and every week 2 women are being killed by a partner or ex-partner here in the UK.

- Piloted the Healthy Teenage Relationships Training: a project for young people to become peer trainers and deliver sessions in schools and youth settings to 14 year olds.
- Delivered healthy relationships training at youth clubs, young people at the Barnet Youth Crime Conference and to adults as part of Safeguarding Month at NLBP
- Developed an in depth proposal to extend the healthy relationships project to reach a wider number of young people in schools and to train up 30 peer trainers a year.

Feedback from the Healthy Relationships Training:

"The best part of the training was the play we read out showing the beginning of an unhealthy relationship"

"I liked that the trainers are young because they can communicate with us on the same level"

"I thought it was good the trainers were young people because it was comfortable to speak to them about this topic."

Key Outcomes and Achievements 2013/2014:

- Created a survey for young people around their experiences and attitudes towards the Police, Youth Services and Social Care. Survey ready to launch summer 2013 (this will include going to youth events in Barnet to target young people).
- Taken part in the BSCB Review Day
- Continued healthy relationships training
- The approval by the BSCB of the Youth Shield Business Development Proposal to provide substantial funding to Youth Shield

Youth Shield
Youth Members of the Board

Organisation: Barnet Youth and Community Service

Internal arrangements for governance regarding safeguarding children at risk

- Youth & Community Service deliver/operate all safeguarding processes within the Children's Service guidance and policy
- All Youth Support Service staff are recruited with an enhanced CRB and undergo a Warner Interview

- Members of the Management Team are represented on the Children's Safeguarding Board, Professional Advisory Sub Group, Raising Educational Achievements (REA) for Looked After Children, Inclusion and Tracking Transition group, Multi-Agency group (MAG) ,Pupil Placement Panel and the MASH
- All staff are required to attend Safeguarding training within 3 months of being employed and are responsible for updating their training at required periods
- Quarterly Health & Safety meetings include Safeguarding with details of accidents and incidents
- Head of Service attends special review child protection case conferences as required

Work undertaken and achievements in 2012/2013

- Supporting delivery of the Junior Citizens Scheme – attendance at workshops and funding
- Contributed to the CAF Practitioners forum and CAF steering Group
- Delivery of Positive Activities (to 1,921 young people) to targeted areas and groups of vulnerable young people during school holidays and evenings and work programmes for NEET young people
- Development of counselling provision at 2 drop-in sites
- Delivered Evolve training to all staff for risk assessment inputting
- Implementation of Court Assessment meetings in relation to attendance
- Delivery of targeted work on a casework basis
- Targeted Youth Support early intervention multi-agency approach
- Meetings held with Practitioners working with young people in Barnet from the statutory, voluntary and private sectors. The meetings during 2011-12 included focus on Safeguarding, Safer Places for young people and gangs. Each meeting was attended by between 70 to 90 Practitioners with additional communications going out to over 700 Practitioners
- Further development of the Barnet Youth Board which is the youth council for the Borough of Barnet. It represents 13-19 year old young people across Barnet secondary schools, colleges and many community groups. It aims to give young people a voice and allow them to take their views to decision makers. As well as schools (including PRU's), there are members representing children in care, young carers, faith groups, Youth Shield, BLAB (Barnet Libraries advisory board) and disabled young people.

Work Planned for 2013/2014

- Continued targeted delivery of Positive Activities to targeted areas and groups of vulnerable young people during school holidays and evenings and work programmes for NEET young people
- Training to all providers in Child Protection awareness
- Training to all providers in Risk Assessments
- Partnership in the Junior Citizens 2012
- Targeted 'gangs' work through courses e.g. boxing and mechanics.
- Alternative education provision packages for non-attendees and young people at risk of exclusion
- Regular meetings with Practitioners which will include updates/information on safeguarding developments
- Continued delivery of targeted work on a casework basis.
- Implementation of 'Detached' and 'Outreach' work.
- Development of UKYP and the youth voice through the Participation strategy group in line with the 'United Nations Convention on the Rights of the Child.'
- Embed Counselling Provision for young people
- Support and inform the Young Carers agenda
- Develop and deliver Sexual Health and information programmes to individuals and groups. This includes information on 'staying safe'.

