
# ISCB Annual Report

## 1st April 2018 – 31 August 2019

Independent Chair
Alan Caton OBE

# Letter from the chair

**I am pleased to present the Islington Safeguarding Children Board (ISCB) Annual Report covering the period 1st April 2018 to 31 August 2019.**

This report sets out the work of the Board and its understanding of the effectiveness of safeguarding arrangements across Islington. The report also aims to give those people who live and work in Islington a greater understanding of the way agencies work together and individually to keep children safe from harm and abuse.

The period covered in this report was again challenging for all of the partner agencies who continue to work in an environment characterised by fewer resources and increased demand.

This has ultimately led to a reduction in capacity and resources in key safeguarding areas such as sexual health, mental health, school nursing services and specialist police child protection officers. This can lead to children experiencing delays in accessing services and support. The Board continues to monitor the impact of this reduced capacity and is scrutinising the agencies responses and planning to respond to increased demand.

Having said that, this report provides evidence of the commitment and determination amongst agencies and professionals to keep all of Islington's children safe.

It was during this period that Islington's safeguarding arrangements were subject to external scrutiny by Ofsted when they and their partner inspectorates conducted a joint targeted area inspection (JTAI) of the multi-agency response to sexual abuse in the family in Islington. The inspectors' findings highlighted that;

'….partners have good engagement with the Board. Their consistent attendance and ownership of the work of the Board's sub groups demonstrates a shared responsibility to improving outcomes for children and help agencies to hold each other to account'.

'ISCB Partners have created a learning environment with constructive challenge that drives continuous improvement in operational practice'.

July 2018 saw the publication of *Working Together 2018* in response to the *Children and Social Work Act 2017*. This act introduces significant changes to safeguarding arrangements. The Board and its partners have worked well together to develop new multi-agency safeguarding arrangements which will replace the Local Safeguarding Children Board on 1 September 2019.

Included at the rear of this report there are a number of key messages for all partner agencies and strategic partners. These messages are to ensure that safeguarding

and protecting children in Islington remains a priority for all.

Finally, may I take this opportunity to thank on behalf of ISCB all of the organisations and individuals in the public, voluntary and private sectors who work tirelessly across Islington to improve the safety and quality of life of our children and young people.

I commend this report to you and invite you to feedback your thoughts on how we can continue to develop and improve in order to keep all of Islington's children safe.

**Alan Caton OBE**
**Independent Chair**
**Islington Safeguarding Children Board**

# Introduction

## PURPOSE OF THIS REPORT

**Legislation [1] requires Local Safeguarding Children Boards (LSCBs / the Board) to ensure that local children are safe, and that agencies work together to promote children's welfare. The Board has a statutory duty[2] to prepare an annual report on its findings of safeguarding arrangements in its area:**

*"The chair of the LSCB must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area.*

*The annual report should be published in relation to the preceding financial year and should fit with local agencies' planning, commissioning, and budget cycles."*

## AUDIENCE OF THIS REPORT

The report should be submitted to *the Chief Executive Officer* of the Local Authority, the *Leader of the Council*, the *Local Police and Crime Commissioner* and the *Chair of the Health and Wellbeing Board (H&WBB)* to:

- note its findings and,
- inform the Independent Chair of actions they intend to take in relation to those findings.

## REMIT OF THIS REPORT

This report follows the *ISCB Annual Report 2017/18*[3] and covers the period from 1st April 2018 to 31 August 2019.

## METHODOLOGY

In writing this report, contributions were sought directly from board members, chairs of sub-groups and other relevant partnerships.

The report drew heavily on numerous monitoring reports presented to The Board and its sub-groups during the year, such as Local Authority Designated Officer (LADO) Report, Private Fostering Report and Corporate Parenting Board report.

## PUBLICATION

The report will be published as an electronic document on The Board's website.

