Independent Review of Enfield Safeguarding Children Partnership

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Context

The Children and Social Work Act 2017 and Working Together 2018 dissolved the requirement for Local Safeguarding Children's Boards (LSCB) and required three key partners - the Police, Health (CCG) and the Local Authority - to set up Multi-Agency Safeguarding Arrangements in their area.

The three Strategic Partners for Enfield, determined under the Children and Social Work Act 2017, comprise the London Borough of Enfield, the North Central London Clinical Commissioning Group, which has changed to the North Central London Integrated Care Board and the Northwest Basic Command Unit of the Metropolitan police. The new arrangements are referred to as Enfield Local Safeguarding Children's Partnership (ESCP). Enfield's new arrangements as the local Partnership were agreed in June 2019, coming into effect in September 2019.

The initial arrangements involved an independent chair /scrutineer who help facilitate the changes into the new Partnership arrangements. The agreement of the Partnership is to have a rotating Chair from the three statutory partners. Since April 2022 the Detective Superintendent, Head of Public Protection for the North Area BCU (Enfield & Haringey), Metropolitan police has chaired the Executive group. In order to provide independence and external oversight to the ESCP arrangements, the Partnership agreed to have an annual review undertaken by independent scrutineers of their partnership arrangements.

Specification for the Review

As stated in Working Together 2018, the role of independent scrutiny is to provide assurance in judging the effectiveness of multi-agency arrangements to safeguard and promote the welfare of all children in a local area, including arrangements to identify and review serious child safeguarding cases.

The scrutiny must be objective, act as a constructive critical friend and promote reflection to drive continuous improvement.

The independent scrutineers will consider how effectively the arrangements are working for children and families as well as for practitioners, and how well the safeguarding partners are providing strong leadership. The scrutineers will evaluate against the requirements for a Multi-agency Safeguarding Partnership as set out in Working Together 2018.

The extent to which the arrangements are delivering against their purpose, which is to support and enable local organisations and agencies to work together in a system where:

- children are safeguarded and their welfare promoted
- partner organisations and agencies collaborate, share and co-own the vision for how to achieve improved outcomes for vulnerable children
- organisations and agencies challenge appropriately and hold one another to account effectively

- there is early identification and analysis of new safeguarding issues and emerging threats
- learning is promoted and embedded in a way that local services for children and families can become more reflective and implement changes to practice
- information is shared effectively to facilitate more accurate and timely decision making for children and families

The review will also examine to what extent the arrangements link to other strategic partnership work happening locally to support children and families. This will include other public boards, including Health and Wellbeing Boards, Safeguarding Adults Boards, Channel Panels, Improvement Boards and Community Safety Partnerships.

This will cover to what extent the lead representative from each of the three safeguarding partners plays an active role, as well as the extent to which all three safeguarding partners have equal and joint responsibility for local safeguarding arrangements.

Process/methodology of review

The review methodology was developed and undertaken as a tool for understanding strengths and areas for improvement in the way the Enfield Safeguarding Children Partnership (ESCP) works together to safeguard and promote the welfare of children in the local area. A team from RedQuadrant undertook the review. RedQuadrant provided three independent scrutineers with experience and backgrounds within Children's Services, Police and Health and who have also worked in multi-agency safeguarding partnership settings. To undertake the review, a comprehensive list of documents and policies from the Partnership was provided. The team of independent scrutineers met with a range of partners /practitioners, individually and in focus groups, to ascertain a range of views from partner agencies on the impact of the Partnership arrangements.

[1] The focus of the review and questioning in the meetings was based on some key areas:

- The three core partner leads are actively involved in strategic planning and implementation
- The wider safeguarding partners (including relevant agencies) are actively involved in safeguarding children
- Children, young people, and families are aware of and involved with plans for safeguarding children
- Appropriate quality assurance procedures are in place for data collection, audit and information sharing
- There is a process for identifying and investigating learning from local and national case reviews

[1] Taken from Six Steps for Independent Scrutiny: Safeguarding children arrangements. Institute of Applied Social Research, University of Bedfordshire) Pearce, J (2019) Six steps to independent scrutiny

- There is an active program of multi-agency safeguarding children training

We would particularly like to thank the ESCP Business Unit, and in particular, Bharat Ayer, Chloe Pettigrew and Licia Sinnott, for the organisation of the review, supplying the documents requested and setting up the meetings with key individuals and then rearranging the meetings at short notice. We would also like to thank all the staff who have taken part, for their thoughtful and frank evaluation of the current Partnership, ideas and suggestions for improvements.

Findings

Implementation/ agency engagement

The new Partnership arrangements built on a strong history of collaborative partnership working, with positive comments that multi-agency working had improved as people have worked together to manage the challenges to safeguarding children brought on by the pandemic. The membership of the Executive and chairing of the subgroups aims to be balanced across the partner agencies with equal commitment and contribution to the safeguarding and welfare of children and young people within Enfield

The consensus in the review of the current safeguarding partnership is one of an improvement on the safeguarding board model. Particularly important is having the leadership forum membership from a core group of key senior and strategic leaders from police, local authority and health who have a shared vision for safeguarding, accepting of challenge and committed to improving the lives of all children in Enfield. This forum has strong leadership and is more balanced in agency response, providing for more challenge and open discussion, with potential for more equality and balance in the sharing of safeguarding responsibilities.