- Identification of positive interventions to prevent and divert young people from low level offending through the 'Out of Court disposals' route.
- Partnership work with the CIC team, delivering group work to the young people in foster care and their carers.
- Collaboration with the IFF team in relation to co working cases particularly in relation to School Attendance issues.

Karen Ali
Operational Manager
Youth & Community Service

Organisation: London Fire Brigade

Internal arrangements for governance regarding safeguarding children:

- London Fire Brigade (LFB) has a policy specifically for Safeguarding Children which is known by all fire officers.
- If an officer suspects there may be a safeguarding issue, details are forwarded to the duty Assistant Commissioner who will decide whether to make a referral to the Local Authority or not.

Key Outcomes and achievements in 2011/2012:

- LFB has started a new partnership arrangement with Barnet's Neighbourhood watch schemes and the MPS to identify at risk people to ensure that home fire safety visits are targeted at the individuals who most need them.
- The initiative commenced last year to identify premises in the borough that have had more than one fire in the home over the past two years has now been reinforced and is being promoted right across the North West area of London. As these premises are identified, LFB staff ensure that a Home Fire Safety Visit has been provided and that all appropriate measures have been considered to prevent further fires occurring. This includes liaison with other agencies including Barnet Social Services.
- LFB is actively campaigning to promote domestic sprinklers and fire suppression systems. We continue to work closely with Barnet Homes and other housing providers to look for an appropriate solution for our most at risk individuals.

Work Planned for 2012/2013:

- Continued working with the Children's Safeguarding Board, seizing opportunities to make vulnerable people safer.
- Continued working with all identified partners, improving links when necessary to make vulnerable people safer.
- We will continue to promote the LFB's Juvenile Firesetters Intervention Scheme to partners.
- We will continue working with YOS, promoting the LFB's Local Intervention Fire Education programme.
- We will again be an active partner at Barnet's 4 week Junior Citizen event.
- We will continue to work with various youth groups, engaging with children to promote fire safety.
- We will have an Open Day at Finchley Fire Station on 1st September 2013, the day will primarily be for promoting fire safety to young people.
- LFB will carry out over 2600 Home Fire Safety Visits within Barnet during 2013/14, with at least 80% of these to vulnerable people or within areas that we have identified as being at higher risk of fire.
- Focus working with individuals at risk of fire due to rough sleeping /squatting/beds in sheds.

- Focus working with individuals at risk of fire due to hording tendencies.
- Develop closer links with Barnet mental health trust and voluntary mental health charities in the borough to identify high risk individuals.

Steve Leader
Borough Commander
Barnet

Organisation: The Barnet Group

Internal arrangements for governance regarding safeguarding children at risk:

- The Barnet Group is a local authority trading company, owned by Barnet Council. We are the parent company to Barnet Homes, a social landlord which manages 15,000 council homes, and Your Choice Barnet, a social care organisation providing services to people with learning and physical disabilities
- The Barnet Group staff and contractors may come into contact with children in a number of ways and many people who use the service will themselves be parents, grandparents or related to children in some other way. Some of these adults may have difficulties that have an impact on their children, for example, alcohol or substance misuse or domestic violence, and it is important that staff are alert to potential risks of harm or other concerns about children.
- Barnet Homes have specific policy and procedures for safeguarding children. Awareness training is given to all staff and Barnet Homes complies with all safer recruitment processes. All mobile working staff are CRB checked and these are periodically renewed.
- Barnet Homes have a standing invitation to the BSCB and has a its own safeguarding group who meet monthly.