[1] Children Act 2004

[2] Apprenticeships, Skill, Children and Learning Act 2009

[3] http://www.islingtonscb.org.uk/Pages/default.aspx

## DEMOGRAPHICS

**London Borough of Islington has a population of about 241 600 which is estimated to increase by 10% in 2039. Islington is the second smallest authority in London (after the City of London), but has the highest population density.**

The population profile is on average younger than those for London are and England, with 45% being young adults aged between 20 and 39 years. There are approximately 47,900 children and young people aged 0-19 living in Islington, and around 77,000 0-25 year olds. The proportion of children from a BME background is relatively high at 66% and a significant proportion of children live in households where English is not the first language

In the 2019 Index of Multiple Deprivation (IMD), Islington was found to be the 53rd most deprived local authority in the country and 6th most deprived in London. It is the tenth most deprived based on IDACI (Income Deprivation Affecting Children Index), an improvement from being the third most deprived in the 2015 release, with 27.5% of children living in income-deprived households. 20% of Islington 0-18 year olds live in households where a parent or guardian claimed an out-of-work benefit, based on the latest data for 2017.

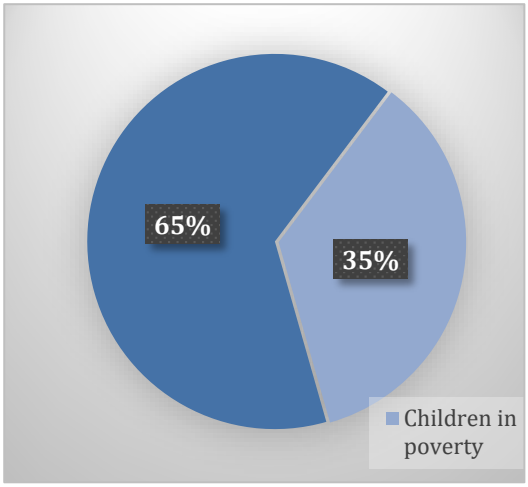



*Figure 1 - Islington Children in Poverty*

Of 123 Lower Super Output Areas (LSOA) in Islington, none is within the least deprived (IDACI) quintile nationally, and six are within the second least deprived quintile. At the other end of the scale, 69 Islington LSOAs are within the most deprived (IDACI) quintile nationally, and 33 in the second most deprived quintile.

Most housing is in flats with no outdoor space - only 13% of the borough's land is green space, the second lowest proportion of any local authority in the country. Overcrowding levels are similar to the London average at 11% of households.

Educational attainment has improved in Islington. The most recent Ofsted Official Statistics show that 91.0% of Islington's schools are 'good' or 'outstanding' as

judged by Ofsted, which is above the national average of 86.0% (as at September 2019). The number of young people who are not in education, employment or training (NEET) was 1.8% in 2018/19 (compared to 2.6% across the country), although the proportion whose status was unknown was higher than the national average. Overall, the borough has a high proportion of residents with low or no qualifications (25%) and a very high proportion of highly qualified individuals (48% have university degrees), who will generally be working in professions.

## CHAIRING AND LEADERSHIP

Alan Caton OBE independently chairs the ISCB, and he has been the independent chair since September 2013.

### *Accountability*

There are robust accountability mechanisms between The Board and chief officers in the authority with quarterly *Safeguarding Accountability Meetings* taking place between the Chief Executive of the LB of Islington, the Lead Member Officer of the Council, the Lead Member for Children's Services[4], Director for Safeguarding and Family Support and the Director.

## AGENCY REPRESENTATION AND ATTENDANCE OF THE BOARD

Islington agencies are well represented with a range of suitably senior officers attending the ISCB on a regular basis. Where necessary, representatives send delegates if they are unable to attend.

## BOARD STRUCTURE

The structure chart (Figure 1) on page 14 shows how the functions of the LSCB are organised. Most of the Board's functions are discharged through one of The Board's six sub-groups that report to the ISCB chair at the *executive meeting* whereas strategic oversight sits with the main board who is accountable for the Board's statutory functions.

Sub-groups continue to be chaired by a range of senior multi-agency partners.

The ISCB business unit supports the Independent Chair, Board, and sub-groups.

*ISCB Executive Meeting*, *Chair: Alan Caton, Independent Chair of ISCB*

Key responsibilities of the sub-group are to

- Develop, implement, and monitor the Islington Business Plan.