Leadership Strategic planning/Priority areas

During the pandemic, the Executive meeting was sighted on immediate challenges and high-level issues. This was good practice and enabled partners to understand each other's pressures.

Within the Annual Report, the priorities for the ESCP are set out, alongside those of the Safeguarding Adult Board. There are a number of priorities focused on practice. However, from looking at the priorities, and the Executive minutes, the strategic priorities are not clear. It might be useful for the Executive to identify three strategic priorities.

In 2022, there has been a change to the chairing and scrutiny approach for the ESCP. The Independent Chair/Scrutineer has stepped down and the three strategic partners have agreed to each take on chairing for a year. The risks to this are when there have been changes to the individuals in key roles. This should be confirmed at top level for each partner to ensure that this is maintained.

From an ICB perspective, there is an acknowledgement that chairing will be provided at some point for the ESCP executive, and there is now capacity for the ICB chairing for a subgroup. There are good relationships across the ESCP at a strategic level and this can also be seen at the frontline. To quote a safeguarding lead:

"In Enfield, challenge is looked at as positive"

Throughout the conversations held there was a definite sense of there being no blocks at any level to find a solution to any professional disagreements. People know who to talk to in other agencies and can resolve issues.

The Practice Improvement Group was well understood and valued. This seemed to be viewed by the scrutineers as the engine room for the ESCP, along with the business team. In regard to the Executive and who the three statutory partners are, this did not come across as strongly which suggests that there needs to be more visibility of the strategic leaders, e.g., via newsletters,

The Alan Wood's report[2] queries the seniority of partners involved in multi-agency safeguarding arrangements and the delegated authority for leading and representation on the Partnership. The Chief Executive Officer of the council, Borough Commander for Police and the Chief Executive Officer of the ICB do not attend, but these are the Chief Officers responsible for the Partnership. It is important that there are mechanisms in place to ensure that they are kept informed of and held to account for safeguarding children in Enfield through the Partnership arrangements.

Engagement by the Health system

There has been a major transformation across health which has led to the CCGs being replaced by the Integrated Care Board (ICB), overseeing the Integrated Care System. There was evidence that other partners and agencies were aware of the ICB.

From the review of the minutes of the Executive, there has been inconsistent attendance by health members. This is due to movement of key individuals from the CCG/ICB and providers.

The ICB now has its safeguarding structures in place. The Chief Nurse for the NCL ICB has executive responsibility for safeguarding and delegates this responsibility to the interim Director for Quality. There is a substantive Designated Nurse for Safeguarding Children in place along with an interim Designated Doctor and substantive Named GP.

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2 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/526329/Alan_Wood_review.pdf

The Director of Quality covers NCL and attends all LSCPs and Safeguarding Adult Boards. This enables her to have a helicopter view of NCL and is a key opportunity for LSCPs and SABs to highlight any issues or inequalities between boroughs.

The ICB is working to change the face of safeguarding by bringing together leads across NCL. The plan is to gain consistency across the ICB but to also ensure there is borough (place) leadership as well. This work has identified the inequalities of some services between NCL boroughs. The outcome has been for additional services to be provided in Enfield.

The Designated Nurse, who has been in post since April 2022, attends the Executive and the subgroups. Since the pandemic a partnerships meeting has commenced involving the three strategic partners, plus education. The meetings commenced on a weekly basis and are now held monthly. The group feeds into the Practice Improvement Group. This group is valued by the ICB as it has enabled discussion about critical issues. For example, the group has considered Child Protection Medical Examinations which has led to social worker training to support referrals for medicals.

The Designated Doctor leads on CPMEs and has delivered the training for social workers which has improved the quality of referrals for CPMEs. This will be followed by a learning event to consider bruising which has arisen from the physical abuse audit. There does need to be LSCP awareness that the paediatric capacity for CPMEs is extremely challenged in Enfield. This should be addressed by the ICB to ensure that the Enfield service is equitable to those in other NCL boroughs.

The ICB has established a Complex Children commissioning team. Although the Assistant Director is not a member of the ESCP, she works closely with the ICB safeguarding team. The commissioning team links with the Local Authority, which enables joint funding for placements for children. The work aims to support the LA in finding placements for complex children, to act to limit delayed discharges from hospitals affected by behavioural and social issues.

There are good links between the CDOP and the Local Maternity and Neonatal system to enable learning from deaths.

The health focus group was limited in size and breadth of participants due to the Queen's death prompting a need to change the date at the last minute. Two provider safeguarding leads participated. They were able to describe the learning from cases arising from the LSCP work and the good response to case issues. They explained how the frontline teams have been involved in multi-agency audits. This is seen as a constructive experience, with team champions undertaking the research for the audit of cases within their teams and facilitates immediate learning.

GPs in Enfield are involved in the multi-agency audits. There is an active safeguarding forum which has had contribution from the independent reviewer and CSC. However, there are increasing pressures on GPs nationally. This needs to be noted by the ESCP in its role of

‘taking the temperature of the system’, and how that impacts on GP capacity to have sight of children in Enfield.

From an ICB perspective, the priorities for safeguarding children's priorities are serious youth violence, contextual safeguarding, the economic climate and how to ask the questions needed to enable practitioners to be effectively professionally curious.

