Barnet
Safeguarding
Children Partnership

Barnet Safeguarding Children Partnership

Annual Report 2022–2023

Caring for **people**, our **places** and the **planet**

FAMILY FRIENDLY BARNET

NHS
North Central London
Integrated Care Board

METROPOLITAN POLICE

BARNET
LONDON BOROUGH

Barnet Safeguarding Children Partnership

Annual Report - September 2022-September 2023

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Introduction: Thank you for taking the time to read this 2022-23 Annual Report of the Barnet Safeguarding Children Partnership (BSCP). BSCP continues to bring together the Local Authority, Health and Police as statutory safeguarding partners alongside wider agencies including education, Probation and our local voluntary community and faith sector (VCFS). We shall refer to all throughout this report as 'Partners' and 'the Partnership'.

The impact of the Covid19 pandemic, cost of living crisis and global conflicts have had an impact on children, affecting their mental health and economic security. These events have affected the most disadvantaged in our communities and have exposed the deep-rooted and intersectional inequalities of race, religion, gender, gender-identity and disability in society. As a Partnership, we want to create a borough that is family-friendly, where we work in collaborative partnerships with our local communities to find solutions that will improve the health, wellbeing, economic stability and life chances of our children and their families. We will work together to tackle inequalities and social injustice so that all children can reach their potential and achieve great outcomes. To do this, we will listen to children, parents and those working with and supporting them and take action to create the change they need.

At the time of concluding this years Annual report the Partnership has been horrified to witness the violence in Gaza & Israel. Recognising the conflict will affect our communities, families and their children we have been working closely with school leads to ensure immediate support where required such as in providing school places for children displaced across the region. In addition, we have provided emotional wellbeing support for those affected through our Barnet Integrated Clinical Services (BICS) provision and provided extensive brokerage and support across schools, media, police and the local voluntary and charity sector. We will continue providing support wherever we can to all those affected for as long as is required.

This year we have developed and published a new Children and Young People's Plan 2023 to 2027 which sets out an **ambitious, cross cutting, multi-agency Plan that children and young people have co-produced with us, placing them firmly at the centre of decision making and in line with our My Say Matters child participation and family involvement strategy.** A broad range of Partners and parents and carers have also contributed to the development of the Plan and have informed our 4 key drivers to underpin delivery of the Plan:

1. **Great Partnerships:** Participation & co-production means that children, young people, parents and carers can discuss and co-decide on all matters that affect them, like family, school, community matters, local government policies & legal policies. It means that their voices are being heard.

2. **Inclusion:** We want to ensure that whatever benefits and opportunities there are in Barnet must be afforded to all.

3. **Great Outcomes:** Tackling the gap and fighting inequalities We aim to ensure we understand how children and young people experience inequality of opportunities and experiences in Barnet and why this might be, to start to tackle these inequalities.

4. **Children and young people having fun:** Play is an essential right of childhood which stimulates brain development. For all young people it's the fun part that balances the stressful times. It's where important social skills are gained and healthy social development is learned through expression.

The Children & Young People's Plan has further been informed by the Young People's Resident Survey (YPS) which is a bi-annual face-to-face survey of Barnet young residents aged 11-18, undertaken by an independent research company. The survey has been undertaken since 2016 which gives indications of trends in young people's views over time. 500 Barnet young people were interviewed as part of the most recent YPS, the majority of which (89%) agreed that Barnet is a family friendly place to live, although children with a disability were less happy with their local area as a place to live.

The top 3 priorities for children and young people are: 1) protecting people from anti-social behavior, 2) protecting people from harm and, 3) supporting people with mental health concerns. 51% of children said that

knife crime remains among their top personal safety concerns, although the number of children who placed this in their top three concerns is significantly lower than in the previous survey. Similarly, the level of concern over gangs (35%) is also significantly lower than in the last survey and young people taking drugs has also fallen (34**%**). However, children reflect that they want to feel safer in their communities.

Our progress in achieving our vision of a Family Friendly borough is monitored and rated through our Family Friendly Index – a range of data and intelligence relating to changes over recent years that includes views of children and young people as well as Partnership information from social care, health, education, housing and crime data. This will enable us to be held to understand the impact of the change we are making and be held to account. Our ambition is to use feedback from children and parents to further inform the development of the Partnership's work over the course of the next year and beyond.

Education: In terms of day-to-day multi agency Partnership work for children and young people, we wanted to start this report by highlighting that, despite global challenges such as the pandemic, children in Barnet schools have made good progress and continue to secure hugely positive educational outcomes. This is testament to all children and young people, supported through the work of the Partnership.

Educational development and achievement have improved consistently in recent years in the borough. Over 97% of Barnet schools are good or outstanding and Barnet continues to be in the top 10% for many measures of achievement in schools. Newly published Key Stage 4 (KS4) data from the Department for Education (DfE), shows that Barnet is second in the country for Progress 8, which measures the progress that students have made between the end of primary school and the end of Key Stage 4 (16 year olds). The Barnet Progress 8 score for the 28 schools in the Borough was only beaten by the Isles of Scilly Local Authority, which has only one school in it. The attainment of students in Barnet by the end of KS4 (i.e. grades achieved) was also very strong, ranked third best in the country.

For safeguarding, in 2022/23 there were 45 full Ofsted inspections of Barnet state schools of which 44 were judged to be 'effective' for their safeguarding. One school received two inspections in the academic year as they were graded inadequate for leadership and management because safeguarding was not judged effective. Robust action planning and significant support and challenge from the Barnet Education & Learning Service (BELS) team resulted in a 'Good' judgement overall in June 2023 with safeguarding judged as 'Effective'. Three Barnet independent schools were judged at their last Ofsted inspection to be Inadequate due to safeguarding. When an independent school is judged Inadequate for safeguarding, we approach the school to offer support but also challenge how they are going to make the necessary improvements to safeguarding. We have identified that only a small number of independent schools currently attend Designated Safeguarding Lead briefings. A Partnership Board is currently being convened to oversee the quality of independent schools in Barnet and this will be addressed through this Board. The Board will include leaders from independent schools in Barnet.

Positively, the Schools Safeguarding Lead holds regular safeguarding briefings every six weeks attended on average by 40 schools. Since January 2023, the briefings have been used as a platform to share safeguarding updates and deliver bespoke training. Some of the topics discussed have covered areas such as Keeping Children Safe in Education 2023, updates on the Prevent Duty , regular updates from MASH and training on domestic abuse and supporting families and training upon responding to Harmful Sexual Behaviours. The sessions have also provided Designated Safeguarding Leads (DSL) with a platform to share concerns and best practice and effectively communicate with a range of partners. The training sessions have also allowed DSLs to keep in touch with current safeguarding themes and implement any changes needed within their settings in a timely manner. The Chief Executive and Director of Education and Learning for BELS or the Co-Head of School Improvement prioritise attendance at DSL briefings to demonstrate BELS commitment to improving safeguarding in schools and hear first-hand of the challenges and concerns of schools to enable an appropriate and sustainable BELS response.
Our School Safeguarding Lead is regularly contacted by Headteachers and DSLs and assists with general safeguarding enquiries and concerns.

Schools are offered raising awareness of safeguarding and child protection training (previous level one) which highlights the Barnet context, the context of individual schools and can be flexible in picking up any issues/updates following Local Authority Designated Officer (LADO) investigations, school complaints and child safeguarding practice

reviews. This is a two-hour interactive session, and these have been delivered 'in person'. This year's training had a greater emphasis on child-on-child abuse and how schools can respond to concerns raised, in particular supporting victims and perpetrators. There have also been updates on the new bruising protocol, the legislation around forced marriage, the importance of liaising with the LADO and the need to understand and report low-level concerns. Schools can also buy in external trainers through Barnet Partnership for School Improvement (BPSI).

Childrens Social Care: Contacts at the 'front door' of children's services or Multi Agency Safeguarding Hub (MASH), have been 15% higher than pre-pandemic volume throughout 2022/23 although this has started to reduce. There were 10,103 contacts received in the MASH over the six-month period March – September 2023. This represents a 6.7% decrease compared to the same reporting period in 2022 (n=10,812) and is 13% higher than pre-pandemic reporting during April - October 2019 (n=8929).

The MASH comprises a range of agencies including Metropolitan Police, our 0 – 19 Healthy Child Programme provider, Solutions 4 Health (S4H), Barnet Education & Learning Services (BELS), Barnet Children's Social Care, Child & Family Early Help, Change, Grow, Live (alcohol and substance misuse service), Barnet Homes, London Probation Service and Solace Advocacy & Advice (Domestic Abuse) Services. The Partnership actively works together to screen contacts received into the MASH, share and analyse information held across multiple client data systems and build a picture of the child's history, current circumstances and agency involvement so that proportionate and timely decisions can be made about the type and level of services children need to safeguard their welfare, meet their needs and improve their outcomes. In addition to this the Partnership works hard to ensure that the quality of decision making is high at this critical stage of the help and support offered to children at risk. The Partnership takes a pro-active approach with regards to its assurance in this regard; out of 28 audits completed in the year of contacts to the MASH, the majority 89% of overall gradings were good or outstanding. On the domain of quality of decision making 82% of audits were graded good or outstanding, evidencing good quality decision making.

The conversion rate from contact at the MASH to referral remains consistent, although the higher volume of contacts into the MASH mostly led to a higher rate of No Further Action or signposting to Universal and Universal Plus services outcomes. The Partnership has been leading sessions across the system of help for children to introduce the refreshed pan-London Safeguarding Children Partnership Continuum of Help and Support; this work is set out later in the report. A newly created Early Help post co-located with MASH has been established to support referring agencies to access Universal and Universal Plus support directly. The MASH steering group is a sub-group of the Partnership and meets quarterly to examine the effectiveness of the MASH partnership arrangements and practice by drilling into data and outcomes which creates opportunities for shared learning and service development. The MASH partners have a regular physical presence in the office which facilitates regular opportunities for dialogue, information sharing and decision making. The MASH attends Designated Safeguarding Lead, GP and Head Teacher Forums on at least an annual basis and has designated links with some community services to support relationship building through a single point of contact.

The number of referrals to the Local Authority Designated Officer (LADO), in respect of allegations made by children against staff within the Partnership, for this reporting year has decreased from last year. Education continues to make the highest number of referrals and the highest number of allegations were against school staff; which is expected given this is where children spend a significant amount of their time. **The LADO receives a high volume of calls from professionals in the borough seeking advice and discussing thresholds; there were 155 LADO contacts in the past year.** The LADO has instructed agencies to refer to OFSTED where safeguarding concerns have been identified with Childminders, Nurseries or Schools. Partnership working remains key to the LADO's success in working with agencies. The LADO has met with the Youth Assembly to consult and co-produce a new LADO leaflet for primary and secondary pupils. This is due to be launched soon and a training video is also being produced for volunteers and professionals which children are also supporting to develop. The LADO has provided training to all residential providers and independent schools in Barnet to ensure LADO is well understood and is actively involved in the London LADO Networking Group. Oversight and scrutiny of the LADO function is provided by the Performance and Quality Assurance subgroup yearly, with the production of an annual report received by all Partners.

In respect of Children in Care at the end of September 2023 there were 336 Children in Care whom we were responsible for, 60 of whom are Unaccompanied Asylum-Seeking Children**.** 82 children entered into care during the

six-month period to end of September 2023, of these children 14 are Unaccompanied Asylum-Seeking Children (UASC) and our readiness to look after these vulnerable children arriving in this country and to work with national partners is positive, but there is no doubt at times of increasing financial pressures this places stretch and challenge upon the local system. For children aged under 16 years who have complex needs and are at risk of entry into residential care, there is a placement sufficiency risk which can force reliance on unregistered homes. This is a national issue and to address the problem locally we started a programme of developing small local children's homes to complement our existing 6 bed offer at the Green Bank House children's home, while working with Ofsted to expedite registration of provision at Edgerton Gardens where planning consent has been obtained for a solo provision. We are working nationally to address concerns we have with a new complex child group, which is being coordinated by the Department for Education. A new national framework for semi-independent provision post-16 is coming into place this year and we are working with providers to ensure registration is carried out. We have 49% of our care experienced young adults in independent accommodation with wraparound support, with a lower proportion in supported accommodation as our goal is to prepare and support young people in independent living and comparative studies shows we perform well on this aspiration. Data is showing we have low numbers of adoptions, and we are working with courts to expediate proceedings. We have also a number of children in early permanence placements which ensures timely adoptions meeting the needs of those children.

The Early Help partnership has developed a refreshed Child and Family Early Help Strategy 2023 – 2027 in consultation with children, parents, key stakeholders and members. Child & Family Early Help Services have gone from strength to strength since our Child & Family Hub model was introduced in October 2018. It is supported by a well-established and growing network of services work that work together and provide support when children, young people and their families need it. Our three Child and Family Early Help Hubs are linked to several satellite buildings where a vast range of early years, family support, prevention, diversionary and targeted support is available to children and families. This includes midwifery, health visiting, breastfeeding, parenting support, parental conflict, positive activities, mental health support, welfare advice, groupwork programmes and a range of other services – a true Partnership approach.

The Child & Family Early Help Service has a strong place-based presence with local advisory boards that invite local providers and parents to contribute to the way in which services are planned and delivered. **Parent Champions have undertaken 'mystery shopping' activities to provide feedback on user experience of the settings and the 'Empowering Parents, Empowering Communities' training is creating space for parent-led parenting programmes that expand the reach and impact of the service.** Between October 2021 and April 2023, we have supported 19,155 individuals through the Household Support Fund for which Child & Family Early Help Services been key, ensuring schools and community settings are clear on how to access the fund. For Summer BACE 2023, Barnet increased engagement via a targeted communication campaign on social media, in schools and directly to families in need, including families living in asylum hotels. Over 40 activity camps were commissioned across the borough with more than 4,000 children accessed BACE activities. The Child & Family Early Help welfare advisors continue to work alongside families providing support for those struggling with the cost-of-living. Early Help Assessments are developed in partnership with families, so they are focused on the help families need and decisions are made together. **Between March and September 2023 there were 1898 open Early Help Assessments; Barnet has the highest rate of Early Help Assessments in London. Audits completed in the last year show the majority, 79%, have an overall grading of good or outstanding. The Child & Family Early Help Service benefits from a stable and experienced management team that provides robust oversight and support, enabling good practice to flourish.**

A special mention in this year's Annual Report must go to the Barnet Youth Justice Service (YJS) and Multi-Agency Partnership for attaining 'Youth Justice SEND Quality Lead Status' with a Child First Commendation. The YJS demonstrated effective evidence-based practice against the quality assurance framework at the first time of asking. This is a great achievement and a testament to strategic and operational commitment, investment, Partnership approaches and endeavour over an extended period. Amongst the features of the work that contributed to this award are: a long-established relationship between the Local Authority SEND Team and the Youth Justice Service, further strengthened by refreshed Terms of Reference for the relevant multi-agency panels. In addition, multi-disciplinary and co-located staff (such as Educational Psychologist, Speech and Language Therapist, Forensic Psychologist & Youth Justice Liaison and Diversion Practitioner) that play a critical role not only in ensuring timely expert support for identified young people, but also in up-skilling frontline staff through training and consultancy.