[4] Section 19 of the Children Act 2004 requires every top tier local authority to designate one of its members as Lead Member for Children's Services. The LMCS will be a local Councillor with delegated responsibility from the Council, through the Leader or Mayor, for children's services

- Oversee the functions of Islington LSCB' sub-groups.
- Oversee the Learning and Improvement Framework.
- Agree priority actions against the Board's core business.
- Develop the Board's forward plan and set the agenda for board meetings.
- Receive and agree policies and procedures received from sub-groups.
- Review relevant national policy developments and initiatives, prepare briefing papers to The Board, and recommended actions that may be required.
- Monitor attendance and agency representation at the Islington LSCB and its Sub-groups and make recommendations as appropriate.
- Provide in-depth scrutiny around The Board priorities, including s11 duties

*Training and Professional Development sub-group, Chair: Stella Balsamo, Named Nurse, Whittington Health*

Key responsibilities of the sub-group are to:

- Identify the inter-agency training and development needs of staff and volunteers.
- Develop and implement an annual training and development prospectus.
- Monitor and evaluate the quality of single and multi-agency training.
- Ensure lessons from Serious Case Reviews (SCRs) are disseminated.
- Measure the impact of multi-agency training.

*Quality Assurance sub-group, Chair, Laura Eden (recently, Deborah Idris), Head of safeguarding & Quality Assurance.*

Key responsibilities of the sub-group are to:

- Develop agreed standards for inter-agency safeguarding work.
- Establish and maintain appropriate mechanisms and processes for measuring the quality of inter-agency safeguarding work.
- Contribute to the development of strategies to address any shortfalls in effectiveness.
- Monitor and evaluate the quality of safeguarding work within individual Board partner agencies.
- Contribute to the development of strategies for single agencies to address any shortfalls in effectiveness.

***Policy and procedure sub-group (ad-hoc)***

This sub-group is convened on a Task-and finish basis only

- Continually review and monitor ISCB's policies, practice, and procedures.
- Plan the piloting of and / or introduce new multi-agency working practices.
- Maintain an up-to-date knowledge of relevant research findings.

- Develop / evaluate thresholds and procedures for work with families.
- Assume editorial control over the ISCB web site and Newsletter.
- Going forward into the new financial year, this will sub-group will function as a task-and finish group.

*Missing, Child / Adolescent Exploitation sub-group, Chair: Detective Superintendent Treena Fleming / T/Detective Superintendent Jane Topping, MPS, North Central BCU*

Key responsibilities of the sub-group are to:

- Agree and monitor the implementation of a child exploitation strategy and action plan to minimise harm to children and young people.
- Raise awareness of all forms of exploitation within agencies and communities.
- Encourage the reporting of concerns about exploitation.
- Monitor, review and co-ordinate provision of missing and child exploitation practice.

*Case Review sub-group, Chair: Laura Eden / Deborah Idris, Head of safeguarding & Quality Assurance.*

Key responsibilities of the sub-group are to:

- Consider all cases that may potentially meet the criteria for a serious case review.
- Appoint a suitable panel to carry out a serious case review.
- Commission a suitable independent reviewer to carry out a serious case review.
- To evaluate and monitor implementation of agencies case review action plans.

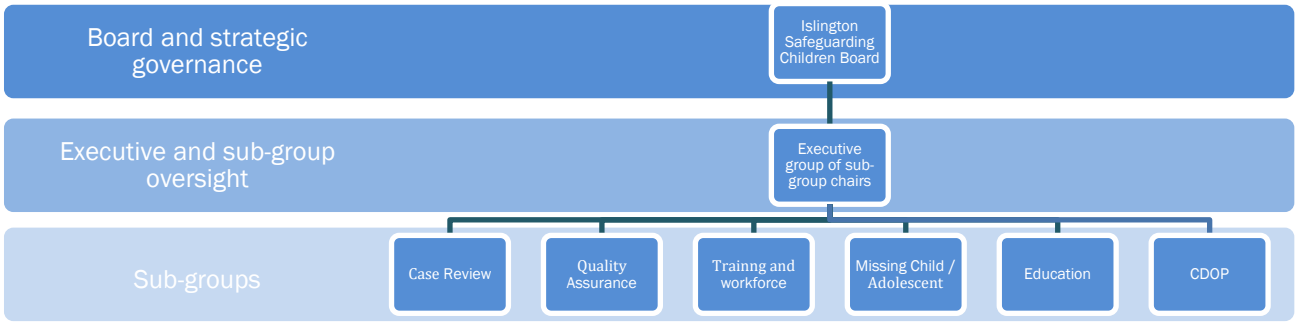
*Education Sub-group, Chair: Nicola Percy, Head of New North Academy, Recently Anthony Doudle, Head of Primary School Improvement*

- To provide opportunities for the ISCB to hear and learn from Education providers in order to strengthen multi-agency working.
- To draw on the experiences of a core group of professionals engaged in the safeguarding and promotion of well-being of children and families to inform policies, procedures, and practices of the ISCB.
- To support the dissemination of recommended best safeguarding practice in education across Islington schools and settings.
- To collaborate with the ISCB to further strengthen agencies collective efforts to safeguard children.