Engagement of Police

The Met Police at a strategic level is showing good commitment to the Partnership by their chairing of the Executive Board. This is not just seen by them as a chairing of a meeting but as supporting the children safeguarding partnership in a leadership role. They also chair the Insights sub-group. The chair has also had a meeting with the safeguarding ambassadors and although this was in his capacity as a local police senior officer it was also importantly in his role as the chair of the safeguarding children’s partnership executive board.

Other strategic police leaders also engage well with the partnership, in particular through the work of the partnership in examining activity for vulnerable adolescents and young people. This is best demonstrated through the SAFE and MACE meeting structures that are reported in the Vulnerable Adolescent sub-group.

Their Met police budget contribution of 5k is readily accepted and acknowledged as too low. They supplement this by supplying for two days a week an analyst to the business unit, which is seen as a strength and welcome addition.

The commitment of the police below strategic level is seen as less consistent, and minutes of meetings often show no police in attendance and the meeting is not quorate, and this requires someone from the meeting to get someone from the police to attend at times who is different to previous attendants. There is a belief and commitment that this resource position has now stabilised and there will be a more consistent attendance at meetings going forward.

The police focus group were unaware of any of the safeguarding partnership policies, procedures and guidance. However, they were extremely well aware of the local threshold policy and felt from their point of view that it was extremely good with Enfield local authority keen to know as much as they could about their children and families. There is 100% attendance by the police at initial child protection case conferences (IPCC) and strategy discussions.

The focus group expressed an opinion of very good working relationships with not only the local authority, but also other partners, including schools and in health with the named and designated safeguarding professionals.

Engagement of Children's services

Children's services are represented on the ESCP by the DCS and the Executive Director, who has a role across both Children and Adult services, with other leaders well represented on other subgroups of the ESCP. There is stability across the Council at a senior level with the Chief Executive Officer and Executive Director having worked together for many years. Children's services are prioritised and protected in Enfield and the CEO is aware of his responsibilities and accountability and kept regularly briefed. He meets frequently with the Borough Commander and senior officers in the ICB. The Lead member in Enfield is relatively new to role, but he too is mindful of his responsibility in relation to safeguarding children. He is not currently part of the Partnership, but consideration is being given to making him a participant observer within the arrangements. Children's issues including the Annual report are reported to the council's scrutiny committee and cabinet.

One area that the Executive may want to consider following the JTAI in Solihull and the Children Practice Review Panels reports into Arthur Labinjo – Hughes and Star Hobson is to have regular reporting from the multi-agency MASH steering group. *'The leadership of the partnership did not have a strong line of sight to frontline practice. Performance information & multi-agency learning from audits were not brought together at partnership level. This was evident notably in the quality assurance of MASH arrangements.'* This needs to be accountable to the Executive for delivery and provide data on the effectiveness of the multi-agency front door arrangements, as well as capacity of agencies to undertake their role in information sharing.

Frontline social workers were not aware of the partnership and its work, all spoken to were not aware of the changes from Boards to Partnerships, the reasons and implications. One had researched the ESCP website before our meeting and was impressed with some of the information available, such as the Professional curiosity guidance and had circulated to colleagues in her team. Asked how this could be made more real for them, they would appreciate collapsing a large report (CSPR) into something they would read and could digest easily, and to provide updates for team meetings and training. All spoke generally positively about relationships with other agencies

Role of Business unit – The Business unit and the joint Board Manager were spoken of highly by all agencies involved in the review. The unit struggled during the pandemic with capacity however, since moving into the new arrangements with additional resource with the data analysis post and the independent reviewer, this has placed the partnership and business unit in a much-improved position. The appointment of the new Childrens' Business Manager will make a significant impact on the ability of the partnership to strengthen the arrangements further and to address the recommendations contained in this report.

Connections with other statutory boards

The business unit are the glue and the key communication pathway between the executive board, sub-groups and other task and finish groups. However, communication could be improved between the work of the executive board, the sub-group chairs and also the attendees of each of the meetings to help with the development of a more cohesive leadership at the various different levels of the Enfield Safeguarding Children Partnership.

The Safeguarding Adult Board and Children Partnership are closely linked through the joint business unit and some joint sub-groups. Safer, Stronger Enfield (CSP) are also closely linked through the joint work of the Enfield MACE and SAFE meetings and processes. There is an equally close link with the local Youth Justice Board and this is further cemented by the SAB independent chair also chairing the LYJB.

The links between the safeguarding children partnership and the Health and Wellbeing Board are less defined. Even though Enfield have tried to carry out some local cross borough safeguarding partnership discussions, due to no fault of their own, except for Barnet, other children's partnerships have yet to commit to this. Enfield are part of The Association of Safeguarding Partners (TASP) and are ready participants in all the networking, resources, materials and webinars they have to offer.

Subgroups

The Practice Improvement Group - The Practice Improvement (PI) Group leads on multiple areas of safeguarding business for the partnership i) Safeguarding Adults Reviews ii) the work of overseeing local child safeguarding practice reviews, learning from national reviews, and translating these findings into system improvements which can include updating policies and organising training. iii) The group will also be responsible for analysing children's multi-agency audits to make sure that learning has been embedded and ensure the effectiveness of existing policies or practices. iv) Ensuring that policies and protocols for Adults and Child safeguarding are up-to-date and that they are reviewed regularly.