There are strong links to the Pupil Referral Unit, Virtual School and a large number of Borough schools and academies, increasing opportunity and impact of early identification and early help. The service is well integrated with Child and Family Early Help Service and offering early help provisions for Out-of-Court Disposals, Turnaround and custody base provisions via Tri-Borough Project Engage (Barnet, Brent and Harrow) to engage with young people during what is known as the 'teachable, reachable moment' and link them with positive activities and to access universal provisions in the local communities. The commendation also recognised a clear and sustained commitment to resettlement and after-care, unconstrained by service "hard-stops" in terms of age or statutory responsibilities and a child-first focus that includes residential trips for identified children with complex needs and co-produced service materials informed by the child's voice

Police: For our Partners in Policing, acute demand and resourcing challenges exist across the Metropolitan Police Service (MPS). An MPS initiative of posting new Detectives into the volume crime investigations with Response Policing strands has given positive results on North-west BCU - giving confidence to the Detectives in investigation and prisoner processing prior to them being posted to Public Protection and Local Investigations. This provides an expectation of improving retention of officers as a result. Across the MPS, Public Protection (PP) has been recognised as below the necessary staffing to carry out essential functions. Consequently, an uplift of 485 officers for PP has been announced MPS wide. This is split between the 12 BCUs and includes on each Basic Command Unit an additional Detective Chief Inspector (to specifically manage offenders and proactivity targeting the highest risk offenders known within the MPS and additional Detective Inspector and an uplift in researchers and Police Conference Liaison Officers (PCLOs) across MASH and Child Abuse Investigation Team Referrals.

Locally on NW BCU officers from other strands are being attached to the Community Safety Unit to assist in the response to Domestic Violence, and the Rape and Serious Sexual Offences teams to assist in the response to serious sexual assaults. These initiatives have been assisting to reduce workloads and improve responses whilst NW BCU Public Protection remains under strength across all teams, awaiting the positive results of a recent recruitment campaign.

Over the period September 18th to 27th 2023 His Majesty's Inspectorate of Constabulary and Fire & Rescue Service (HMICFRS) visited all 12 MPS Basic Command Units to interview a range of teams in order to understand the MPS response to missing children and those suspected to be at risk of exploitation. Units interviewed at North West BCU included: Child Criminal Exploitation (CCE) /Child Sexual Exploitation (CSE) / Missing children / Rape & Serious Sexual Offences / Local Investigation – Gangs engagement / Neighbourhood Policing Teams for Schools**. In early October 2023 HMICFRS published a report outlining accelerated causes for concern with regards to Missing children and risks of exploitation, outlining that: *"The force needs to improve how it identifies and assesses risks, and how it responds, when children are reported missing."***

HMICFRS identified that children who are regularly missing should have been treated as High risk and those who have missing episodes which are out of character. With regards to Exploitation the report outlined: *"The force should improve its investigations when children are at risk of, or harmed by, criminal or sexual exploitation."* The concerns centered upon the closure of reports where victims of the exploitation did not wish to assist police investigate and prosecute offenders. However, it was found that reasonable lines of enquiries were not always carried out to identify the perpetrator and that this left risks to the public and to other children.

The MPS leadership team are steadfast in their commitment to ensure the risks that children and young people are facing are appropriately identified, risk assessed, investigated, and responded to, and that those who abuse or exploit them are brought to justice. In response to these concerns about the MPS response to vulnerable children and young people in the New Met for London the commitment to strengthening the response is set out. As part of this work the MPS are investing in an additional London wide 565 posts, 72 of which will be deployed to build capacity within the exploitation teams. In tandem with this the MPS are undertaking work to redesign the targeting operating model to deliver a more holistic approach to child protection matters. In design is a new Children and Young People's strategy that will drive a 'Child First' approach. In the immediate short term the MPS are putting in place immediate measures to better protect children now. These include appointing a new Lead Responsible Officer for exploitation and a rapid plan to address the Accelerated Causes for Concern overseen by the Assistant

Commissioner.

A key collaborative checkpoint over the past year has been a jointly funded community safety programme by the Council and the MPS focusing on the Grahame Park Estate in the west of the borough. Clear, Hold, Build has already had significant success over the last couple of months. On a radio interview with LBC Radio, it was fantastic to hear directly from residents who have already started to talk about the impact that Clear, Hold, Build is having. Parents feel happier to let their children play outside as there is less anti-social behaviour happening around the estate. As well as the high-profile police activity in the area, the community safety team and other officers have been identifying crime hotspots, improving CCTV, and closing empty properties that can become a magnet for crime. A huge thank you to all officers involved, and we look forward to continuing to improve the environment around Grahame Park for our residents in the future.

Health: For our Partners in the Health arena, following the passage of the Health and Care Bill in April 2022, Clinical Commissioning Groups were dis-banded, with statutory responsibilities transferring into the newly established North Central London Integrated Care Board (NCL ICB) on 01 July 2022. NCL ICB, comprises the London boroughs of Barnet, Enfield, Haringey, Islington and Camden. NCL ICB has responsibility to coordinate services and plan health care in a way that improves the health of its population and contributes to the reduction of inequalities between different groups across NCL and this is integral to the Safeguarding agenda. Within NCL ICB Executive responsibility for safeguarding in the ICB sits with the ICB's Chief Nursing Officer. In December 2022 the ICB appointed a Director of Safeguarding to support the Chief Nursing Officer in ensuring statutory requirements are met. The Safeguarding team comprises borough based Safeguarding Children Designated Nurses, Doctors, Professionals, Named General Practitioner for Safeguarding, and the child death review process aligned to our five boroughs.

At the time of writing NCL ICB are currently going through a consultation process as part of an organisational change programme. In order to deliver the Population Health and Integrated Care strategy, change is needed in order to meet population demand. The pandemic has further highlighted the significant health inequalities that exist within our population and the NCL ICB continues to work with our partners across health and social care to better focus our resources on addressing these inequalities and on driving improvement in population health outcomes across NCL boroughs. Over the past year as a result of the newly established ICBs, Safeguarding Assurance Group (SGAG) have been established. The terms of reference have been agreed with health system leaders in July 2023.The group is a key strategic forum within the Integrated Care System (ICS) that will inform the process of safeguarding assurance for the ICB. The purpose of the SGAG is to provide a strategic forum within the ICS for health partners across NCL ICS system to seek assurance on the performance of the ICB and commissioned health services with regard to the discharge of statutory safeguarding responsibilities and duties in line with the Safeguarding Children, Young People and Adults at Risk in the NHS Safeguarding Accountability and Assurance Framework (NHSE 2022). The SGAG will provide the ICB and ICS with a further strategic mechanism to support the delivery of the NCL ICB Safeguarding and Looked After Children strategy, identify ICS safeguarding concerns/risks and opportunities for improvement and learning, including addressing inequalities and routinely and systematically share and triangulate intelligence, insight and learning on safeguarding matters across the system to gain assurance the statutory safeguarding responsibilities are met.

It is important that BSCP holds Partners to account when service delivery is not as strong as we would wish to see. This has occurred this year in respect of the provider of our 0-19 Healthy Child Programme provider – who provide an integrated health visiting and school nursing service that supports children and young people aged 0 to 19 and their families. Following an Inadequate judgment upon the category of 'safe' (which incorporates safeguarding of children) the Leadership of BSCP and its Performance and Quality Assurance sub – group has afforded scrutiny, challenge and support wherever necessary to improve the service provided to children and families. At the time of concluding this Annual Report this remains an ongoing process and we would expect to provide further updates for Partners over the coming months upon the delivery of the Healthy Child Programme.

This year has presented opportunity for the first time since the pandemic for the Partnership to come together to actively discuss and consider national reform proposals to children's social care. Over the summer of 2023 we held our first in person conference as a safeguarding partnership since before the pandemic. Over 60 key stakeholders

attended a lively day of discussion and debate where we focused upon readiness for reform across children's social care and multi-agency safeguarding arrangements and in particular reflected upon key proposals for reform within the Governments *Stable Homes, Built on Love* social care reforms, and the draft proposals outlined within Working Together 2023. We will of course enact any legislative change as a result of any of these reforms as and when they come in force.

As ever our Multi Agency Safeguarding Arrangements outlines our governance processes in line with Working Together 2018. **To deliver upon these arrangements our 2023/24 Business Plan sets 6 key priorities for the Partnership to work towards**. They are not listed in order of any priority:

1. Strengthening leadership and partnership
2. Tailoring our work to local themes
3. Driving continuous safeguarding practice improvement
4. Responding to serious child safeguarding cases effectively
5. Creating a strong feedback loop with children, families, and practitioners
6. Measuring and evidencing the impact of our work

The BSCP Leadership Forum monitors the ongoing implementation of the Business Plan and this report outlines evidence and impact as a result of embedding in practice our continual learning. We hope that you can review plenty of evidence of transfer of knowledge into practice so that the local safeguarding system continues to strengthen year after year. This year we have laid down 4 cross-cutting shared safeguarding themes of:

- Female Genital Mutilation (FGM),
- Safer Sleeping,
- Promoting multi-disciplinary approaches
- Promoting Family Networks.

These shared themes represent a pro-active approach to tackling safeguarding challenges faced by children and young people and more upon these are laid out later in this report.

We want to thank all those colleagues that are working across the Partnership in a variety of roles, to support children, young people and families every day. Significant pressures lay ahead in the field of muti agency safeguarding work but we feel that that this Annual Report outlines how we respond as *'One Partnership'* to the challenge and we are immensely grateful for all that our do across the borough on a daily basis for children and families.

Tony Bellis, Acting Detective Superintendent, Met Police, NW BCU

David Pennington
Director of Safeguarding Chief Nursing Directorate, NHS North Central London Integrated Care Board

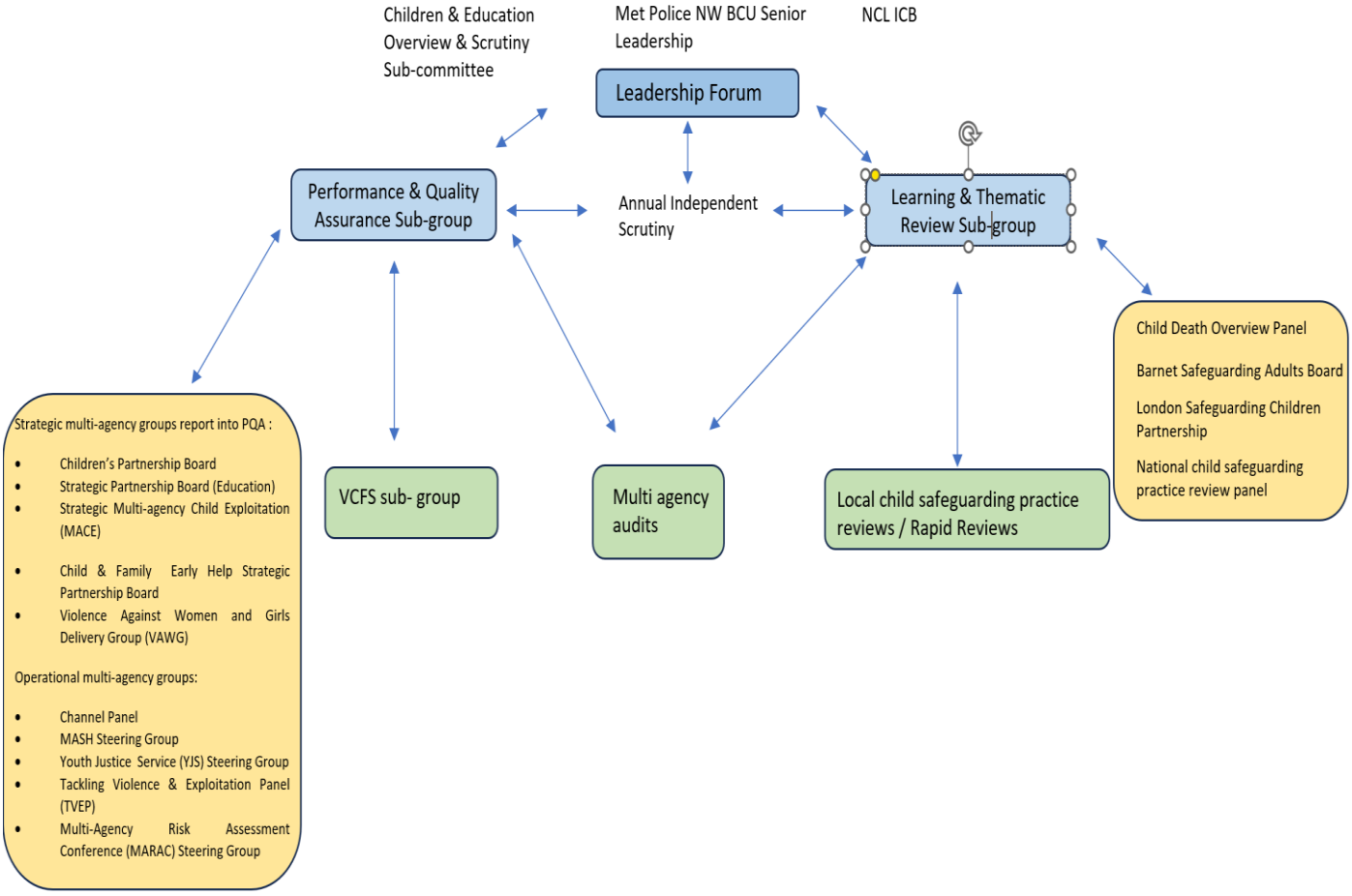
John Hooton, Chief Executive, London Borough of Barnet.

About BSCP: Leadership Forum: BSCP is overseen by a small Leadership Forum with membership from the three statutory partners of Local Authority, Health and Police with a rotating Chair. The Chair serves as the single point of contact for the BSCP over the length of a term, which is one year. A primary Term of Reference for the Leadership Forum is to oversee the delivery of the BSCP business plan, agree the funding for the Partnership each year by the Leadership Forum and receive quarterly updates from the Performance and Quality Assurance Panel (PQA) and Learning & Thematic Review Group (LTRG) to address stubborn or pertinent issues within the system as well as scrutinising and actioning system-wide reports such as Child Safeguarding Practice Reviews.