*Child Death Overview Panel, Chair: Jason Strelitz, Assistant Director, Public Health / Dr Leonora Weil, Acting Assistant Director, Public Health.*

Key responsibilities of the sub-group are to:

- Collect and analyse information about each unexpected death with a view to identifying any learning.
- Notify the ISCB of cases that may need to have a Serious Case Review (SCR).
- Review and respond to any matters of concern affecting the safety and welfare of children.
- Review and respond to any wider public health or safety concerns arising from a particular death, or from a pattern of deaths.
- Put in place procedures for ensuring that there is a co-ordinated response by the Authority and its Board partners and other relevant per-sons to an 'unexpected' child death.
- Alert The Board about professional practice concerns that may require a review



# Key ISCB activities

**In previous reports, The Board set out the rationale for choosing our current priorities, and this is the fourth update on our work plan. The Board and sub-groups' key-activities are captured in the ISCB business plan.**

## BOARD PRIORITIES

These priorities reflect our desire to improve the collective effectiveness of agencies in three key areas:

- Addressing the impact of neglect on children, including to help children become more resilient.
- Addressing the consequences / harm suffered because of domestic violence, parental mental ill health, and substance abuse.
- Identification of children who are vulnerable to sexual exploitation, criminal exploitation, and gangs.

## KEY ACTIVITIES OF THE MAIN BOARD

The Board scrutinised work in the following areas (in chronological order):

### *Private Fostering arrangements*

The Local Authority's annual report to the Islington Safeguarding Children Board (ISCB) is a requirement under *The Children (Private Fostering Arrangements for Fostering) Regulations 2005*.

#### Current Private Fostering Situation

There were **ten** notifications in the year 2018-2019. This is slightly higher than the previous year where nine notifications were received. The total number of private fostering arrangements is 12, involving 16 children.

#### Compliance with Private Fostering Standards

The Regulation (as before) requires the Local Authority to comply with the following Standards:

*Standard 1 – Statement on Private Fostering*

*Standard 2 – Notification*

*Standard 3 – Safeguarding and Promoting Welfare*

*Standards 4-6 – Advice and Support*

*Standard 7 – Monitoring and Compliance with Duties and Functions in relation to Private Fostering*

The report showed that the Local Authority complied with the above standards. Statutory visits were carried out as required although a small number of visits were delayed on reasonable grounds e.g. the child not available because of holiday with their parents, college commitments etc. All visits were, however, carried out despite being delayed.

Similar to last year's arrangements, most of

the children are female (75%). They come from a diverse range of ethnic backgrounds incl. Caribbean, African, Bangladeshi, Cambodian, Korean, Portuguese, and British.

Six notifications came from social workers within the Safeguarding and Family Support Service in relation to (or related to) children already open to the service. Family members were the next most common referrer along with colleges/homestay notification. The remaining referrals came from other local authorities, a school and border police

***Recommendations from 2017/18***

*Recommendation 1*: *Continued quality assurance of privately fostered children by Safeguarding and Quality Assurance Service and the Performance team, so there continues to be regular visiting to these children and thorough assessments to ensure they are safeguarded and their wellbeing promoted.*

This has continued. The senior management team have agreed that this quality assurance and advice function will transfer to the *Permanence Team* later this year.

*Recommendation 2: All ISCB training to consider Private Fostering and ensure any updates in legislation and procedures are incorporated, as a compulsory element to the training, ensuring new staff is provided with this training and current staff receive refresher training*.

This continues to be the case; private fostering remains an integral part of all safeguarding training.