The PI used to meet six weekly but now meets by mutual agreement eight weekly and the membership, including the three statutory partners, is quite broad from across the Partnership. A review of the recent (last three) minutes of the meetings shows good attendance by different agencies. There has been a lack of attendance at the beginning of meetings and consistency of police attendees at the meetings. The meetings are well chaired and agenda items are concluded and resolved. There is clear evidence and acknowledgement that the business unit skilfully manages the agenda extremely well.

Although the minutes of the meetings demonstrate discussion and occasional challenge this is not recorded on a regular basis and raises the question that the extensive business that each meeting has to navigate does not allow adequate time for meaningful challenge and scrutiny. The chair of the sub-group when interviewed, although understanding why this

view could rightly be made, felt that mostly, but not always, adequate discussion and challenge did take place and were maybe just not recorded as such in the minutes.

In terms of CSPRs, with the chair of the PI sub-group being an adult specialist, it is felt by this scrutineer that he brings an independence to the process. It is, however, felt that the management of CSPRs, and in particular the implementation and monitoring of recommendations from rapid reviews and the reviews, would benefit from a separate meeting structure.

There needs to be a mechanism in place to ensure that the learning and the recommendations from SCRs and case practice reviews have been fully implemented and embedded into practice. This could, and should, still report to the PI group but for practice improvement purposes only, and to the executive board for sign off by them before publication. There also needs to be consideration about whether the PI group has the capacity to address this considerable workload and whether it is achievable.

Vulnerable Young People Sub-Group -This sub-group is a really good initiative for Enfield and seen by the partnership as one of their priority groups.

The Vulnerable Young People sub -group role is to provide oversight of Enfield's response to a number of different critical safeguarding concerns that specifically involve their young people. For example: i) Missing Children, at a recent meeting of the group there was a challenge and then drive for this to include those children missing from education. ii) Child Sexual Exploitation. iii) Child Criminal Exploitation. iii) Children privately fostered (this is any age and not restricted to young people). iv) Children that have been Trafficked and Modern Slavery. v) FGM (this is also any age). vi) Children involved with gangs (this encapsulates serious youth violence). vii Domestic Abuse (this is only for those young people who are aged between 16-18 and are victims fitting the legal definition of Domestic Abuse.

Although this is an extensive agenda it is felt by this independent scrutiny that there is a gap within these critical safeguarding concerns, which is those young people experiencing extreme effects on their emotional wellbeing and self-harming. This would include those displaying overt signs of suicide ideation. CDOP and other groups, for example, the PI are looking at learning from those children that take their own lives, but it would fit to have young people's emotional wellbeing within this VYP sub-group included.

Within Enfield there are a number of other key specific groups that focus on different areas of the work of this sub-group. In particular the SAFE and MACE panels and the Safer Stronger Communities Board in Enfield. The sub-group is very clear that they don't want to duplicate the work of these other partnerships groups and their role at the VYP is to maintain a strategic overview of the work of these groups and where needed challenge quality of services provided to Enfield's young people. The analysis of the minutes and

discussions with the current chair would support the view that very little duplication takes place within the meeting structure. What is less evident is what impact the VYP sub-group has on the work of the other groups and any influence on commissioning opportunities for young people. It is though fully accepted and a real strength that due to attendees at the meeting that a number of the different groups work is fully intertwined. A number of the other groups are co-chaired by members of the VYP sub-group.

The attendees at the meeting are the right people to be at the meetings. They are very knowledgeable and passionate about the business. Meaningful challenge is seen in the meetings, for example, the discussions in relation to the SYV performance report provided to the meeting, and the police decision to reduce the numbers in their exploitation teams.

There is shortly to be a safeguarding adolescent and well -being practice week taking place in Enfield, which is seen as good practice.

The sub-group meets quarterly, the challenge asked by this scrutiny visit is, is this sufficient to meet the needs of an extensive area of partnership working.

A completed holistic Enfield Adolescent Strategy that encompasses all the work of the sub-group and associated group is being developed but should be prioritised and not just be focussed solely on exploitation (Waltham Forrest have an excellent example of this.)

Safeguarding Community Engagement Group

The Safeguarding Community Engagement (SCE) activity group has a two lay member who act as chair and deputy chair, which gives a clear independent voice to members of the community into both the Children's Partnership as well as the Adults Board. The lay members felt supported to contribute to the partnership, particularly by the Board Manager and felt that they were given the freedom and support to challenge agencies.

The purpose of the Safeguarding Community Engagement group is to engage local organisations with community champions or networks, offering them safeguarding partnership training on specific areas of risk. The SCE Group is also able to highlight areas that need to be monitored or explored further to the Safeguarding Adults Board, or the Safeguarding Children's Partnership. They also provide oversight of the Safeguarding Ambassador programme and scrutinise and contribute to newsletters, website, annual reports and strategies.

As stated below in the engagement section, this group's activities and reach could be enhanced with greater links into faith and church groups, to ensure wider participation. It is understood there is also a plan to recruit more lay members, which will strengthen the voice of different parts of the community within this subgroup.