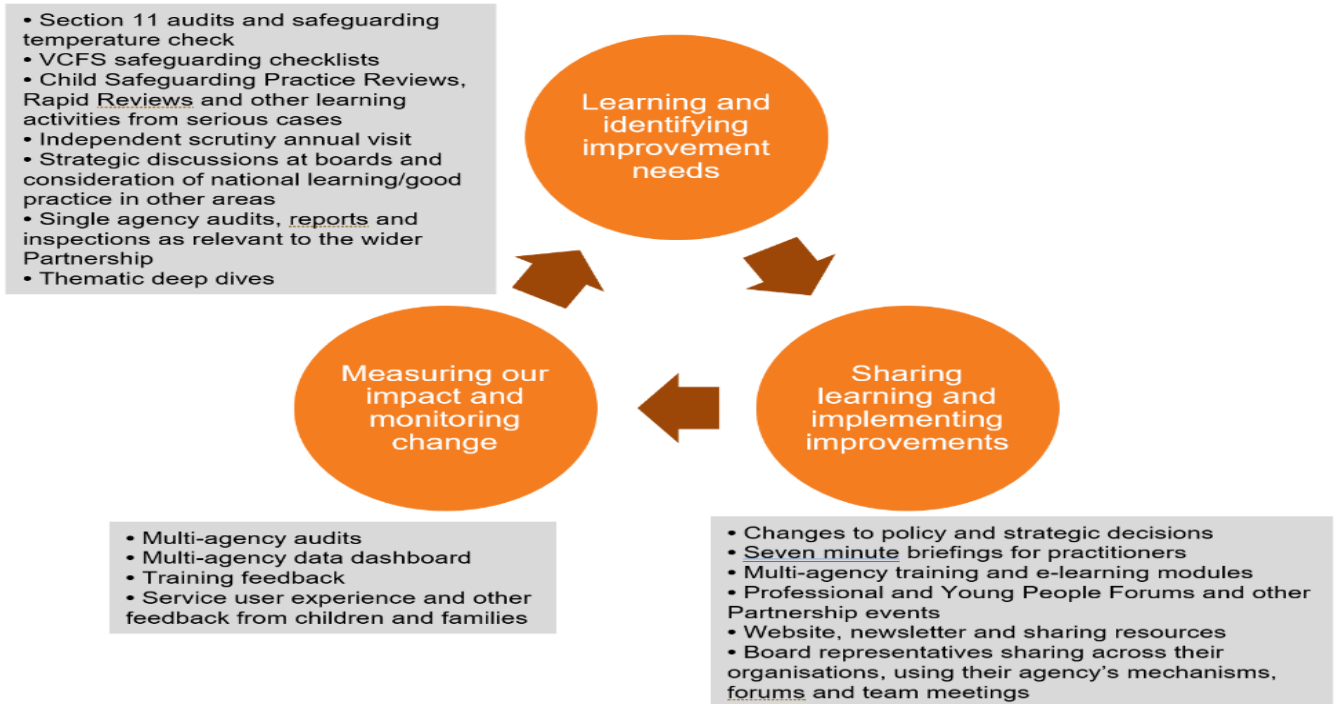
Performance and Quality Assurance subgroup: The PQA is chaired on a rotating basis by the 3 senior safeguarding leads of health, social care and police partners. It holds representatives from many partner organisations within those 3 statutory strands of the Partnership. It has a crucial scrutiny and assurance function, reviewing multi-agency performance data and a range of annual reports including from the MASH, LADO, Vulnerable Adolescents Community Partnership Education and other upon request. PQA takes an active role in monitoring and advising many of the BSCP activities, including development and scrutiny of the multi-agency data dashboard, multi-agency audits, the workforce development training programme, scrutiny of service level reports including MASH, private fostering and LADO, Section 11 audits, Professional and Young People Forums and thematic deep dives. This forum also includes regular reports from the Voluntary, Community and Faith Sector subgroup

Learning and Thematic Review Group: The Learning and Thematic Review Group is chaired independently by Bridget Griffin, a hugely experienced multi-agency safeguarding professional, and has a membership from across the council, police, health, community safety, public health and a legal adviser. It undertakes Rapid Reviews, oversees local Child Safeguarding Practice Reviews and other bespoke learning activities and monitors the implementation of recommendations. It also reviews national Child Safeguarding Practice Reviews and other relevant learning and good practice to implement in Barnet.

Voluntary, Community and Faith Sector Sub-group: Our VCFS subgroup aims to bring the voice and knowledge of VCFS organisations to the Partnership, as well as to improve safeguarding practice across the sector and increase engagement with Partnership activities and training.



Section 1: Learning & Development: A key focus for the Partnership continues to be upon ensuring that the learning we obtain from national safeguarding reviews, local safeguarding reviews, multi-agency audits and other learning activity is embedded into practice. All of the learning activity we undertake within BSCP is driven forward by our Learning & Improvement model as demonstrated below:



Learning from local Child Safeguarding Practice Reviews and Rapid Reviews: Over the past 18 months BSCP has coordinated and published Child Safeguarding Practice Reviews (CSPRs) and submitted to the national panel Rapid Reviews leading to the identification of important learning which means that we are well placed to improve the local multi-agency system. **We have received positive feedback from the national panel upon the quality and concise identification of learning within them.** The grid below provides an overview of the cases we have reviewed, and critical learning and practice themes identified within them:

Case	Critical learning themes identified:
Child L CSPR	• Role and responsibilities of Leaving Care Personal Advisers reviewed. • Information sharing across GP network strengthened • Probation and Leaving Care arrangements • Step up / step down arrangements – Continuum of Help & Support (thresholds) • Housing protocols for 16/17 year olds
Child A CSPR (anonymous publication)	• Suicide/filicide risk • Information sharing - particularly across public / private providers • Embedding a Think Family approach • Intersectionality and cultural competence
Child KL Rapid Review (CSPR underway)	• Malnutrition • Application of thresholds across the Continuum of Help & Support. • Working with families where engagement is reluctant or sporadic
Child GA & RA Rapid Review	• Application of thresholds • Timeliness of strategy meetings

	• Intersectionality
Child SS Rapid Review (CSPR underway)	• Working together to safeguard children who are victims of exploitation • Supporting vulnerable families moving from private housing into Local Authority housing • Adultification • Adopting a Think Family approach • Intersectionality and cultural competence.
Child AS Learning Review	• Child protection medical examinations • Importance of cross Partnership challenge & escalation • Intersectionality • Sharing of information involving children with complex needs

Our Learning & Improvement model has tracked and developed learning from these local reviews and provided challenge to partners upon how effectively they are embedding this learning in practice. **Multi-agency peer to peer challenge workshops have been hosted every 6-8 weeks inviting key Partners to update upon progress and the following provides insight into how we are continually improving the local system.** Some reviews hold repeat learning themes which have informed the dissemination:

Child Safeguarding Practice Review - Child L: In February 2023 the Partnership published a local child safeguarding practice review entitled 'Child L',. This was an independent review into harm experienced by a child who was known to both Barnet and Brent multi-agency safeguarding services. The child was placed in the care of the local authority and is safe and well. The review was conducted jointly with Brent Safeguarding Children Partnership and included an extensive analysis of the multi-agency services provided to Child L and his mother. The review includes a summary of learning. The review also found several examples of strong and committed multi-agency safeguarding practice over the unprecedented Covid19 pandemic. Barnet and Brent accepted the recommendations of the review in full and continue to act, both locally and nationally, to take forward the recommendations. Critical

CHILD L: EVIDENCE OF PUTTING LEARNING INTO PRACTICE AND ITS IMPACT:

BRUISING PROTOCOLS: The review identified the problem of needing to be clearer upon bruising protocols in order to provide frontline health and other professionals with a knowledge base and action strategy for the assessment, management and referral of pre- mobile infants and non-mobile children and young people who present with bruising or unexplained injury. The protocols can be found here . **Police Partners report that as a result the Bruising Protocol had been disseminated to officers and have evidenced during an interaction with a lady in the street officers were dissatisfied with an explanation of how a toddler she was caring for had sustained the bruises they witnessed. Applying the Bruising Protocols, she was arrested, and the child was safeguarded.**

- INFORMATION SHARING PROTOCOLS: New information sharing tools have been developed such as a GP data sharing and information sharing form which is a standardised form expected to be used by all Barnet GPs. This development is a direct result of learning taken from the Child L CSPR and was seen as a problem. The template has been circulated to all GP practices and an all-Barnet GP session has been held to raise awareness and provide guidance on info sharing. Case studies of the change in practice have been provided by the GP network and include: **A family subject to an ongoing Child Protection plan saw the multi-agency review group require some more information. The GP data sharing form helped identify missed appointments with a GP - which helped the chair to formulate a more detailed picture of the family.**

-For a family receiving support through a child in need plan the data sharing form helped the GP to recall if there were ongoing mental health issues in the family – the mother had just been diagnosed with severe schizophrenia and this information promptly informed the child in need plan from the outset.

learning themes within this review featured: working across boroughs when care leavers are parents and live with their children, implementing joint supervision with agencies and developing an offer of provisions and support at the Early Years Parenting Hub for Care Leavers. Further learning centered upon developing Partnership understanding of Supervision Orders.

CHILD L: EVIDENCE OF PUTTING LEARNING INTO PRACTICE AND ITS IMPACT (CONTINUED):
For Partners at the RFLNHSFT there have been significant improvements to the electronic patient record (EPR) to ensure staff recognise, respond and refer effectively where safeguarding concerns are identified. **This is a direct learning and action point from this CSPR. The Child Protection Information System (CP-IS) is now fully embedded into EPR for children attending unscheduled care in the emergency department and urgent treatment centre.** This ensures frontline staff are aware of children and young people who are on a child protection or looked after plan or have been in the last 12 months. CP-IS also alerts staff when mothers attend whose unborn baby is subject to a child protection plan.

Within this CSPR, key learning focused upon how as a Partnership we respond to situations where children do not attend critical health appointments – often seen in national reviews as key practice episodes that can lead to harm for children. As a result, in line with guidance from the Royal College of Paediatrics and Child Health, an audit was completed regarding the use of the did not wait (DNW) RAG rating in the emergency department, used by Emergency Department staff when children and young people are removed from the department before being seen or before they have had treatment. This showed how cases are identified where further follow up is needed by either clinicians or the safeguarding team**. Evidence of transfer of learning into practice is outlined in the case study below:**

A child under 2 and their mother did not wait to be seen following a head injury and there was no information about how the child had sustained the injury. The safeguarding team were made aware using the RAG rating proforma and were able to follow up with the mother, getting a history of how the child, who was walking, slipped and bumped their head. They did not wait as mum had become less worried after speaking to a family friend who was a GP and the child had remained very well. This information was then shared with their health visitor.

Further strengthening of cross Partnership information sharing protocols, as a result of learning from this review, centered upon the Partnership revising and updating its unborn protocol which sets out guidance and locally agreed procedures to practitioners working with pregnant women in early help, health agencies and Children's Social Care settings. This is with the purpose of ensuring every unborn baby in need of support and protection is safeguarded through multi-agency assessment, planning and decision making as early in the pregnancy as possible. This is a critical stage in safeguarding vulnerable unborn children and the protocols have been disseminated extensively through BSCP webinar dissemination on this review.

CHILD L CONTINUED: SUPPORTING CARE LEAVERS NEEDS: Critical learning from the Child L CSPR featured on how to better improve housing needs of Care Leavers. **This revised approach supported the pan-London Safeguarding Children procedures to be updated with more accurate guidance and can be found here** (Ref: Sc 1.8 and 5.8) . Furthermore, the Partnership committed to developing a revised joint protocol for 16- & 17-year-olds and this was published in March 2023 upon our website here . **A specific care leaver housing panel, which is co-produced between leaving care and Barnet Homes has been developed with the first panel taking place in May 23.**

The enhanced offer for Care Leavers has been embedded within the Parenting Hub. This is a Family Services single agency service which links with Early Help and Childrens Social Care - providing highly specialised mentalisation based parenting programmes for parents with complex trauma needs. It supports pre-proceedings assessments as well as targeted support. It is now managed under Barnet Integrated Clinical Services (BICS). More on the Parenting Hub is detailed on within the Family Networks section of this report.

Child Safeguarding Practice Review – Child A: Over Spring 2023 the Partnership concluded a local CSPR following the death of a child and his mother in Summer 2022. This CSPR identified some critical learning themes upon: suicide and filicide, information sharing across public and private sector health agencies and intersectionality when working with families using a 'Think Family' approach.

CHILD A CSPR: EVIDENCE OF PUTTING LEARNING INTO PRACTICE AND ITS IMPACT:

INFORMATION SHARING ACROSS PRIVATE AND PUBLIC HEALTH AGENCIES: **The review panel engaged a provider of private mental health care who was the provider of services for a family member within this case – this was a lengthy and extensive process, but one seen as vital to ensuring the review held key stakeholders to account.** Information sharing, or lack of, between public and private health bodies has been viewed for some time as a key area in need of strengthening in order to secure improved outcomes for children and families – particularly at a time when more people turn to private health care provision. **The private provider engaged extensively with the review and we are pleased to evidence that significant improvements have been made by them in respect of their safeguarding responses including: a review of their use of language interpretation services; intersectionality training for clinicians has been provided, a new Head of Safeguarding has been recruited and there has been extensive learning dissemination across their service.**

At the time of writing the Partnership is working with NHS England to provide a platform to engage senior health care leaders and policy makers in order to flag the importance of laying clear protocols for private health care providers within safeguarding and information sharing. We hope this work will continue into 2024 to provide long lasting change for those involved within this review. In order to protect the welfare of the family this CSPR was not published publicly, but learning has been shared with the national Child Safeguarding Practice Review Panel and some key practice developments and impact is outlined below.

Within our own Partnership, the dissemination of learning from this case has been extensive. This includes Partners at North London Mental Health Partnership (NLMHP) undertaking a Board Level Panel investigation from which the findings and outcomes have been shared with Partnership. Many of the areas which have been strengthened center upon processes and information sharing. Local community representation was secured on the review panel to ensure that issues of intersectionality, cultural competence in practice and how to address stigmatising issues such as mental health with minority ethnic communities were considered and how we can as a Partnership strengthen responses in these areas.

As a result of this learning activity, Partners at NLMHP now ensure that a consent form is given to service users during initial contact to gain immediate consent to share information with GPs. Reminders, encouragement and challenge is provided to practitioners during supervision to communicate with GPs and to be child focused. Across our GP network specific information sharing/seeking sessions for GPs have been held, led by safeguarding leads. GPs ask patients whether they are using private health care and if yes, consent is gained for them to communicate with private providers. Assessment forms have been changed; they now include a question asking for consent to contact other providers.