Key outcomes and achievements 2012/2013:

- Safeguarding had been included the latest Barnet Group Business Plan to implement best practice safeguarding across the Group.
- The Barnet Group have implemented phase 1 of MASH and our representative for MASH is Afi Hossein.
- Our Domestic violence procedure was reviewed in 2013 and a referral must be made to Children's services/MASH where children are considered to be at harm.
- Representative from Barnet Homes will be on the newly formed Gangs Strategic Meeting Group.
- Our Internal Safeguarding group has developed and now has a senior manager from LBB's Children's Services as a member for partnership working and best practice sharing

Work Planned for 2013/2014

- MASH awareness training for all staff.
- Review to take place of all safeguarding policies and procedure. Safeguarding triggers and monitoring to be incorporated into our new I.T. systems due to go live throughout 2013/14.

- Audit of safeguarding within Barnet Homes has/to take place? *Gladys I noticed on previous minutes this was mentioned but I do not know anything more*
- Continue to work with the Intensive Family Focus Team.
- Work with the Gangs Strategic Meeting Group.
- Continue to communication and promotion of safeguarding across the Group

Helen Faith/Gladys Mhone
Vice Lead/Lead persons for Children Safeguarding for the Barnet Group

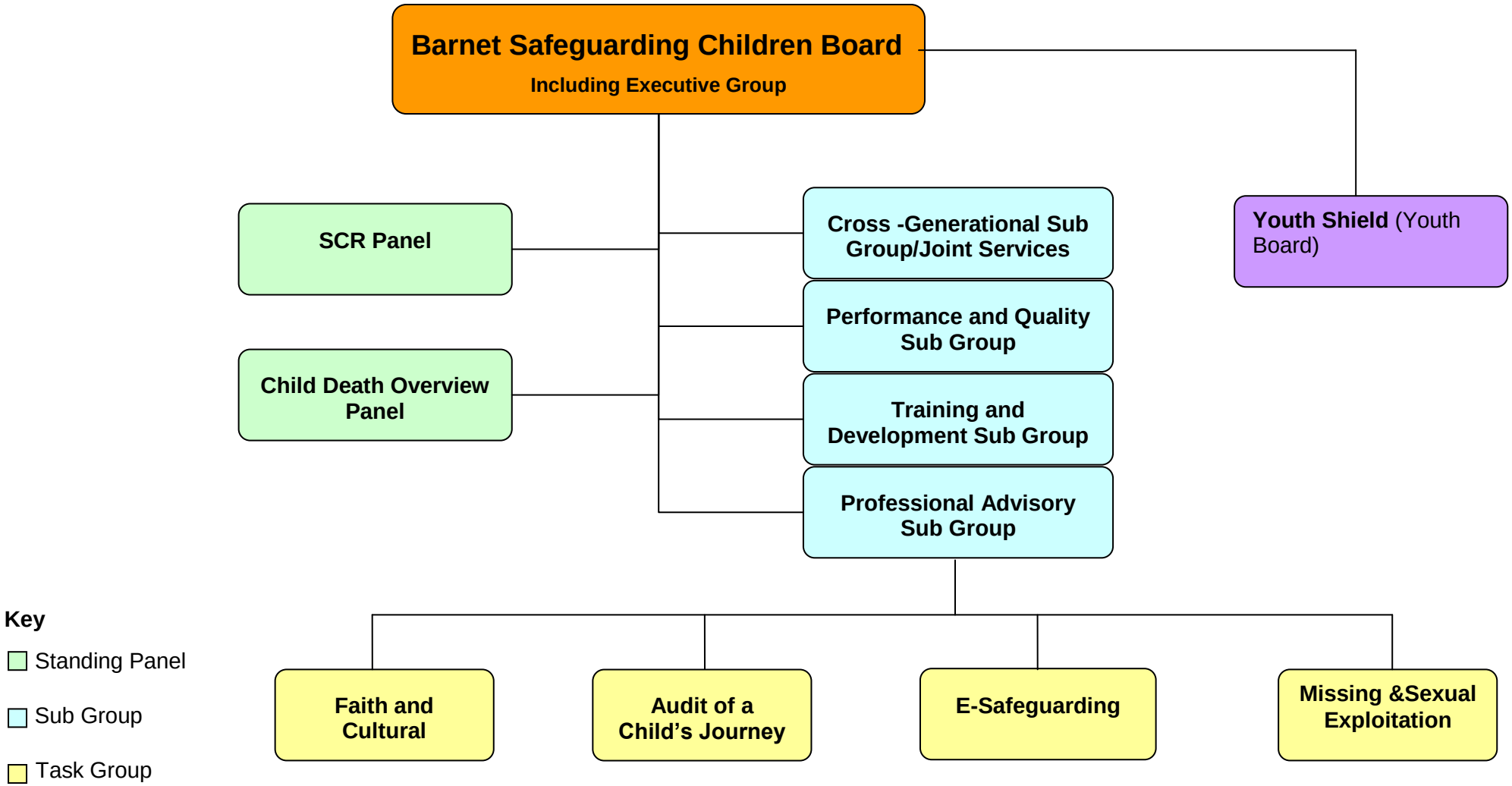
Appendix 4: Barnet Safeguarding Children Board Sub Groups