The Insight Activity group is a newly develop group led by the police with a particular focus on responding nimbly to emerging needs from the community and measuring the impact of the effectiveness of the partnership arrangements. The Insights Activity Group is responsible for developing horizon scanning intelligence to identify current and future risks to the effectiveness of the Safeguarding Children Partnership arrangements. With the support of the data analyst funded by the police and shared with Haringey, the plan is to develop analysis products to enable the Safeguarding Children Partnership to meet the Working Together 2018 (WT2018) requirement to:

"Support and enable local organisations and agencies to work together in a system where there is early identification and analysis of new safeguarding issues and emerging threats"

It is recognised by this group that it needs to do more to measure the impact and outcomes of multi-agency work, both for practitioners and children and young people in Enfield. The groundwork for this has been laid, with the data and analysis being provided by the police, which has added considerably value to this group, but this work needs to be further developed, including bringing together multi-agency service user feedback. The Chair of this group has laid the foundations for this by meeting with the Young Ambassadors group.

The Executive group needs to be clear on its priority areas and set clear delivery targets that can be measured against by this Insight group. There are safeguarding proxy measures/ performance indicators that could be supplied by agencies, which allows the Partnership to both challenge practice but can also provide assurance against delivery. The ESCP needs to be clear what partnership data it requires and for what purpose so that partners can provide it, although there may be some difficulties breaking down some data into place specific data from Police and health. The Group requires agencies to share client level data, where vulnerabilities exist, and emerging threats but it unclear whether this is being received from all agencies, so that the group can evidence impact and respond to emerging risks. The meeting minutes viewed have analysis and focus on VAWG, including Domestic violence highlighting the top 20 call outs; forced marriage; exploitation hotspots; child protection plans and sexual assaults in schools and colleges.

This group has huge potential for making a significant difference in safeguarding children and adults in Enfield, if it can harness the data needed and focus the practice of agencies on the areas identified to address emerging safeguarding needs.

Child Safeguarding Practice Reviews

Working Together, 2018 states: *'Locally, safeguarding partners must make arrangements to identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area. They must commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken.'*

To meet the requirements of this section of Working Together 2018 and as part of their multi-agency safeguarding arrangements, Enfield Safeguarding Children Partnership places the primary responsibility for the CSPRs and their associated processes in their Practice Improvement Activity sub-group. There are also Child Safeguarding Practice Review (CSPR) panels and task and finish groups that take place as required as well as the Rapid Review process and their associated meetings. The Executive Board is used as the meeting for final sign off of the reviews before publication.

There have been two reviews published in the last few months with a third completed and awaiting sign off by the Executive Board, this is due to be published in the next few weeks. Both of the published reviews, Andre and Josef, were independently authored. They led to actions being completed and positive action taken by the partnership, for example, a missing persons coordinator put in place and other activity relating to contextual safeguarding and professional curiosity resulted. Partnership learning workshop have been held and extremely well attended.

The review that is soon to be published was also independently authored and supported by a specialist subject matter expert as an advisor to the review showing good practice. The author commented that they felt that the rapid review was very through. This rapid review has been examined by Red Quadrant and agrees with the author that the rapid review was thorough and helped to shape not just the report but immediate learning that needed to be actioned. The use of the local independent reviewer in these and other cases is seen throughout and demonstrates independent scrutiny.

Good practice is shown by the Practice Improvement Group who are also looking at learning for Enfield from other Local, London and National based reviews. A good example of this is the setting up of the Child Q task and finish group. This has helped the Enfield partnership to examine how they and their frontline practitioners deal with race in practice. After analysing the national review into the deaths of Arthur Labinjo-Hughes and Star Hobson, this prompted the partnership to make an immediate change to their multi-agency audit programme to examine child physical abuse.

Further good practice is shown by the close integration of the work of the Child Death Overview Panel into not just the CSPR process but also the work of the practice improvement group. A good example is the desktop review in relation to the death by

suicide of a young person. There was a lot of multi-agency learning arising from this review and a number of themes that the group will now take forward.

There needs to be a mechanism in place to ensure that the learning and the recommendations from SCRs and case practice reviews have been fully implemented and embedded into practice.

Quality assurance/ data and audit

How does the Partnership know how effectively the partners are working together to safeguard children, and how do you measure the impact of the Partnership? As there is no independent scrutineer role within the Partnership, there needs to effective, respectful challenge from partners of each other's performance. There also need to be the mechanisms and processes in place so that the three key Partners have the necessary evidence to inform this challenge.

The addition of the Independent Reviewer to the capacity of the Business unit has added value to the area of quality assurance for the ESCP. She has taken ownership of developing the multi-agency audit programme for the partnership. The recent multi-agency audits undertaken have raised areas for improvement. There was evidence of actions being taken to address this such as good guidance on professional curiosity. There have been 7-minute briefings to cascade learning from these activities, which are a good way of briefly disseminating learning. However, it was disappointing that some practitioners spoken to as part of the review did not know about these. The co-ordination of learning and improvement work following reviews, audits and serious incidents appeared reliant on emails and not enough dialogue about issues and progress.

The physical abuse audit has been completed but has not yet been presented and signed off by the Executive group. It is understood themes such as absence of training for joint s47 investigations, requirements about visiting including seeing children at home and use of interpreters arose. However there appears insufficient audit activity/evidence prior to these two Multi agency audits, especially during the pandemic, to offer assurance on multiagency practice mainly due to capacity. It is acknowledged that the last s11 and s175 audit was undertaken in 2020 and that plans are in place to address this now.