*Recommendation 3: Team managers and Deputy Managers across the service to review and monitor initial and on-going visits to ensure that social workers are completing these within timescale and each visit meets the statutory requirement.*

This is taking place as evidenced in supervision records and management direction on case files. There remain a challenge in avoiding delays, many of which are due to families not being able to prioritise visits. More work will need to be done to examine the reasons for delays in the year 2019/20.

*Recommendation 4: Social workers to continue to provide privately fostered children and young people with information about their right to have an advocate, seeking their views about this and informing the designated private fostering lead if any child would like to be provided with an advocate so this service can be put in place*.

This continues to be the case.

*Recommendation 5: Consideration to what action can be taken by the CCG and Whittington health to assure themselves that their staff is aware of their duties in relation to Private Fostering.*

Private fostering is part of all safeguarding training within the trust.

*Recommendations*

1. Quality assurance and monitoring of privately fostered children to be transferred to the Permanence Service in partnership with the Data and Performance Team. Emphasis on future quality assurance will be around late visits.
2. ISCB will continue to include Private Fostering as a compulsory element to safeguarding training.
3. Team managers and Deputy Managers across the service to review and monitor initial and on-going visits. An audit of late visits should be carried out to understand the challenges better.

### *Safer Workforce*

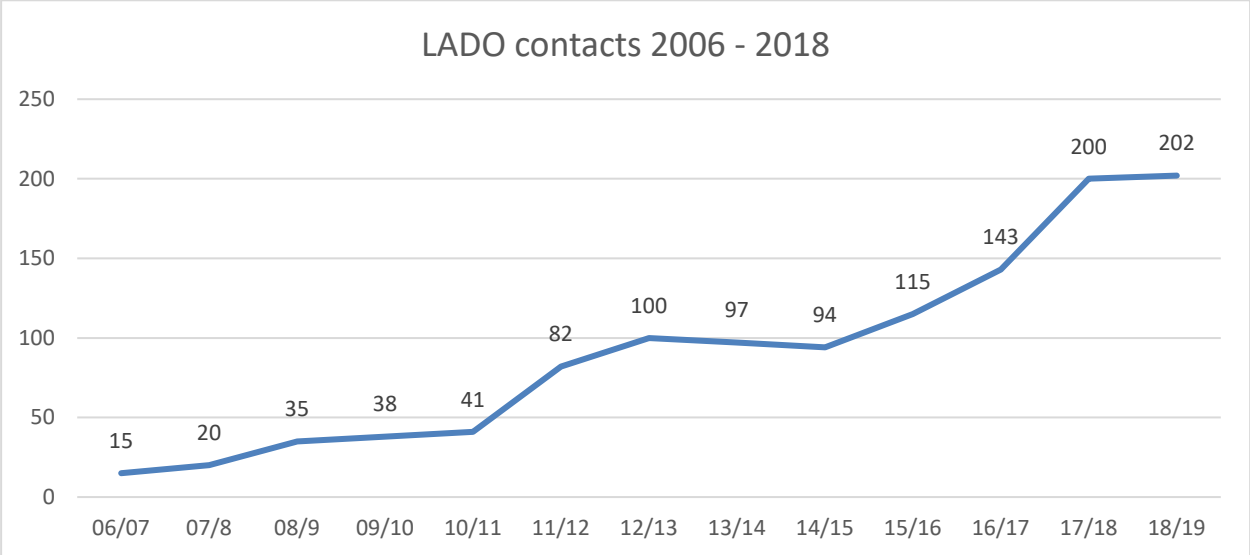
Children and young people are occasionally harmed by professional who are responsible to promote their welfare and safeguard them. This is never acceptable and the Board wants to be sure that those who work with children are carefully selected and that concerns or allegations are thoroughly investigated by the LADO, and in accordance with the Board's procedures.