INFORMATION SHARING CONTINUED: NLMHP is the 2nd mental health organisation that the Child Protection-Information Sharing (CP-IS) digital system is being piloted and is currently live. The Trust has completed 4 training sessions with 3 planned sessions remaining, this is with an aim to ensure that CAMHS front line clinicians are aware of the children on child protection plans through the CP IS system and are able to implement appropriate actions to safeguard them, accordingly, ensuring collaborative and effective working relationship with social care. NLMHP recently appointed a Practice Development Nurse / Clinical Nurse Specialist for the Day Service within the Beacon Centre based at Edgware Hospital. It is a service that will operate between the hours of 9-5pm, Monday to Friday. The service will operate as a step-down centre for inpatients, and a step-up centre for patients in the community, crisis teams and emergency departments. The plan is to connect with all the CAMHS services to encourage referrals to the service and reduce inpatient admissions.

ADOPTING A THINK FAMILY APPROACH: Over 80 partners attended a series of webinars disseminating the learning from this CSPR. At the heart of the dissemination was the concept of promoting a 'Think Family' approach within safeguarding. Essentially, this is about making sure that practitioner's identify wider family needs which extend beyond the individual child or young person they are supporting.

Child Safeguarding Practice Review – Child KL and Rapid Review for Child GA & RA:

In Spring 2023 the Partnership came together to review two separate safeguarding incidents involving young infants. All children are now safe and well and looked after by the local authority. One Rapid Review for Child KL has now been taken forward as a local CSPR to be published early 2024. Primary learning themes centered upon application of thresholds for children receiving services and information sharing across GP and health networks when children do not attend GP appointments:

CHILD KL CSPR AND CHILD GA & RA RAPID REVIEW: EVIDENCE OF PUTTING LEARNING INTO PRACTICE AND ITS IMPACT: APPLICATION OF THRESHOLDS: Key learning centered upon children who were in Universal health settings and should have been receiving support at a higher level of intervention either through a coordinated Early Help response, or more targeted statutory child protection level. The Partnership has since adopted a new pan-London Continuum of Help and Support Threshold Document **.** This new continuum provides a framework for practitioners who are working with children and families in Barnet and aims to help identify when a child may need additional levels of support to achieve their full potential. It provides information on the levels of need and gives examples of some of the indicators that a child may need additional support. The London Safeguarding Children Partnership's Editorial Board will review the Continuum of Help & Support Quarterly and we will update the local version accordingly. To embed the new Continuum across the Partnership a concerted and extensive awareness raising series of webinars and learning dissemination commenced securing over 350 Partners engaging. Across the partnership key Partners have audited cases, spent time speaking to practitioners about the new Continuum and delivered extensive training. For our Partners in education dedicated sessions have been established for safeguarding leads in schools and support is provided by the MASH team for schools who make above average referrals in order to ensure that the right outcomes are achieved sooner for children and families. Across all areas of the Partnership work to promote and embed the new Continuum of Hep & Support is taking place. Level 3 safeguarding by the RFLNHSFT includes the oversight of the Continuum of Help & Support and when to make a referral to the MASH. This work has extended to our Housing partners too who have been included in this review and we are pleased that the sharing of learning with our Housing partners has developed this year. MASH continues to develop partner interface and contribute to service developments through local forums and training such as the Head Teachers forum, GP forum, Prevent, MAPPA, MARAC, wider forums such as London Councils MASH partnership. Training on thresholds has been provided to Health colleagues including Midwives and pediatricians. In March, an Early Help Social Worker was appointed to join the MASH and lead work with partner agencies, particularly those where high volumes of contacts lead to no further action/signposting. The Social Worker will ensure agencies are clear on the support available for children and families so they can be directly referred for help rather than sent to MASH.

CHILD KL CSPR AND CHILD GA & RA RAPID REVIEW: EVIDENCE OF PUTTING LEARNING INTO PRACTICE AND ITS IMPACT: APPLICATION OF THRESHOLDS (CONTINUED): To further test whether children and families were receiving the right levels of support our 0-19 Health Child Programme provider, Solutions 4 Health, undertook and extensive audit of 600+ cases. The audit was designed to assess whether cases were correctly sitting in the universal caseload and if needs had been appropriately identified and regularly reviewed.
During June and July 2023, a 99% confidence audit was carried out. Members of the safeguarding team, the virtual ward and team managers reviewed 651 Universal records, looking at key Healthy Child Programme assessment points to understand whether they had been seen and whether a full assessment had been carried out and risks identified and whether appropriate follow ups had been in place to support families. If it was identified that a family had an unmet health needs an appointment for a reassessment was made at the time. **Positive findings included:** Contacts are being done in a timely way (83% of new births within 14 days, with 98% being done by a HV)); 98% of 6–8-week reviews by 8 weeks, 98% of 9-12 month reviews by a year and 100% of 2-year reviews by 30 months). 20% of families required follow-up from the audit, and this was done at the time – the majority were due to no face-to-face contact because of the pandemic. This is being offered where appropriate.80% in the universal caseload had no red flags identified. Those that did, were largely due to the child not having a face to face as above. Anecdotally, there were many cases of good practice identified during the audit, but one in particular was of a mum who had suffered a previous still birth and was given a lot of follow up and support from the Health Visitor after the birth of her next child. **Going forward, regular dip sampling of the Universal caseload will occur to ensure children & families are assigned to the correct level of need using the LCON. This is also checked during safeguarding supervision.**

In terms of the impact all of this work is making upon the local system, more time is needed to monitor this. Our Annual Report last year highlighted an extended period of upward trend in numbers of contacts into MASH and data is now showing positive signs of a stabilising system, as relayed within the Introduction section of this Annual Report. However, the contact rate remains around 15% higher than it was pre-pandemic. Pan London data shows that Barnet had the second highest level of contacts to MASH in the North London region and showed the highest percentage change (+15%) from Q2 2022/23. Barnet was ranked 5th highest for rate of contacts across all London Boroughs in the same reporting period. It us hugely important therefore when applying the Continuum of Help & Support that children and families are receiving the right support, by the right service, at the right time.

There are notable increases in contacts to the MASH from education and health agencies, the higher rate of contacts is not leading to a higher rate of referrals to Children's Social Care which suggests that there is not an increase in safeguarding risk. Data has been shared with education and health safeguarding leads and will be further interrogated to better understand what is driving the increase in referrals to MASH. Data continues to be provided to Senior Managers showing the top ten referrers, schools, and health agencies which have resulted in Signposting to MASH to enable continuous tracking and scrutiny. In education this is being led by the Designated Safeguarding Lead.

We are developing systematic reporting of step up and step down between Early Help and Children's Social Care statutory services. Data shows that over the last year over 95% of step ups from Early Help to Children's Social Care are stepped up for additional support on Child in Need plans and not because of an escalation to Child Protection Plan, showing that families are being effectively supported and parents are building resilience in their families. The learning from this review stresses the need to continue developing the role of the Lead Professional. When we identify that a family needs support from more than one agency we will start a Team Around the Family (TAF) process. This is where all the people who care about or are working with a child form a team that works together to help support them. One professional will take the lead and ensure that services are coordinated and working effectively towards the change that is needed for the child and family. The lead professional can be any professional working with the family and who is part of the Team Around the Family, they will act as a single point of contact for the child and their family throughout the period of assessment and support. They will work closely with the child and family to ensure everyone is clear on how, when and where support will be provided.

CHILD KL CSPR AND CHILD GA & RA RAPID REVIEW: EVIDENCE OF PUTTING LEARNING INTO PRACTICE AND ITS IMPACT (CONTINUED) Information sharing when children do not attend GP appointments: In both cases upon review health partners identified that more could have been done to support the families when the children did not attend GP appointments. In particular, when newborn infants are not registered at GP practice this should flag concerns. **As a consequence, the following strengthening has taken place as a result:**

- **The GP practice will re-integrate Health Visitor notification emails back into their process for non-attendance. Specifically, where a baby is not registered or brought to the postnatal and baby check by 10 weeks of age, the practice will contact the 0-19 team to ask if they have seen mother and baby, if there are clinical or developmental concerns and any safeguarding or risk factors.**
- **The GP practice and Named GP recommend that attendance of Health Visitors at regular practice meetings would offer a planned forum for information sharing and exchange. This will help identify and mitigate children and families at risk.**
- **If there is no reply or outcome from the above, of if there are other outstanding concerns, the Named GP for Safeguarding Children can be contacted for advice and assisting interfacing between agencies.**
- **The practice will add patients who are living out of area and have been asked to register with a practice local to them to their "grey list" in order they may proactively track their registration status.**
- **The practice will aim to make antenatal referrals via face-to-face review and assessment wherever possible instead of patients self-referring to services.**

The Partnership continues to receive updates from health Partners upon how this strengthening of the system is improving the level of provision children and families receive. We expect to publish the full local CSPR in early 2024.

Child SS CSPR: The Partnership has commenced a local CSPR following an incident of serious youth violence within the borough. The young person sustained life changing injuries and is in recovery with the full support of key Partnership services. Primary learning themes have been identified at the early stage of this review of: working together to safeguard children who are victims of exploitation, supporting vulnerable families moving from private housing into Local Authority housing, adultification, adopting a Think Family approach and intersectionality and cultural competence in practice with children and families are all to be explored by the Partnership and how to strengthen our local system will be considered. Some key practice improvements have already been put in place outlined below and we hope to publish the full CSPR early 2024:

CHILD SS CSPR: EVIDENCE OF PUTTING LEARNING INTO PRACTICE AND ITS IMPACT: EARLY-STAGE FINDINGS AND ACTIONS: Intersectionality: Children from Black, racially minoritised, or other marginalised backgrounds are disadvantaged by the historical, structural, and systemic racism that exists in society, hindering their progress. Across BSCP we are committed to anti-racist and anti-discriminatory practice. This review at this early stage has identified that more could have been done by multi agency partners to consider how cultural, religion, social biases and equality and equity of service were considered in practice. All areas of the Partnership have been asked to reflect on this. For children's social care, The Practice Standards 2023 – 2027 sets out a framework which has been developed for practice leaders, managers, and practitioners so we have a shared understanding of the resilience-based approach the Partnership holds and how we use a strengths-based approach in supporting children and families, in which recognition of religion, cultural heritage and ethnicity is held in mind through all stages of intervention.

Across our multi agency workforce development programme training focusing on mentalisation-based techniques, trauma-informed approaches, Social GRACES, confident conversations in race and communication with children with disabilities has been promoted with strong attendance from staff. These efforts aim to enhance practitioners' skills in building trusted relationships with children and young people from all backgrounds, promoting their well-being.

CHILD SS CSPR: EVIDENCE OF PUTTING LEARNING INTO PRACTICE AND ITS IMPACT:

For Police partners use of the THRIVE+ model supports Officer's understanding of intersectionality in practice and how they may relate to specific vulnerabilities of victims. For health Partners, NCL ICB ensure that supervision with staff, recording of information, audits and service away days all consider intersectionality and continual learning for practice/clinical work.

Further learning at this early stage of the review, centers upon how health assessments for looked after children, who come into care through a Section 20 parental agreement, are delivered. Immediate work and strengthening of this process between health and children's social care Partners includes:

- **Health Partners have developed a joint Initial Health Assessment (IHA) process map, which has been agreed with Partners.**
- **Current exploration underway to develop a health consent form for social workers to use when gaining section 20 consent from parents**
- **CSC have agreed to have a Looked After Child (LAC) lead administrative worker to support coordination of LAC health documentation for IHAs. This person will liaise weekly with the health LAC coordinator to ensure good information sharing.**
- **Future joint LAC CSC and health meetings quarterly to support joint challenges and good practice with the first in September 2023.**
- **Health assessment leaflet developed by LAC health team, shared with CSC to support social workers when discussing health assessments with children, carers and parents.**
- **Independent Reviewing Officers are to escalate LAC who have not had their IHA at the first review to Head of Service in CSC.**

Child SS was frequently missing, and this report outlines at the start the recent Police review into how the Met responds to missing children, and that the response needs to be stronger. Separately, but at the same time , what should further strengthen this area of practice is the Strategic Needs Assessment which has been completed under the Serious Violence Duty and which will formulate a Serious Violence Strategy for the multi-agency Safer Communities Partnership , due to be published in January 2024. In addition, the Tackling Violence and Exploitation Strategy that we have been consulting on over the summer with children and parents, key stakeholders and local VCS providers will provide a refreshed strategy and approach and will be launched in March 2024 after a period of co-production.

Child AS Learning Review: Relevant Partners came together to conduct a thorough learning review in respect of safeguarding a child with a disability. The child is currently safeguarded and achieving good outcomes. The Partnership felt that although the threshold for a serious incident had not been met, there was an opportunity to identify whether any learning could be taken from this incident in order to strengthen the local system. Practice themes of: timely and effective child protection medicals, appropriate escalation when there is difference of opinion, cultural competency in practice and information sharing involving children with complex needs have all be considered and actions taken, this is summarised below:

Child AS LEARNING REVIEW: EVIDENCE OF PUTTING LEARNING INTO PRACTICE AND ITS IMPACT:

Timely and effective child protection medicals: A key practice theme in this review identified that a child protection medical examination (CPME) undertaken could have been conducted in a more effective manner and that it should have involved Police Partners. **Our lead Health safeguarding Partners and colleagues in Police have subsequently established a new telephone hotline to operate between 8am – 8pm to Police Child Abuse Investigation Team officers and Health colleagues working in clinical Paediatrics settings in hospital. As a result of this work the Barnet Designated Doctor reported an increase in referral numbers for Child Protection Medical Examinations (greater than the total sum 2 years ago).** Not all referrals have been for bruising, some have been for neglect – these were appropriate and timely referrals, and the view by clinicians held is that this new approach is ensuring CPMEs are conducted more thoroughly and in a timelier fashion.

Appropriate escalation: A critical practice episode identified that those involved in supporting the child and family did not hold the confidence nor knowledge as to how to escalate concerns upon decision making. Professional discourse and disagreement are part and parcel of a healthy safeguarding system and can lead to crucial cross agency challenge. **As a consequence, the Partnership has come together and updated and revised its Escalation & Resolution Policy. The RFLNHSFT have since this review delivered training to over 30 health care professionals, outlining and promoting the new Escalation & Resolution policy securing positive feedback and a renewed confidence in providing important cross Partnership challenge and scrutiny in decision making**. Further dissemination of the revised policy has been included in webinars delivered upon the Continuum of Help & Support, as discussed earlier in this report.