There needs to be a focus on reflective practice and work with children, taking the learning from reviews and audits, cascading this, systematically embedding it and being clear about what difference has been made as a result. There is a draft Learning and Improvement Framework which if adopted would provide a process for evidenced and effective quality assurance arrangements. The new Children's Business manager post should help coordinate and support the activity of the independent reviewer to strengthen quality assurance processes in the partnership

There is an agreed audit schedule, but this does not include re-audits of priority areas or to evidence improvements if the audit has found areas of concern. To further strengthen these arrangements, consideration could be given to the PI group also receiving single agency audits from partner agencies, which have been undertaken on safeguarding areas of work in agencies. It is also worth considering developing different types of audit mechanisms, quality conversations or using questionnaires of frontline staff using Survey Monkey or similar, to ascertain their knowledge and confidence in using newly implemented policy or strategies, for example. Finally, the Partnership could consider a more interactive process for s11/ S175, which could be run alternating with the current strategic process. This process would allow a greater insight into frontline staff's understanding of their safeguarding responsibilities and whether these are understood; it could also provide challenge to the partners' strategic/operational understanding.

Where possible children and young people and their families should be involved in multi-agency audits to ensure that there is feedback from service users. Audits should also involve frontline practitioner to improve their learning and engagement.

Engagement/Participation

There is a newsletter which is for both safeguarding children and adults. It is aimed at professionals. It includes learning from LSCPRs, training, changes to policy/procedures both in Enfield and for the London Procedures. It explains the changes to the chairing of the LSCP and what to do if concerned. It is 2 pages. The ESCP might want to consider whether a separate, one page newsletter, would be of use specifically for those working with children and families. It would also be of benefit to highlight the dates of training sessions. The newsletter is aimed at professionals and so it might be worth thinking about how to promote the work of the ESCP across communities and with children too. There are plans in place to update the website and make this more user friendly. Feedback from focus groups shows there is more to be done to raise awareness amongst frontline line staff of the ESCP, what it offers in terms of training opportunities, practice guidance and more importantly, learning from reviews and multiagency audits.

Wider engagement is undertaken by the Safeguarding Community Engagement Group. Lay members who chair this group, provide an independent community voice to the work on the ESCP and the SAB. This is seen as a strength and provides a voice from within the community. Wider engagement of faith groups and recruiting more lay members to this group would be beneficial and would give a broader perspective.

A real innovative project has been the recruitment of young people to become Safeguarding Ambassadors. This is the second cohort of young people recruited and trained through a youth worker and ESCP business to represent the views of young people in Enfield about safeguarding matters. The young people are provided with training to help them undertake this role and meet weekly. They have recently co- produced their work plan to take place

with the Partnership, agreeing to divide their focus into 4 workstreams, taking the lead on health, law enforcement, social care and education. They have created learning tools for children and young people and police, teachers and other professionals, as well as engaging with the Chair of the ESCP and entering in discussion about how it feels being a young person in Enfield. This is being broadened to a wider group of officers on the BCU. Further ideas from the young people are about how they can expand the voice of children and young people, possibly through questionnaires or suggestion boxes in schools. They would also appreciate more direct feedback and impact of their work, 'we said, you did'.

The Safeguarding ambassadors are a real strength and helps provide a perspective from young people as part of the scrutiny of the effectiveness of the Partnership and how well agencies work together.

Wider partnership engagement including schools

How the partnerships work with schools and education has improved within Enfield, but this has been relatively recent. Your own assessment was that the ESCP needs better links into secondary, primary and special school headteachers' forums. Further work is also needed to ensure that each of these school forums are represented in the Safeguarding Children Partnership activity groups.

Systematic dialogue about risks to children and young people between schools, colleges and the Safeguarding Children Partnership was not taking place; noting that schools and colleges have their own assessments of risks and these need to be integrated into the work of the partnership's Insights, and Practice Improvement activity areas. This is now being addressed through the attendance of Education colleagues at the Insights and Practice Improvement meeting and more regular partnership events.

Safeguarding Children Partnership business unit and activity groups were not connected to forums where schools were meetings. This is being addressed through attendance at Designated Safeguarding Leads meetings and Headteacher briefings, but the partnership acknowledges there is more work to be done to create links between activity groups and headteacher forums.

Schools and colleges were not identified as a safeguarding partner in Working Together 2018 but recent reviews including Josh McAlister's Independent Review of Children's Social Care and the Child Practice Review Panel's report into the death of Arthur and Star are recommending that schools should be recognised as the 'fourth partner'. The Director of Education was invited to be a part of the Executive group from April 2022. There has been a general recognition that the wider safeguarding agenda for schools needed additional capacity and a new safeguarding lead post was recruited to and appointed a former headteacher into the role. This member of staff has a significant workload but has made considerable progress. She is well known by schools, who appreciate her input. She has been instrumental in setting up a Designated safeguarding leads (DSL) group in Enfield

which works with schools and other partner agencies to highlight emerging safeguarding themes and disseminate practice guidance. The Executive Director also meets regularly with schools through Headteacher forums.