Chair's Name	Group	Email	Reporting Schedule
Tim Beach	Performance and Quality Sub-Group	tim.beach@barnet.gov.uk	Quarterly
Teresa DeVito (interim)	Professional Advisory Group	Teresa.deVito@barnet.gov.uk	Quarterly
Delphine Garr	Training and Development Sub Group	Delphine.Garr@barnet.gov.uk	Quarterly
Laura Fabunmi	Child Death Overview Panel	Laura.Fabunmi@harrow.gov.uk	Quarterly
Ann Graham	Cross -generational Sub-Group	ann.graham@barnet.gov.uk	Quarterly
Sally Trench	Serious Case Review Panel	swtrench@btinternet.com	Quarterly
Adrian Usher	Faith and Cultural Sub-Group	Adrian.usher@met.police.uk	Quarterly

Barnet Safeguarding Children Board Task and Finish Groups

Chair's Name	Task and Finish Group	Email
Sharon Harrison (interim)	E-Safeguarding	sharon.harrison.clt@gmail.com
Teresa DeVito (interim) & Mark Strugnell	Child Sexual Exploitation incorporating Missing	Teresa.deVito@barnet.gov.uk Mark.Strugnell@met.pnn.police.uk
Teresa DeVito (interim)	Audit of a Child's Journey	Teresa.deVito@barnet.gov.uk

Appendix 5: Barnet Safeguarding Children Board Structure Chart



Appendix 6: Barnet Safeguarding Children Board Budget and Expenditure

Barnet Children's Safeguarding Board Budget Statement at 19/3/2013

	£	£	Balance Remaining/ Carried Forward
Balance B/Fwd 2011/12	35,520.00		
Income / Contributions			
London Borough of Barnet	97,840.00		
London SCB (Met Police)	5,000.00		
Probation	2,000.00		
CLCHT (Community Health)	12,500.00		
Chase Farm NHS Trust	12,500.00		
BEH MH Trust	12,500.00		
Royal Free Hospital Trust	12,500.00		
CAFCASS	550.00		
	190,910.00		
Grant Monies transferred (Munro/ Police Contribution)	**34,245.00**		
Expenditure			
Staffing Costs		78,956.00	
Independent Chair		24,400.00	
JKB Consulting		4,325.00	
Other Services		10,126.00	
Conferences		957.25	
Youth Shield		4,000.00	
Healthy Relationships (Youth Shield)		4,630.00	
Serious Case Review		2,360.00	
GMK Consulting (Case Review)		9,320.00	
Income written off from previous years (2008/09)		12,000.00	
		151,074.25	
Commitments			
Printing / Photocopying		1,729.00	
Catering		4,081.00	
Mobile phones		98.00	
Miscellaneous Expenses		668.75	
		6,576.75	
Totals	**225,155.00**	**157,651.00**	**(67,504.00)**