Cultural competency in practice: Ensuring that individuals and systems work or respond effectively across cultures, in a way that acknowledges and respects the culture of the person or organization being served, underpins what we mean by cultural competency. A critical learning theme within this review centered upon this. **For Partners at Central London Community Healthcare NHS Trust (CLCH), who provide specialist school nursing support, this has led them to ensure that when system files are opened a template reminder appears informing staff of the need to record ethnicity and cultural representation so as to ensure it is a core focus of the individual receiving the interventions.** The Partnership has produced a cultural competency in practice toolkit, and revised and refreshed it to include physical chastisement and is available for the whole Partnership to inform practice: BSCP cultural competency practice statement and tools designed and published on BSCP website:

Information sharing for children with complex needs: Opportunities for reflection and discussion for children with complex needs was identified as a practice theme within this review. Since then, the school involved in providing education for the child has established multi-disciplinary forums that facilitate reflection and discission about the psycho-social needs of all children with complex needs. Partners at CLCH are invited to be part of this multi display approach. Further support threads have been established to facilitate more effective information sharing by way of the school sharing bests practice across the SEND Headteacher Forum, supported by Partners at BELS. Colleagues at RFLNHSFT have further embedded peer to peer safeguarding supervision from Autumn 23, providing a space for colleagues to provide scrutiny and challenge to one another.

Duty of care – protecting staff from online smear campaigns: As a consequence of this learning review the Partnership has committed to issuing a statement outlining a zero tolerance towards abuse of staff from members of the public. At the time of preparing this Report this statement is being finalised.

Wider multi agency audits, learning activity and national reviews:

Data: The PQA subgroup have ensured that stubborn and 'knotty' issues within the local system have had the appropriate levels of scrutiny in order to overcome them. Our comprehensive multi-agency data dashboard provides the platform for this. **A good example of how data can be used to provide scrutiny can be seen by the Partnership**

exploring the areas below:

- Our BSCP multi agency data dashboard now reports on A&E presentation of young people with mental health and self-harming incidents. This has led to colleagues in Public Health begin a process of scrutinising comparative data across similarly populated boroughs so that service provision can be better informed across the Partnership.

- **Tracking disproportionality within school exclusions:** The PQA has provided additional scrutiny and challenge upon the issue of disproportionality within schools exclusions provided by data. **The PQA sub group** has learnt that the lead reason for permanent exclusion has shifted and returned to 'persistent disruptive behaviour' despite this category remaining low for many years now. Followed closely by the second most common lead reason for permanent exclusion being 'physical assault on a pupil.' There has been a significant percentage decrease in the number of black pupils being permanently excluded in 2019-2021. However, these statistics are masking a disproportionality between the exclusion of black pupils compared to the exclusion of white pupils. Black pupils living in Barnet are 2.12 times more likely to have a fixed term exclusion than White pupils. In North London only Haringey has a higher comparative rate than Barnet.

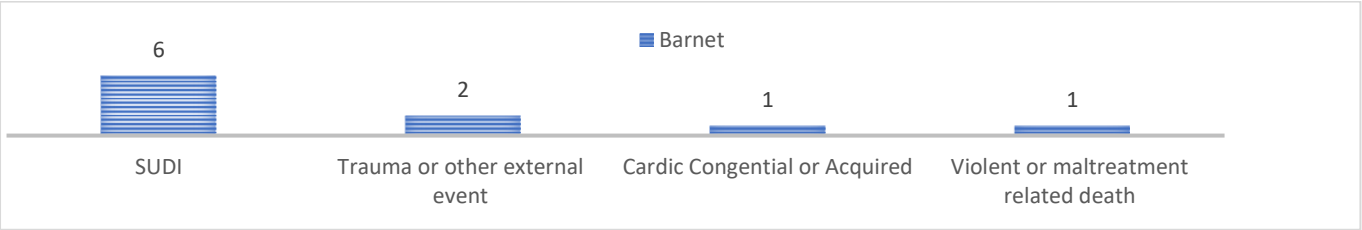
  The work to tackle disproportionality of black boys exclusion across education arose from a review led by Youth Justice Services in north London which in turn resulted in the establishment of the BELS Preventing Exclusions of Black Boys group. This is regularly reported to the Youth Justice Management Board; tackling disproportionality is a strategic priority for the multi-agency Youth Justice partnership and is a priority in our Vulnerable Adolescents Strategy. We know that school exclusion is a key risk factor in children developing poorer outcomes and can increase their vulnerability. 38 pupils who live in the London Borough of Barnet were permanently excluded between September 2022 and July 2023 and 33 were referred to the Pavilion Study Centre (PRU) to further their education before returning to mainstream school. Any pupil who does not live in Barnet but who has been permanently excluded from a Barnet school will have been referred to their home borough for support back to education. From the 38 pupils permanently excluded 26 pupils were male and 7 pupils were female. There is a shift in permanent exclusions of girls since 2019 and to date there remains a clear gender imbalance regarding permanent exclusion with twice as many boys being excluded than girls compared to previous years which showed there was a growing concern that White British girls were being permanently excluded in Barnet at a greater rate. There is a clear gender disparity between the ethnicity of permanently excluded pupils with 5/7 girls being WBRI (White British) in comparison to 4/26 boys. The highest ethnic group of permanent exclusions of boys is MOTH (Any Other Mixed Background) with 9/26 boys. The number of secondary permanent exclusions in 2022/23 was 32. This compares to 23 in 2021/22, a rise of 9 permanent exclusions. Permanent exclusions in Barnet predominately occur in the secondary phase, in line with national data.

  In addition to the aforementioned reporting to the Youth Justice Management board, the Partnership holds a strong working partnership with schools and services, supporting multi-agency working when a child is at risk of exclusion. Schools identify the need for an at-risk notification to the education welfare team to support schools with pupils who are awaiting an EHC outcome. The Partnership has developed a strong Inclusive Advisory Team (IAT) and Autism Primary provision that work closely with schools and the Meadway Primary Nurture Hub. The Pavilion Study Centre provides respite packages of intervention and assessment for pupils at risk of exclusion and an outreach programme to schools commissioning mentors. The RON Mentee Programme has extended its offer of specialist support for students at risk of exclusion in Years 7-11 to prevent permanent exclusion of secondary pupils working with students engaging in an offsite direction or respite provision. As a consequence of this the Schools and Settings Standards Partnership Board (SSSPB) is in place as part of the wider governance structure for the partnership between the council, Barnet Education and Learning Service (BELS) and schools as overseen by the Children's and Young People's Partnership Board. It acts as a forum to keep under review those aspects of the Barnet education strategy that relate to: Equalities and appropriateness of the curriculum, pupil attendance, pupil exclusions , disproportionality between ethnic groups, the authority's monitoring, challenge and support of maintained schools and EY settings regarding equalities, exclusion and attendance and other relevant statutory functions. Partners at BELS continue to tackle disproportionality through the Preventing Exclusion of Black Boys Project

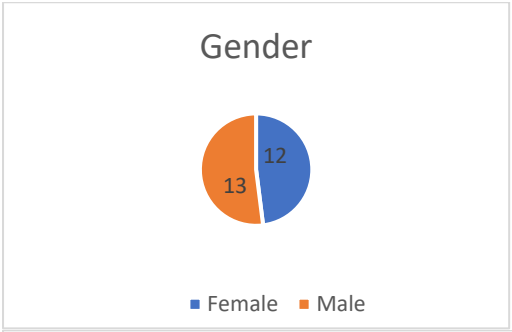
- **The PQA sub group has tracked numbers of registered Private Fostering arrangements.** As part of our ongoing awareness raising campaign, and following the Covid-19 pandemic, the Partnership has restarted its promotion activities regarding private fostering. This has included updating the website, to ensure that communications about private fostering are audience focused, current and accessible and developing a database of partner agencies, where these updated materials will be disseminated across the borough. The Private Fostering Lead and Team Manager have worked alongside the Partnership to present a webinar to partners, including health, school, education, and the police. BELS partners have presented information and circulated posters and leaflets to both Primary and Secondary Headteachers at their termly forums. The Private Fostering Annual Report and regular updates are presented at Partnership meetings to ensure awareness at senior level across the partnership. Communications have been disseminated throughout Children's Services to ensure that practitioners understand where and how to refer private fostering cases. There is also a duty phone line and a recently created private fostering email, for practitioners, other professionals, and members of the public to access should they wish to discuss anything related to private fostering with the Social Work Lead. Bespoke inhouse training has been provided to the Carer Support Team to ensure that private fostering practice is current and incorporates learning from historic SCR's. Advice and support has been provided to the MASH, which supports the Private Fostering Lead to complete all the necessary checks and visits within the statutory timeframes. MASH and the Carer Support Team have forged close relationships and have regular liaison about cases that could fall within the Private Fostering Regulations. This relationship has been crucial in determining if there is a private fostering element to cases coming through the front door.

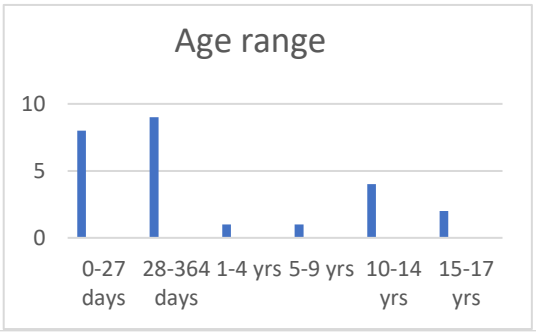
Child Death Overview Panel: This year has continued the strengthened alignment between BSCP and the formal Child Death Overview Panel (CDOP) processes, owned by NCL ICB. Any child death is tragic, and any learning identified by CDOP is important to share across the wider BSCP to reduce the risk of child death. In 2022-23, NCL CDOP received 95 notifications of child deaths through the eCDOP system. Of these cases, 25 were for Barnet children. Of the notifications received for Barnet, 10 were for unexpected deaths. *Working Together 2018* defines an unexpected death when the death of a child was not anticipated as a significant possibility 24 hours before the death. The Child Death process requires the CDR partners to convene a multi-agency Joint Agency Response meeting for each unexpected death. A Joint Agency Response (JAR) meeting is convened for all unexpected deaths, ideally within 72 hours **There were 9 JAR meetings in Barnet in 2022/23.**

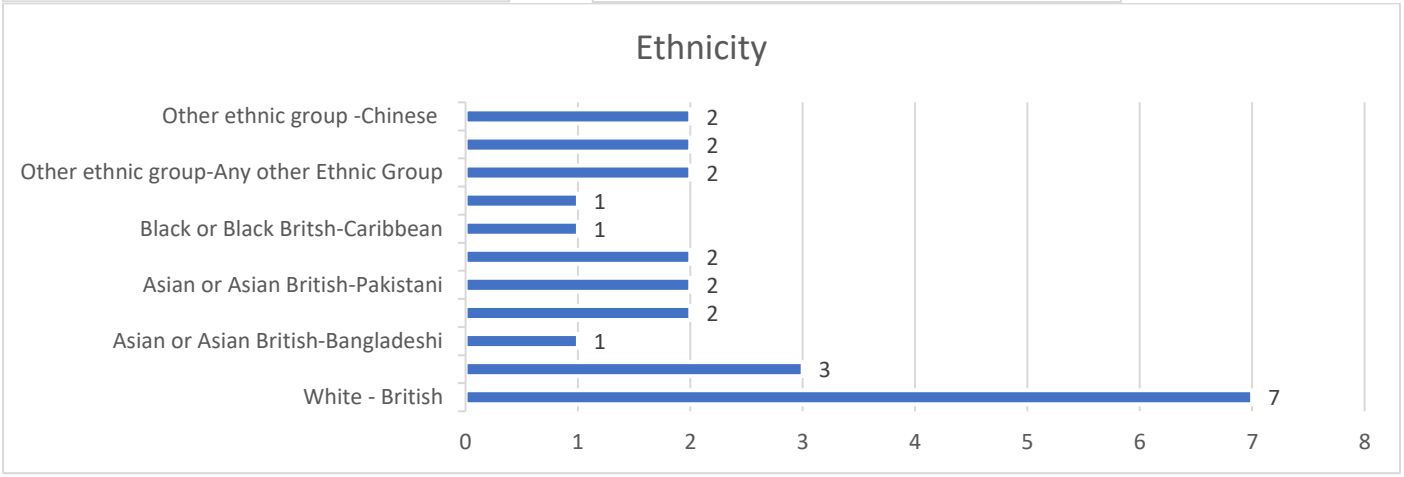
- Immediate safeguarding steps were taken where appropriate in relation to siblings and family support.
- Immediate learning highlights the ongoing need to raise awareness on safer sleeping.
- Two of the child deaths are also being reviewed under the NHS Serious Incident Framework.
- There was a significant delay in notification for 1 child who would have met the criteria for a JAR. The family were living abroad at the time of the death. **The reason for notification for each JAR is outlined below:**



Further data analysis is provided below highlighting a breakdown of information of the 25 children in Barnet who were notified to the CDOP, with 52% of the children being male , and the most prevalent age range for the children is being in the 1st year of birth and later in early adolescence. At the time of writing BSCP LTRG is considering the recommendations of a recent report by the National Child Mortality Database and the deaths of children due to traumatic incidents, and how the learning here can be absorbed into practice by the Partnership.







Multi-agency workforce development: The multi-agency safeguarding training offer available to all of the Partnership remains robust and is continually adapting to meet the changing needs of local safeguarding issues. Feedback received from participants highlight satisfaction with the quality of course content and the delivery skills of trainers. Our Learning in Context approach offers a comprehensive and practical learning experience for our workforce. It is designed to be accessible, relatable, and applicable, with a focus on timely and targeted learning opportunities. The Partnership provides a combination of training through e-learning, workshops, and face to face learning activity.