Schools spoken to as part of this review, talked about some initiatives such as being invited to shadow MASH which gave them a better understanding of the work of children's services. Schools would welcome more opportunities to be part of the partnership and have a voice about safeguarding issues ie safer schools officers, sharing information through Operation Encompass and working with children's services. Examples were given about a project through the PRU, which resulted in an attached SW and SALT post, which has enhanced the response and support to children and families who attend. Schools feel that their voice on occasions is not heard and gave examples where they have struggled to escalate concerns, especially where families have chosen to educate their child at home (EHE) where there are safeguarding concerns.

There does not appear to be a formal structure about involving and ensuring that frontline practitioners/schools know and understand the work of the Partnership and can offer a feedback loop between the strategic and operational levels. Frontline staff's understanding of the partnership was limited.

Annual Report

The draft annual report 2021-2022 is a joint one with the Safeguarding Adult Board. This report is extremely long and although covers adequately the statutory requirements of an annual report it would be more useful for professionals and those recipients of the report, for example council and H&WB board scrutiny committees, if it was separated into two different reports, one for children and one for adults. Previous reports have had a summary report published on the website which makes for easier reading. The Engagement group also provide suggestions for making it easier to read. The most recent draft covers learning from rapid reviews as well as published CSPRs; it is essential it covers this as there is no other externally facing record of this learning.

Working Together 2018 requires the Safeguarding partners to agree arrangements for Independent Scrutiny of the report they must publish at least once a year. As part of the RedQuadrant scrutiny it is suggested that a short precise of the work undertaken be added including an assurance statement.

Budget

'The safeguarding partners should agree the level of funding secured from each partner, which should be equitable and proportionate, and with each relevant agency, to support the local arrangements to safeguard and promote the welfare of children in their area. The funding should be transparent to children and families in the area and sufficient to cover all elements of the arrangements.' (Working Together 2018)

In the Multi-Agency Arrangements published in 2019, it was noted that the local partner contributions would remain the same for, at least, 2019/20. This showed the funding was mainly from the Local Authority and NHS.

Local Authority £48,000 NHS (CCG, BEMH, NMUH, RF) £45,600 Police £5000 Probation/CRC £2000 LFB £500 Cafcass £500 Total £101,600

This does not appear to include the Local Authority funding for the business team which provide crucial support and direction for the Partnership.

The expectation was that the three safeguarding partners would support and facilitate the work of the Activity areas where they were the lead, with the Chair being accountable to the Executive Group. The Executive Group will be responsible for making sure the Activity groups have people with the correct skillset attending, and for delegating appropriate authority to the Chairperson of these groups to direct and lead the work. The work of these arrangements, alongside the work of the Safeguarding Adults Board, will be co-ordinated by a Safeguarding Partnerships Team.

In reality, it has not been possible for increased funding by the three statutory partners. This has the risk of the ESCP not being an equal partnership, with the LA holding the financial burden. However, this has, in part been overcome, by the positive contribution by police and the Integrated Care Board to fund key roles supporting the partnership, i.e., an independent reviewer and data analyst. To ensure 'corporate memory' for the basis of these roles, it would be useful to include the funding of posts, or teams, within the budget statement. This can demonstrate how the three partners are committing to their accountability for the ESCP.

Scrutiny

Working Together 2018 provides a permissive approach to how scrutiny is undertaken with minimal guidance. While this offers scope for local autonomy, it also means that there is no agreed common process against which evidence of what constitutes 'good' scrutiny can be compared. The ESCP has arranged for annual independent scrutiny to take place in the form of an annual visit from RedQuadrant following the previous Independent chair stepping down. The use of RedQuadrant and request for three scrutineers with a background in each of the statutory partner's disciplines has been commissioned to undertake a Safeguarding review of the Partnership arrangements.

The goals set out for the independent scrutiny were to comprehensively review the activities of ESCP, to ensure statutory duties are being met and to identify areas for further development going forward. This report outlines that this has taken place. However, we are unsure that an annual visit is sufficient to provide a level of ongoing scrutiny for the ESCP. In the current arrangements, it is not clear who holds the safeguarding partners to account, including the Lead member for the local authority. We have been asked to provide options for developing scrutiny further for the ESCP.

A recent piece of research commissioned by The Association of Safeguarding Partnerships (TASP) , the Policing's Vulnerability Knowledge and Practice Programme (VKPP) and the Safer Young Lives Research Centre at the University of Bedfordshire undertook a consultation on Independent Scrutiny.[3] This shows there are many models of scrutiny nationally . Many Safeguarding Partnerships have retained an Independent chair(IC) , who plays a joint role, providing challenge as well as chairing and acting in a leadership capacity - 59% of LSCPs have IC, 90% of these have scrutiny responsibilities . 67% of 100 LSCPs employ Independent Scrutineers with just over three quarters of these employing one Scrutineer. 33% said they do not employ Independent Scrutineers. The majority of this 33% have Independent Chairs undertaking scrutiny and three LSCPs have Scrutiny Committees.

There are a number of options open to the ESCP to consider. One of the major considerations will be budget constraints. There are three suggestions as a way forward outlined below.