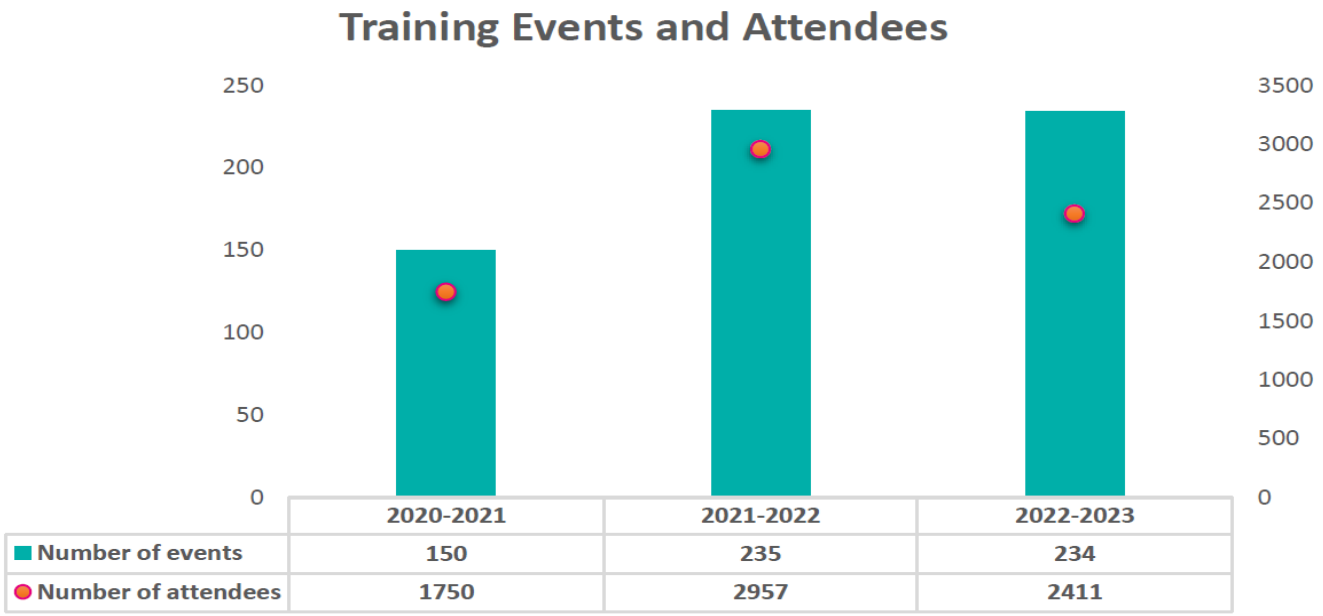


Figure 1: Workforce development training events and number of attendees

The Partnership has maintained the number of learning events this year in line with our commitment to continuous learning and improvement. However, attendance figures have decreased due to demands on time and recruitment and retention challenges right across the Partnership. Moving forward, we recognise the need to strike a balance

between an agile and responsive learning offer. Close collaboration with partners and targeted promotion of courses will be key in increasing multi-agency course uptake.

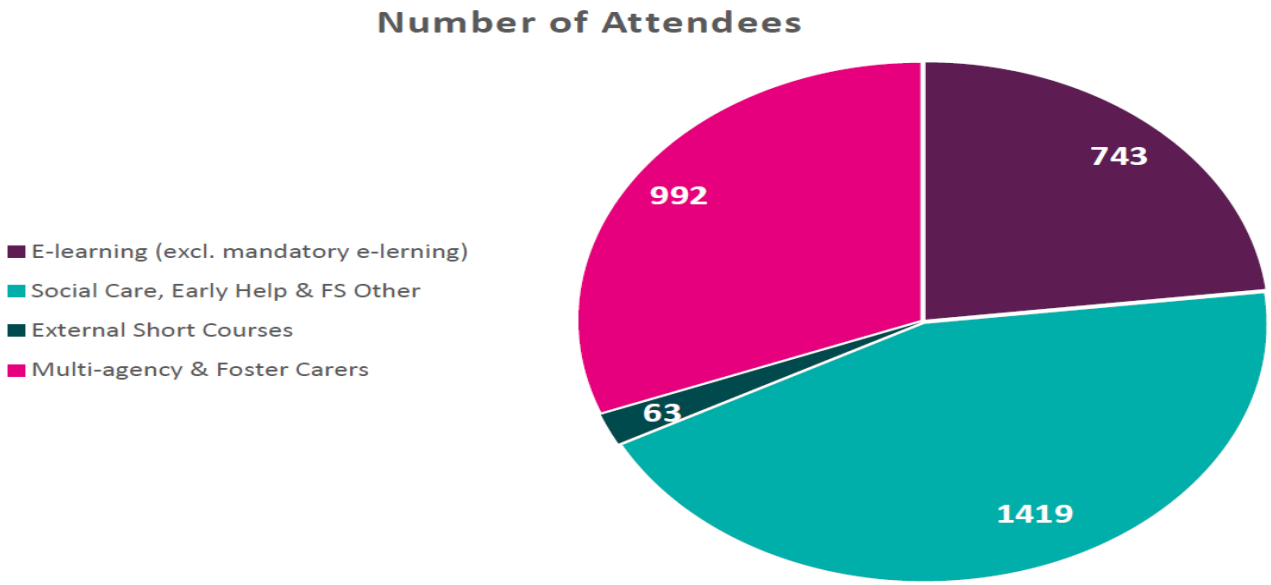


Figure 2: Number of attendees by workshop type

A core element of the multi-agency programme continues to prioritise assessment, intervention, and planning within the social care context. We maintain an emphasis on promoting child-centered and strengths-based approaches, co-production and equality, diversity, and inclusion, ensuring these principles are embedded throughout our training. The well-attended courses are Social Graces, Critical Analysis, and Signs of Safety. There has been an increase in targeted training developed to address evolving service needs, such as Adultification. Overall, we have seen an increase in attendance for all staff and the attendance for BICS, foster carers, and early help practitioners has remained consistent. Multi-agency training attendance has fallen this year, although feedback from the partnership about training opportunities is consistently positive. The decrease in attendance will be explored with partners to ensure barriers contributing to uptake of courses are understood.

To address inequalities, disparities, and racism, we have integrated cultural competence into our training offer and diversified our training providers. The honorarium fund and leadership development programmes available within Family Services have provided valued opportunities for our staff from diverse backgrounds and with protected characteristics. We will continue to prioritise diversity, inclusivity, and support career advancement within Family Services through tailored learning activities and ongoing dialogue on structural inequalities.

For critical Partners in Health the NCL ICB have this year delivered extensive training to our GP network on a range of topics. Feedback has been very positive from these sessions and the value to practice a clear theme throughout. Attendance numbers and feedback positively reflects the commitment of GPs in Barnet to ongoing learning.

Topics included:

- Adverse Childhood Experiences's and effect on future wellbeing (39 attendees)
- Beliefs linked to witchcraft and spirit possession (25 attendees)
- Learning from reviews -Human stories on self-neglect and impact (33 attendees)
- Information sharing and lessons learned from local reviews(47 attendees)
- Responding to and supporting patients with sexual violence disclosure
- Managing allegations against professionals (52 attendees)
- Level 3 safeguarding training delivered to GP Safeguarding leads and GP trainees. This is a rolling programme.

- ❖ Presentation on learning from Child L CSPR (outlined earlier in this report) - delivered to Barnet Federation of GP's (100 plus attendees)
- ❖ Learning from reviews session jointly with BSCP Business manager to 0-19 service with service specific learning. (90 attendees)
- ❖ Development of NCL Safeguarding assurance matrix which incorporates the key components of the SAAF.
- ❖ Designated Nurse support 0-19 service to roll out the ICON infant crying programme (see next section of this report).

In addition to the programme above, BSCP has delivered as a Partnership a series of well attended learning webinars on a multitude of themes mentioned earlier in this report. **The BSCP Learning Repository continues to expand with the following delivered to a total of over 450 Partners over the past year:**

- Publishing Barnet's new Continuum of Help & Support: Over Summer 2023 BSCP delivered webinars designed to raise awareness of the updated Continuum of Help & Support . A webinar can be found below which will help develop your understanding of the levels of need children and families experience and the help & support they can expect to receive: **https://vimeo.com/861148723?share=copy**

- Bruising protocols in mobile and non-mobile children (April 2023): **https://youtu.be/HUlxdaomxp4**

- BSCP webinar outlining Private Fostering arrangements and raising awareness of Special Guardianship and wider kinship care February 2023

- BSCP webinar upon briefing paper published by national safeguarding panel upon domestic abuse and the prevalence of this affecting children, particularly under the age of 1: **https://youtu.be/G675qCqlVKY**

Multi agency learning & improvement: A range of quality assurance activities and measures, alongside performance data, are used to routinely evaluate the quality of early help, social work and multi-agency safeguarding practices. This seeks to ensure that the service we offer to children and families is of a consistently high standard. The Safeguarding, Quality Assurance and Workforce Development Service based within Family Services delivers rigorous oversight, high support, and high challenge with a committed team of systemically trained Quality Assurance Officers (QAO), Conference and Reviewing Officers (CRO) and Independent Reviewing Officers (IRO) led by a Service Manager and Principle Reviewing Officer.

CROs and IROs provide independent oversight and quality assurance for each child subjected to a Child Protection Conference and Plan and Children in Care Reviews and All About Me Plan. They complete evaluation and monitoring forms after every conference and review. They undertake robust mid-way reviews to track the progress of plans and compliance with statutory requirements, on occasion they will escalate concerns to Team Managers to ensure practice is of high standards.
Quality Assurance Officers (QAOs), CROs, and Team Managers (TMs) use an Appreciative Inquiry (AI) approach to undertake regular audits across Family Services. AI is a collaborative, strengths-based approach to change in organizations and other human systems. TM's and CRO's undertake one audit every 2 months as part of the whole service regular audit schedule. QAO's routinely undertake audits, double-lock TM audits, and write 6-monthly narrative QA reports for each part of Family Services.

Alongside, our regular case file audits thematic auditing activity is completed where we want to look at specific areas of practice, focus on certain cohorts or embed learning from national or local learning reviews. **Over 2022/23 we have completed thematic audits on the Quality of s.47 investigations, 16/17 year old homelessness, FGM and Forced Marriage, Private Fostering, and children subject to Public Law Outline (PLO) processes.** Practice Leaders, QAO Officers and Practice and Learning Managers lead multi-agency reflective forums to share findings and learning.

In April 2023 Team Managers in Family Services co-developed a refreshed an audit tool to better capture the impact of practice on children and this was integrated into the system. We wanted our audit tool to help us better understand what works well in practice and reflect our refreshed practice framework which includes strengthening our processes for family feedback to be included.

Throughout, 2022/23, **269 Family Services case audits were completed, some of which are measured against the new tool. Audits remain rigorous and comprehensive enabling quality assurance of practice across a range of domains including diversity, voice of the child, involvement of parents as well as the quality of assessment and planning for children.**

In the arena of Child & Family Early Help Service audits enable the service to focus on areas of practice that can be strengthened evidencing good outcomes for the children who use the range of services on offer. Audit data over the past 12 months shows that under the domains of diversity, parent/carer engagement and child's voice, practice is usually good or outstanding; there is a specific focus on improving recording of direct work and reflecting how individuals' unique diversity and identity informs our approach to supporting them.

In June 2023 a practice development day for multi-agency practitioners was held. Multi-agency audits were undertaken with multi agency Partners from Health, CAMHS, BYCASS (Young Carers), Schools and Adult Social Care; the outcome of the audits demonstrated good multi-agency information sharing and a need to strengthen action planning. Using an Appreciative Inquiry approach, Service Managers and the Assistant Head of Service met with practitioners 1:1 to review their work with children and families. The review evidenced good outcomes, direct work, and meaningful interventions with practitioners demonstrating a good understanding of the needs of children and families they are supporting at an early help stage. Audits demonstrated practitioners are tenacious for families and positively link them into wider programmes of delivery in the borough through strong relationships with Voluntary Community, Faith, Social Enterprise (VCFSE) providers.

The 0-19 Healthy Child Programme is delivered alongside Children Centre settings, there have been some challenges in the delivery this year and our Early Years leads have been supporting S4H to embed into the settings and expand reach to vulnerable families i.e., Asylum Hotels. Between April – August 2023 footfall data showed that families with children under 5 accessed a Children's Centre service 21,296 times and in the same period there was a 5% increase in children under 5 years on Child Protection Plans accessing Children's Centre services following a targeted effort by Children's Centre leads to increase engagement**. During the summer there was a 60% (n=729>1217) increase in take-up of the Free Early Years Education for 2-year-olds (FEE2). The Childcare Sufficiency Assessment (CSA) 2023 is due to be published following a public survey in which families, early years providers and schools have been consulted**. This will inform planning for the extension to the 30-hour offer for children aged 9 months – 5 years in 2024. 4,535 children accessed the 3 & 4 year old 30-hour entitlement; 2,166 of which are using the full 30 hours.

Multi agency audit upon neglect: Further to last year's BSCP Annual Report, and neglect being a safeguarding priority, the Partnership came together in late November 2022 to undertake a multi agency audit which featured the review of 3 children's experiences in receipt of multi agency provision, where neglect was a prominent concern.

Working Together 2018 defines neglect as: *'The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development.'*

We wanted to make sure that of the 3 cases audited by the safeguarding partnership, there was a strong identification of where the experiences were positive for children and families, and where multi agency responses could have been strengthened so that we can build this into future planning and delivery under our Learning & Improvement model.

Within the multi agency audit, common practice themes were identified that it was felt that, going forward, the Partnership would hold in mind as risk factors that could exacerbate any neglect children experience. They were:

- Children with Special Educational Needs & Disability (SEND),
- meeting the needs of young carers,
- transfer of children in and out of services and local areas,
- responses to domestic abuse,
- identifying the impact of poverty upon children through an intersectional lens,
- children who identify as transgender,
- children receiving elective home education

- cultural competency in practice.

Responding to and tackling neglect was identified as an ongoing practice issue to be held in mind across areas of the Partnership and a learning review, found here , has been published and disseminated in order to help practitioners consider this pervasive issue in the lives of children and young people.

National Reviews: This year the primary national review considered by the Partnership has been the Child Safeguarding Practice Review Panel's review into safeguarding children with disabilities and complex needs in residential settings. The PQA sub-group has received an assurance overview from Partners upon the recommendations outlined within the review and include developing a range of programmes and provisions to support children with SEND who cannot remain at home, and to this end pathfinder programmes are being explored for autism support and respite hubs. Where a residential placement is being considered parents and child are supported by SEND case workers, allocated social workers and a joint Tri-partite process oversees the decision making. The Tri-partite working group is refreshing our joint processes, and this recommendation will be added to this work stream.

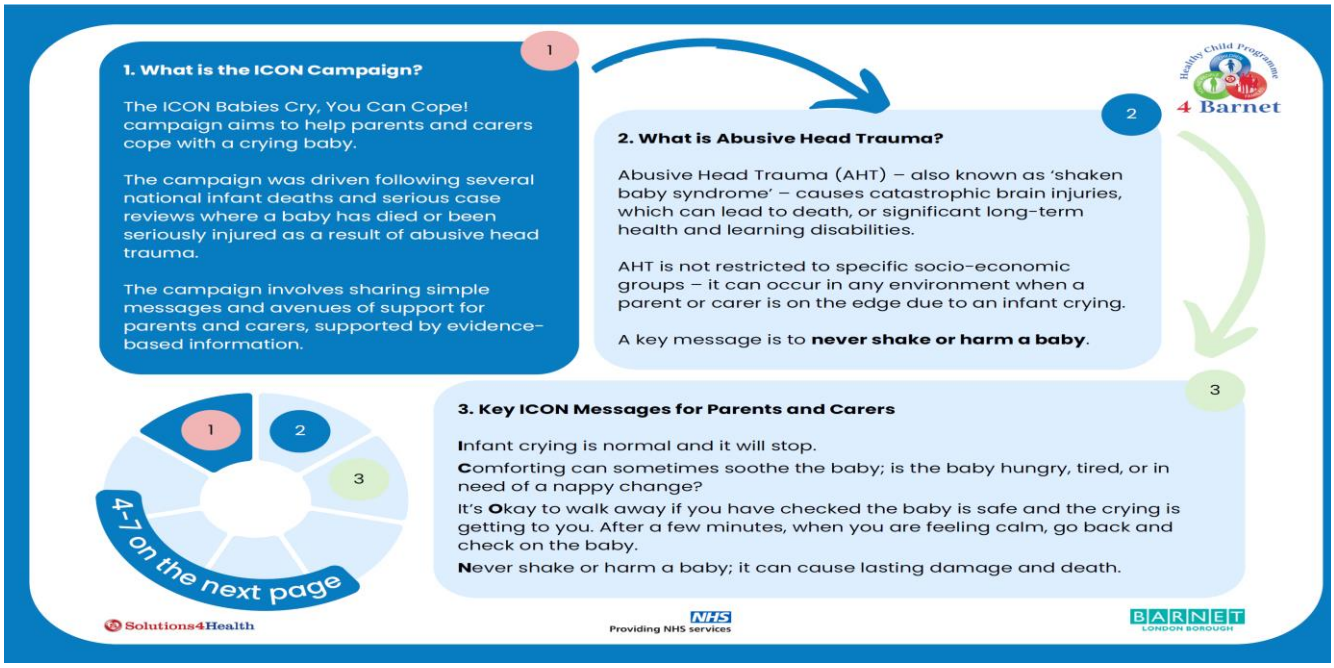
Section 2: Shared safeguarding themes:

Safer Sleeping: While rates of sudden unexpected death in infancy (SUDI) declined steeply in the 1990s and continued to decline until 2014, families living in the most deprived neighbourhoods continue to experience a disproportionately higher rate; the National Child Mortality Database found that 42% of SUDIs occurred in deprived neighbourhoods, compared with 8% in the least deprived.[1] In addition, Babies under the age of one have consistently been the largest category of serious incidents notified to the national Child Safeguarding Practice Review Panel. In 2021, 32% of incidents of non-fatal physical abuse involved children younger than a year old [2] The Myth of Invisible Men review focused on the role of male carers and identified a number of challenges for safeguarding partners. This included the need to explore the vulnerability of babies under one, in depth, with both parents (regardless of whether they live together or are in a relationship with each other) as well as with other new partners. The review also identified the familiar difficulties with information sharing, both within different sections of the health service and across the wider safeguarding system. Furthermore, additional causational links to domestic abuse, Violence Against Women and Girls , substance misuse and parental mental ill health were evident in a large number of reviews where harm was caused to babies and infants . Babies continually crying and not being soothed is identified as a trigger to harm caused to them, often perpetrated by male carers.

To address these issues the Partnership has been pro-active. We have maintained consistency in delivering important programs of intervention which promote safer sleeping and raising awareness of the risk posed to babies under the age of 1 to serious safeguarding incidents. The ICON program aims to help parents and carers cope with a crying baby. The campaign was driven following several national infant deaths and serious case reviews where a baby has died or been seriously injured as a result of abusive head trauma. The campaign involves sharing simple messages and promoting avenues of support for parents and carers, supported by evidence-based information. The Child & Family Early Help Service's reducing parental conflict programme is an early intervention to prevent escalation to domestic abuse; which has often been found as a pervasive issue when harm babies and infants have experienced through inappropriate sleeping arrangements and care is evidenced [3] The service has completed the first year of a new round of 3-year funding from DWP (Department for Work and Pensions) Reducing Parental Conflict Grant. Over the year, 10 awareness-raising virtual workshops have been held for a wide range of professionals about Parental Conflict; refresher training has been provided for Early Help Practitioners around the structured interventions which form part of the Early Help offer. Two workshops via the Tavistock on the Mentalisation Approach, when working with higher levels of parental conflict and two workshops on helping professionals to differentiate the difference between domestic abuse and parental conflict have also been held.

[1] University of Oxford (https://www.ox.ac.uk/news/2023-03-13-new-report-promoting-safer-sleeping-babies-england)
[2] Child Safeguarding Practice Review Annual Report 2021
[3] https://www.gov.uk/government/news/new-review-investigates-babies-harmed-by-fathers-and-stepfathers

SAFER SLEEPING: EVIDENCE OF PUTTING LEARNING INTO PRACTICE AND ITS IMPACT: **Colleagues at the RFLNHSFT** have contributed to several reviews where babies and infants have died or been harmed. Consequently, they have concentrated learning for staff around supporting mothers and fathers to understand the triggers for abusive head injury and the principles of safer sleeping. The Trust has linked with a Father Inclusion Lead from another borough to provide training to our midwives about the importance of including the father the care and advice around pregnancy and the newborn. They have worked with Barnet Domestic Abuse & Violence Against Women and Girls strategic team to coordinate training for health staff about the new Domestic Abuse Act. Colleagues have further worked with the WAVE Trust who screened their award-winning documentary Resilience which promotes trauma informed care and the science of adverse childhood experiences. **Partners at S4H have ensured that safer sleeping** is promoted at antenatal contacts, new births and clinic contacts, where appropriate, Awareness has also been added on flyers and posters in clinics. The **ICON** message has also been added to communications, posters and flyers Training has been delivered to staff and a 7-minute briefing sent out across the service outlined below:



The Safeguarding team from Royal Free London NHS Foundation Trust (RFLNHSFT) deliver ICON training to the Barnet Walk in Centre; these training sessions include an update on Safer Sleeping guidance as part of their strategy to "Actively engage with fathers". Staff will be encouraged to share ICON and Safer sleeping information with fathers who often attend Walk in centre appointments with their babies and may not have been present at the new birth visit with the community health teams. In addition, changes have been made to Electronic Patient Records to improve how the safeguarding information about mother's and father's risk assessments in the maternity period is captured and used to safeguard the unborn. This includes capturing enhanced information regarding partners and fathers of pregnant women and information upon ICON (coping with crying) programme information sharing and safer sleep awareness. Training and briefings have been given to all maternity staff on this. **A recent audit by partners at the RFLNHSFT has demonstrated transfer of knowledge into practice with good compliance with data collection and identified further areas for developments such as in the post-natal period. Maternity services now use Padlet, an online app where information is uploaded for new and expectant parents, including ICON and safer sleeping. Feedback from a mother said:** ***'having this information available to hand gave me confidence that I was doing the right thing for my baby, and I could show my family when they were giving me different advice.'***

The Partnership has throughout 2023 struck a collaboration with the Lullaby Trust to deliver training. Both basic and advanced training options were offered, and a total of 37 practitioners have signed up from across the Partnership. Training will be re-offered to partners in 6 months' time so that more practitioners are given the opportunity to attend.

Family Networks: Family help and family group decision making is a central pillar of the Government's social care reform review and centers upon unlocking the potential of family networks for children as an alternative to them entering the care system. As a Partnership we wish to develop a multi-disciplinary approach to furthering this pillar, strengthening, and innovating wherever we can.

We know that adults with complex emotional needs are more likely to have experienced significant harm growing up due to their own parents' complex needs. They have typically been known to Children's Social Care (CSC) as children and many are care experienced. With the absence of a secure parenting blueprint and the often-harmful impact of their complex emotional needs on their children, there is a greater risk of entry into care, perpetuating a cycle of children experiencing significant harm, CSC involvement, and removal into the care system, frequently across generations. In July 2021 Barnet Family Services developed an Early Years Parenting Hub (EYPH) providing highly specialised and targeted multi-family interventions for parents with complex emotional needs and their children. A wide range of services and organisations were consulted in developing the programme of delivery and when an identified need or theme is raised, they have supported and assisted in delivering a session or jointly delivering the whole programme. The service aims to ensure that parents receive holistic assessment and intervention ensuring that their children, particularly in the early years, can grow up in safe, loving homes with their parents or, where that is not possible, to secure permanency early for children so that they can grow and thrive in stable, caring homes with alternative caregivers across their family networks where appropriate. The intervention model addresses the parent's complex emotional needs, the child's development and the parent-child attachment relationship.

FAMILY NETWORKS: EVIDENCE OF PUTTING LEARNING INTO PRACTICE AND ITS IMPACT: A 3-way joint Parenting Hub Contract is formulated by the EYPH and the social worker alongside the parent(s) which is reviewed regularly to measure progress. The EYPH work also works closely with multi agency Partners and professionals in the wider network including the Early Years/Early Help system to ensure parents are closely linked to universal/universal plus services for children ensuring early preparation for step-down/step-across where appropriate. Multi agency practitioners report:

"The course provided a profound insight into the significance of mentalization for effective emotional regulation and secure relationships. I'm eager to integrate MBT strategies within my work, especially in identifying and managing risks within family networks. This training has expanded my toolkit and confidence as a practitioner".

Across the EYPH Consultations are offered to practitioners and social workers to discuss families that may be eligible for groups, assessment, and support. These consultations form the basis of referrals to the Parenting Hub to promote a quick, efficient referral process. The EYPH jointly manages families alongside the allocated social care team, offering reflection and supervision to aid case management and decision making. The approach ensures a safe, coherent network of professional help is built around families from the onset of assessment to the completion of intervention. **Since the launch of the service November 2021, the EYPH has provided 70 consultations resulting in 14 referrals for Specialist Parenting Interventions for 19 parents and caring for 16 children.**

- All 19 parents had extensive CSC involvement as children.
- parents are care experienced (68%)
- 12 children had previously been removed from 19 parents (63%)
- 5 families had a decision securing permanency for 7 children outside of the family at the 12-
- week assessment.
- 4 families had a decision securing permanency for 5 children after the first 12 weeks of the 18-
- month intervention.
- 1 family (1 parent and 1 child) has completed the 18-month intervention.
- 4 families currently engaging in the 18-month intervention.

Promoting, developing and supporting Family Networks also occurs across our network of Special Guardians, who look after children when adoption is not right for them and they cannot remain with their parents. Often Special Guardians are extended family members such as aunties, uncles and grandparents and they receive multi-disciplinary support to ensure the children who they care for received the very best outcomes.

FAMILY NETWORKS: EVIDENCE OF PUTTING LEARNING INTO PRACTICE AND ITS IMPACT:

Case study: B is 78 years old and a step grandad to T who is 11-years old. T suffered neglect due to his parents' drug abuse and domestic violence. **He was removed from their care and placed under a Special Guardianship Order with his grandparents.** T's birth mother sadly passed away in 2020 and then sadly his grandmother C passed away in 2022. T has therefore suffered the loss of his two significant female care givers in his life and B was struggling to cope with his own grief and trying to raise and support T. B was struggling with a passport application for T and after speaking to professionals it became apparent the family would benefit further support although B was reluctant at first due to worrying about 'social services involvement'. Soon, wider Partnership support kicked in. Further to additional assessment and support the following outcomes were achieve in less than 10 months:

- T was referred by the social worker for grief counselling to Grief Encounter. An assessment was completed, and T is now accessing therapeutic support 1:1 at school.
- It was recognised T would benefit from positive activities given restrictions on B's mobility, so he was referred to Barnet Young Carers, a key Partner across the voluntary sector supporting children with caring responsibility and T engaged with Chickenshed theatre company and other positive activities
- T's primary school were concerned if B was coping and T's presentation wasn't always what it should be – SW supported a in person meeting with the new Head of the school which was a positive, strengths-based meeting and the SG said they felt heard. Out of this the school drew up a morning and bedtime routine for T to stick up at home and try to follow, B made sure T's presentation improved and B decluttered some of the home with the social workers help to create more space and improve home conditions.
- B was quite isolated, grieving the loss of his wife and struggled to accept help for himself – the social worker built a positive relationship with him and through helping to secure some support for T he began to trust the SW to think about B's own needs.

Over Summer 23 a Special Guardian (SG) and kinship care celebration event brought together, for the first time, the network of SG's and our kinship carers such as T and B as detailed above. Outcomes for children at the summer event included children who have had summer holidays with their SG for the first time, SGs reporting that they felt valued and 'seen' by professionals and that a peer-to-peer network is vital to the support they provide the children.

Family networks are empowered to support those experiencing difficulties through the Child & Family Early Help strategy, and in particular Team around the Family processes. This is where all the people who care about or are working with a child form a team that works together to help support them. One professional will take the lead and ensure that services are co-ordinated and working effectively towards the change that is needed for the child and family. The lead professional can be any professional working with the family and who is part of the Team Around the Family, they will act as a single point of contact for the child and their family throughout the period of assessment and support. They will work closely with the child and family to ensure everyone is clear on how, when and where support will be provided.

FAMILY NETWORKS: EVIDENCE OF PUTTING LEARNING INTO PRACTICE AND ITS IMPACT: A family supported by Family Group Conferencing (FGC) has allowed a child to remain with her aunt, and thus with her family, whilst her mother receives support to address her own challenges. Concerns centered upon mother's use of alcohol whilst caring for her child. Police were called on a few occasions. The child is now subject to an Interim Care Order but is living with maternal aunt, but having twice weekly contact with mother and she is also receiving support from Partners Change, Grow, Live in order to address her substance misuse. The child has recently stated nursery which has allowed their aunt to return to work.

The FGC helped mum to acknowledge the concerns of the local authority, to encourage her to address her drinking and the issues it is causing. In enabled practitioners to ascertain who is able to support mum emotionally and who can support maternal aunt care for the child.

The headline data for Family Group Conference (FGC) delivery is below, outlining that 191 children from 121 families were supported as family networks over 2022/23 to address underlying concerns.

	2022/23				Total
	Q1	Q2	Q3	Q4	2022/23
No. of families with Family Group Conferences delivered	35	36	32	18	121
No. of Family Group Conferences delivered (some families have more than 1 FGC meeting)	50	54	44	21	169
Number of children receiving an Family Group Conference	57	56	50	28	191
No. of children referred	83	99	81	32	295
No. of children referred with CIN status*	33	63	59	7	162
No. of children referred on a Child Protection Plan	24	21	10	10	65
No. of children referred who are Looked After Children or in Care Proceedings	26	15	12	15	68
No. CYP escalating after FGC	0	2	5	4	11
No. of CYP safely remaining at same threshold after FGC	44	43	28	20	135
No. of CYP de-escalating after FGC	13	11	17	4	45

FAMILY NETWORKS: EVIDENCE OF PUTTING LEARNING INTO PRACTICE AND ITS IMPACT: Data based on feedback from 175 family members, all of whom participated within a FGC, showed that 94% felt that they were well prepared for the FGC with lots of information which was clearly explained. In addition:

- 90% though the family plan was good and would make a big difference.
- 94% said that they liked the structure of the meeting and found it helpful.