1) There is already some independent scrutiny offered through the independent reviewer in her role undertaking multiagency audits, however she does not have the remit to offer challenge to the ESCP about actions taken and follow through. There could also be a conflict of interests if she is required to undertakes a review of a case, as part of the scrutineer's role is to have an oversight of cases where learning reviews are being undertaken. It could be possible to relook at her remit to cover this, but she would not then be able to write reviews as she cannot 'mark her own homework'. There have been situations of professional disagreement on notification, and you need someone independent and with sufficient seniority to be able to cut across this.
2) Scrutiny arrangements could be enhanced by making use of regular touch base visits and/or commissioning scrutiny to assist with a deep dive or other thematic work throughout a yearly business cycle.
3) The other option to consider is to re- employ an independent chair who could undertake scrutiny as part of their role. Some Partnerships have returned to this

[3] Independent Scrutiny and Local Safeguarding Children Partnership Arrangements – August 2022 javascript:__doPostBack('ctl01$TemplateBody$WebPartManager1$gwpciFullReportIndependentScrutinyandLocalSafeguardingChildrenPartnershipArrangements2022$ciFullReportIndependentScrutinyandLocalSafeguardingChildrenPartnershipArrangements2022$FileLink','')

model acknowledging that the three key partners have 'day jobs' as well as leading the partnership.

Threshold document/information sharing

A requirement for all LSCPs is to have a threshold document that is signed off and agreed by the local partnership. The threshold document for the ESCP has been reviewed and updated and is due to be signed off by the ESCP Executive. The London Continuum of Need is also being agreed and updated as part of the pan- London Safeguarding Procedures and it was suggested to delay publication to include this new version.

The current thresholds document is well known within the specialist police teams and the health system. Community teams use the documents regularly, including in every supervision session. Mental health teams use the document to support any escalation of concern.

The sharing of information and working together message could be strengthened through shared training and for the frontline staff to have more of a voice on the Partnership.

Multi-agency training

Multi-agency training is valued by relevant agencies, but it was reported that this has been cut due to budget constraints. An additional challenge is that some agencies are too stretched to enable staff to attend. However, the local learning events following reviews are considered to be useful.

The multi-agency training is the level 3 and priority areas such as Forced Marriage and Female Genital Mutilation.

There is good work with EYCPS delivering basic and level 1 training to a range of voluntary organisations. This should be seen as a benefit for the LSCP as it means that there is access to voluntary, faith groups and communities. This enables a targeted approach to engagement directly with the groups and through social media.

However, one area highlighted where there seems to have been a reduction in funding is that of training. The training programme shows that attendance has been extremely, limited. This shows that there needs to be a different way of working in relation to multi-agency training. Some agencies and services cover other boroughs. The LSCP could link with other partnerships across NCL, or pan London, to spread the cost of training, as well as looking at online or webinars to address this.

Multi-Agency Training is not well attended by police officers. It is reported that there were eight attendances in the last year and very little attendance at any of the workshops. There are many reasons for this, in particular the level of resourcing is below established levels that would allow regular attendance. This coupled with officers having to attend Met specific and role specific training, for example, the SCAIDP training impact greatly on any

spare officer capacity to attend multi-agency safeguarding training. Although not part of the partnership multi-agency training programme a Detective Inspector organised some local training that some Social Workers also attended. This sort of training could be more formalised as awareness training amongst the partnership and should be encouraged.

It would be good if the training offer could also provide better evidence of impact and evaluation of multi-agency training. In terms of the multi-agency training programme, there is no evidence of the impact on improvements to safeguarding practice in Enfield. It would be of benefit for the ESCP to consider how this can be done.

Conclusion

We can confirm that the Multi-agency Safeguarding Arrangements for Enfield Safeguarding Children Partnership are compliant with Working Together, 2018. The arrangements ensure that children in Enfield are safeguarded, and their welfare promoted. There appears to have been a smooth transition to the new arrangements in the last year, embedding these and engaging partners through the new structure, putting in place good foundations. The review found that the new arrangements are not just a re-badge of the previous safeguarding children board. All three of the statutory partners are committed to the shared vision and workplan, including providing support and commitment throughout all the groups and subgroups. Subgroups were well attended with the right representation at the right level. There is good sharing of information at the strategic level and in links with other partners. Children and young people are given the opportunity to have their voices heard, and their views are listened to.

There is an individual willingness to work to effective inter-agency communication – despite the challenges of the pandemic, diminishing resources and ever-changing landscapes across the Partnership. The Partnership is able to build on a history of strong collaborative arrangements at a strategic level, but it is acknowledged that there is more to do to ensure that this is embedded throughout all agencies with safeguarding responsibilities and at every level of organisations.

Recommendations

- It is important that there are mechanisms in place to ensure that senior leadership are kept informed and held to account for safeguarding children in Enfield through the Partnership arrangements.
- The Executive board to agree 3 clear strategic priorities
- Raise ESCP awareness that the paediatric capacity for CPMEs is extremely challenged in Enfield. This should be addressed by the ICB to ensure that the Enfield service is equitable to those in other NCL boroughs.

- There needs to be a mechanism in place to ensure that the learning and the recommendations from CSPRs and practice reviews have been fully implemented and embedded into practice.
- Strengthen quality assurance mechanisms by adopting and implementing fully the Learning Improvement framework, especially focusing on audits.
- For multi-agency MASH arrangements to be reported regularly to the Executive Board
- Review adequacy of arrangements for scrutiny of the partnership.
- The multi-agency training programme to evidence impact on improvements to safeguarding practice in Enfield.