Further feedback includes:

"The meeting was arranged very quickly, and I was informed at all stages what was happening"
"Glad we got to meet the social worker and she was able to answer any questions we had"
"We're glad X got in touch with us if she didn't, we did not know how bad the situation was (for the family) "

Female Genital Mutilation (FGM): Female Genital Mutilation, Honour Based Violence and Prevent referrals are relatively low in the borough. Despite a child population of over 100,000, Barnet receives very small numbers of referrals to Childrens social care. The Partnership wishes to be curious in this area and place a focus and scrutiny on this issue to enhance understanding and Partnership response. When appropriate Channel Panel, care proceedings and Forced Marriage Protection Orders (FPMOs) have been initiated/obtained and audits of these areas of work demonstrate a good understanding of these harms and a safe and robust response to them.

Alongside regular case file audits, thematic auditing activity is completed where we want to as a Partnership look at specific areas of practice, focus on certain cohorts or embed learning from national or local learning reviews. Over 2022/23 we have completed thematic audits on cases where FGM and Forced Marriage Protection Orders were risk factors and outcomes identified in these audits for those affected were identified as 'good'.

The National FGM Centre eLearning course has been made available to partners and promoted across the partnership. It consists of 5 modules exploring the key components of FGM within the context of harmful practices. Another FGM eLearning course created by Barnardo's will be accessible to partners shortly. The course covers culture and religion, the law, the impact of harmful practices, and direct work with children, young people, and

FGM: EVIDENCE OF PUTTING LEARNING INTO PRACTICE AND ITS IMPACT: Three training sessions on FGM and breast ironing/flattening have been scheduled for school staff over the coming academic year 23/24**. At the time of writing 2 sessions have already taken place for teachers and Designated Safeguarding Leads in and the feedback was incredibly positive, with attendees describing the training as "excellent", "informative" and "powerful".** School staff continue to sign up for the remaining sessions and based on current interest and those that have attended so far, it's likely that there will be over 80 attendees altogether. Education is a delivery space and audience that we have not delivered in previously, directly to schools, and one that is typically hard to deliver in given the nature of the safeguarding issue of FGM. Feedback from Headteachers includes:

"I just wanted to say my deputies and I attended the FGM training yesterday. It was extremely upsetting but incredibly important to hear. I'm so very glad I attended.
We learnt of the training in the Autumn Term Safeguarding newsletter which I have to say is excellent.
It's been a valuable source of information for the deputy DSLs and I.
Best wishes"

The National FGM Centre eLearning course has also been made available to multi- disciplinary partners and promoted across the partnership. It consists of 5 modules exploring the key components of FGM within the context of harmful practices. Another FGM eLearning course created by Barnardo's is being made accessible to Partners late 2023. This will be an e-learning tool and the course covers culture and religion, the law, the impact of harmful practices, and direct work with children, young people, and families. This tool will be placed upon the POD platform which provides multi agency staff across the Partnership access to it. The multi-agency workforce development programme also holds training upon Harmful Practices and is accessible to all Partners.

BSCP also promotes the London Safeguarding Children Partnerships Honour Based Violence and Harmful Practices learning programme, which is a rolling programme, and comes complete with all of the additional resources and literature from gov.uk sources.

families. Right across the Partnership colleagues have embedded and emphasised awareness of FGM as an illegal practice. S4H staff are fully aware of their mandatory reporting duty to report any cases of FGM, disclosed or identified in females under 18. All staff receive training on FGM in their safeguarding training. NHSE webinars on FGM have been shared with staff this year. FGM was also included in safeguarding annual symposium in January 2023. NLMHP show an on-going commitment by way of ensuring that all staff receives appropriate safeguarding training and have maintained over 80% compliance with training in 2022 to 2023; raising awareness of FGM and

harmful practices is at the heart of their programmes. A Safeguarding Training Strategy has been implemented which sets out the requirements and arrangements for safeguarding training provision for all employees including those on bank, honorary contracts, and volunteers. **Partners at CLCH have demonstrated safeguarding assurance in 2022/23 by developing alerts and FGM updates so CLCH staff are reminded of their mandatory duty under the Serious Crime Act (2015) to report Female Genital Mutilation (FGM). Further still, an FGM Summer Briefing was shared widely across CLCH in May 23 as evidence shows that school summer holidays are a time when girls may be at increased risk of female genital mutilation (FGM) either by being taken abroad or from cutters coming to the UK.** CLCH has a FGM Recording and Reporting policy in place to provide clear guidance for staff on the procedure for recording FGM and the mandatory duty to report cases of FGM.

Police Partners remain committed to effective tackling of FGM. All MPS employees have clear directions and checklists to work to, ensuring the best policing response. In these are directions to ensure the voice of the child is considered at all stages of the investigation, and they are appropriately safeguarded using Sec 46 Children 1989 police powers to take the child into police protection, and consideration of any other children in the household, especially female siblings and cousins. Amongst the checklist is that any such referral must generate a Strategy Meeting between police and Children's Social Care, which in turn must trigger a joint S47 investigation. Enhanced secondary investigation reviews are also built in to the operating procedure with a Detective Sergeant reviewing the case between 10 and 18 hours, the Detective inspector within 72 hours and the Detective Chief Inspector within 7 days.

Multi-disciplinary working & building Brand Barnet: At the start of this Report the current challenges were noted upon the recruitment and retention of staff across health, police and social care. These challenges are not limited to these sectors, indeed the wider children's workforce to include education and voluntary sector Partners are all experiencing high turnover of staff and difficulties in recruiting. This is a national challenge, impacting local services. As such, the Partnership wishes to attempt to innovate wherever it can to ensure that working with children and families within Barnet is attractive and supportive and that staff feel connected to a wider workforce delivering incredible work, each and every day for children and families.

A task and finish group has been established around this theme and is ongoing. A learning and development pack has been created which outlines the training offer, specific BSCP resources, the strength of multi-disciplinary practice, and a 'who's who' of officials and agencies across the Partnership. It is our hope that this will be used by all partners during the induction process across the Partnership, no matter their organisation or service.

Plans for a bi-annual, in-person, learning and development induction for new starters in the Partnership are in progress with a view to this being held at Barnet General Hospital. A short paragraph promoting Barnet and the Partnership has been created which can be added to all partners' recruitment documents once agreement has been received.

RECRUITMENT & RETENTION: PUTTING LEARNING INTO PRACTICE & ITS IMPACT:
The Partnership delivered an innovative multi agency and multi-disciplinary staff induction session in October 2023 for new starters right across the Partnership – from health, police, to social care, to education and beyond. Time was spent with new recruits outlining the role of the Partnership, over-arching strategic plans and a review of learning themes held in the Partnership at present. Crucially, feedback centered on how great it was for Partners to understand more about each other's roles in safeguarding children and how they fit within a larger local system and break down silos and barriers. Multi agency induction will now take place every 2 my memory is that we agreed 6 monthly but I may be wrong?months with new themes and focus for each one – we hope this will support the creation of a more connected Partnership , develop Brand Barnet and support the ambition to keep skilled practitioners in our borough working with children and families. Feedback includes: *Thank you ,really enjoyed it ,so great to get everyone together with a wealth of knowledge.*

The Met Police have a pro-active recruitment campaign currently open with advertising. Across the MPS Public Protection (PP) has been recognised as below the necessary staffing to carry out essential functions. An uplift of 485 officers for PP has been announced MPS wide for late 2023. This is split between the 12 Basic Command Units

(BCU) and includes on each BCU 1 x DCI (to specifically manage offenders and proactivity), 1 x DI, an uplift in researchers and Police Conference Liaison Officers (PCLOs) across MASH and CAIT Referrals.
Locally on NW BCU officers from other strands are being attached to the Community Safety Unit to assist in the response to Domestic Violence, and the Rape and Serious Sexual Offences teams to assist in the response to serious sexual assaults. These initiatives has been assisting reduce workloads and improve responses whilst NW BCU PP is still under strength across all teams, awaiting the positive results of the recruitment campaign.

RECRUITMENT & RETENTION: PUTTING LEARNING INTO PRACTICE & ITS IMPACT: NW BCU Public Protection teams have reduced staffing levels compared with other BCUs across the MPS. The Child Abuse Investigation Team (CAIT), who operate at approximately 70% of their budgeted workforce; have improved their positive outcome rates from 3% (*as reported in the 2021 – 2022 partnership annual report*) to as high as 15.3% (*'4th June 2023 weekly data'*). CAIT outcomes have been included on weekly data since May 2023, the NW CAIT have been the top performing team across the MPS CAITs for some weeks, and amongst the top 3 at other times, and consistently achieved positive outcomes of over 10%. This is testament to the NW CAIT dedicated staff and effective Partnership working for children and families.

The Children's social work workforce census is an annual statutory census for all local authorities. Data shows that there has been a 13% increase in social work vacancies across London, and a 10% increase in agency workers. There is a 20% turnover rate of staff across London and England over the 12-month period 1 October 2021 to 30 September 2022. From 2020 Barnet is showing an overall decrease in Social Work vacancies covered by agency where it peaked in 2020 which is positive given that the trend in London and England is that vacancies have increased. It is still slightly higher than the average but is heading in the right direction. Barnet Family Services also has a lower than average sickness rate when compared with London and England, suggesting a healthier (and potentially happier) workforce.

Since 2020, Family Services has also increased the number of permanently employed social care staff, where the trend in London and England shows a decrease. It is still lower than the average, but the trend indicates a positive sustained change. Childrens social care holds an 18% turnover rate of permanent staff which puts Barnet slightly under the London wide average. Since 2019 there has been a sustained lower staff turnover rate than the average borough in London and it is forecast to continue through 2023 into 2024. shows Barnet's retention rate of Social Worker's is higher, when compared to other London and South East authorities. The picture across London broadly shows that there are more leavers than starters, which explains the reliance on agency staff. Part of this may be attributable to the increased locum rates for social care staff across London and home counties/the rest of England which continued to increase until the London Pledge was implemented in the summer of 2022 which may not yet be reflected in this data. We have an 18% turnover rate of permanent staff which puts Barnet slightly under the London wide average. A recent recruitment campaign generated 16 offers to Newly Qualified Social Workers to complete their ASYE year. To date this is the largest group and they are all in various stages of the onboarding process with a view to starting September 2023 at the latest. A further advert will go out later this year with a view to starting in January 2024. This is an ongoing cycle and by the far the most successful part of our recruitment process.

RECRUITMENT & RETENTION: PUTTING LEARNING INTO PRACTICE & ITS IMPACT: A Project Manager has been in place across Family Services supporting the *Conditions for Success* programme to enable a better work environment including better connectivity, better access to meeting rooms and secure spaces – all in place to make Family Services an even more attractive place to work. Managers are having informal discussions with candidates who resign with a view to examining options to enable staff to stay in Barnet. They are also being offered confidential exit interviews with the HR Business Partner. A recent review of the recruitment and retention rates resulted in a 5% increase for social care teams such as Intervention & Planning, Duty & Assessment Teams, Children in Care teams. A retention bonus has also now been added to Newly Qualified Social Worker roles to make Barnet an appealing employer and helps attracts a good caliber of candidates. In addition, there have been several internal candidates who have been promoted internally, securing staff in Barnet.

Across Health Partners recruitment and retention of a skilled workforce has consistently been one of the greatest

challenges over the past year. Nationally, there is a shortage of both school nurses and health visitors. S4H has been actively recruiting and have recruited into key roles and are continuing to do so with on rolling adverts for both professions. Health Partners are looking at innovative ways in which we can develop our own staff and change the way we deliver services. Recruiting into substantive posts remains very challenging. Most of the Public Health Nurses working in Barnet are working through agencies. S4H recently has had to reduce dependency upon use of agency staff due to cost pressures and are working with commissioners on future models of service.

Conclusion:

The Partnership is pleased to publish this Annual Report which we feel reflects the huge amount of work and positive impact across multi -agency services for the benefit of children and families and in the interest of keeping children safe. We are also proud that amongst all this work, our priorities and themes from previous years have continued to go from strength to strength in their delivery and support for children. This is particularly reflected in the work undertaken to tackle Domestic Abuse (DA) and Violence Against Women and Girls (VAWG) - which affects children and their opportunities to achieve positive outcomes so profoundly. Right across the Partnership our DA & VAWG Strategy 2022-25 has led to positive collaborations and partnerships with survivors, voluntary sector, faith groups and charities, our partners in front line multi agency delivery and across the council, and it is through this that we are meeting the aims of our strategic approach. Young people involved in our youth voce forums, under the banner of our My Say Matters strategy, tell us clearly that there is no place in society for gender-based abuse and violence, misogyny, sexual harassment and hate. All our information regarding the help and support we offer to residents who may be experiencing domestic or sexual abuse can be found on our website. Key achievements and milestones include:

- Barnet VAWG Team securing £1.46m funding from MOPAC to lead delivery of the Culturally Integrated Family Approach (CIFA) perpetrator programme in Barnet and across 9 other authorities in London in partnership with RISE Mutual CiC until 2025

- Barnet Child and Family Early Help Services secured a third year of DWP funding for its successful Reducing Parental Conflict Programme and has continued to deliver Children Overcoming Domestic Abuse (CODA) parent/child programmes

- Safelives delivered accredited Independent Domestic Violence Advocate (IDVA) training to 23 learners from the voluntary sector, Youth Services, Early Help, Children's Social Care, Adult MASH,RFLNHSFT , Barnet Homes, drug and alcohol services, and specialist DA services who have gained Level 3 IDVA Certificate in Domestic Abuse and have formed a DA Champion Network across the borough

- Barnet Homes have successfully bid for MOPAC and Against Violence and Abuse (AVA) funding to develop a specialist housing team and partner with domestic abuse survivors to co-create change

- The Community Safety Team have encouraged 57 of Barnet's 73 licenced venues to participate in the 'Ask for Angela' initiative

- Safe and Together training is being rolled out to the children's workforce with the aim of strengthening practice to keep children safe and together with non-abusing parents

- 86% of GP Practices in Barnet have completed or partially completed IRIS training aimed at early identification of domestic abuse, leading to an increase in GP referrals for victims

- Barnet's VAWG Team partnered with Middlesex University's student led Changing the Culture Initiative (CCI) to co-deliver the #HearMyVoice initiative focused on the narratives of individuals, groups and organisations in the local community

• Barnet Council has committed to working towards culture change for staff, systems and the community through its 3-year Action Plan led by a team of STOP VAWG Ambassadors and Champions

•Barnet council became a signatory to the Women's Night Safety Charter and a transformation programme, led by Street Scene's Director, to develop a pilot network of Safe Haven's in East Finchley will be launching in December 2023

Looking ahead, the Partnership will seek to implement any requirements laid down by the forthcoming review of Working Together 2018, following on from the period of consultation. The financial pressures facing local government and other statutory bodies will also have to be considered by the multi-agency Partnership over the next 12 – 18 months and beyond but we will remain, as ever, steadfast in our commitment to children and keeping them safe. Thank you for taking the time to read this Annual Report.