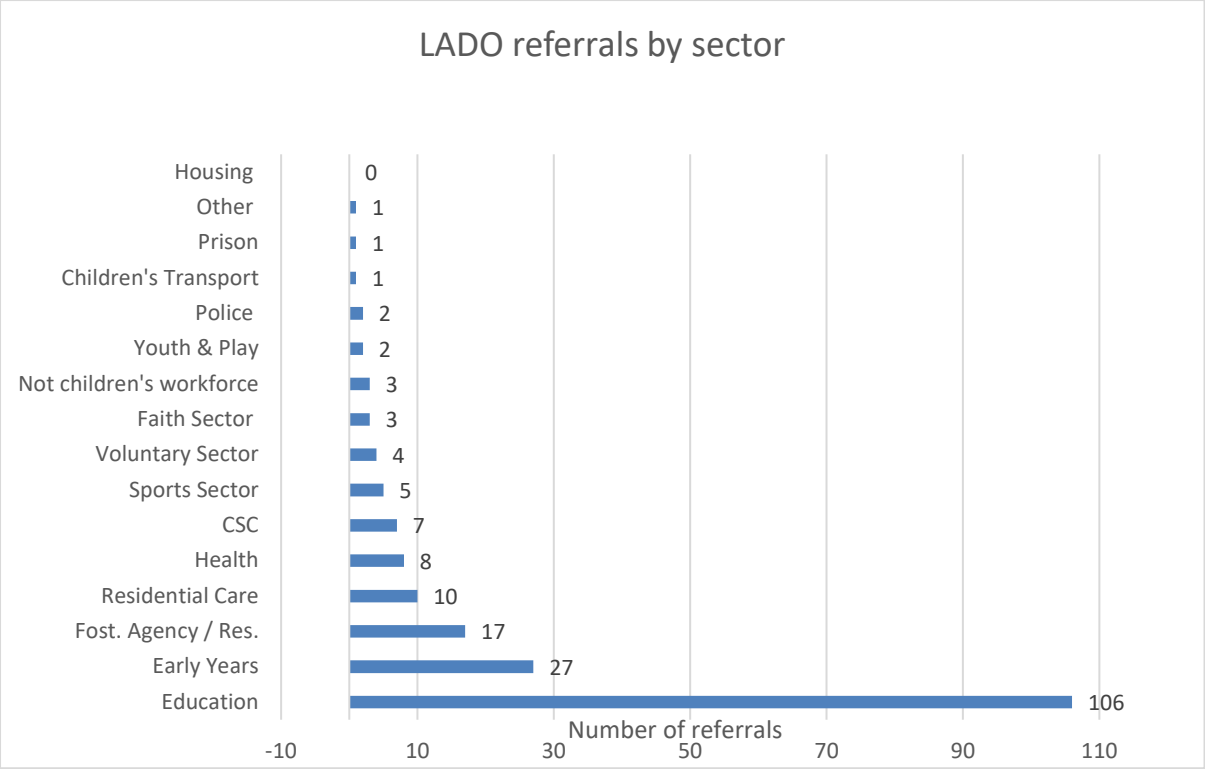
### LADO report

The ISCB received the 2018/19 LADO Annual Report for scrutiny.

### Sources and nature of referrals

As in previous years, a variety of agencies between them made 202 referrals, which is only 2 more than the previous year. This






plateau halts an almost unbroken increasing trend since 2006.

The vast majority of allegations relate to teaching staff, which is proportionate in view of the fact they are the major employer of the children's workforce, having the most contact with children than any other agency. The Principal Officer Safeguarding in Education remains crucial in supporting head teachers and designated safeguarding leads.

The next most likely referral-setting is Early Years and referrals were very well supported by Safeguarding Leads in Early Years.

The wide variety of referral sources suggest that managing allegations procedures are well known across the professional network.

| LADO Referrals Nature of concerns | N | % |
|---|---|---|
| | Previous year in brackets | |
| Physical | 82 (73) | 41% (36%) |
| Private-life matters | 36 (50) | 18% (25%) |
| Complaints / Care standards | 42 (34) | 21% (17%) |
| Sexual | 14 (24) | 7% (12%) |
| Emotional | 12 (15) | 6% (7%) |
| Neglect | 16 (4) | 8% (2%) |

**Nature of referrals**

The table above sets out the nature of referrals that were made to the LADO.

The majority of contacts were concerns about *physical abuse*.

Complaints about *care standards* follow which is a rise from last year, for the first time overtaking *private life matters*; these did not meet the LADO threshold since there was no allegation that a child was harmed. Agencies were advices to follow their disciplinary or complaints procedures.

The third highest number of contacts related to *private life matters*; such contacts only progress to an ASV meeting if there is a police investigation or if a member of staff's own children become subject to child protection procedures.

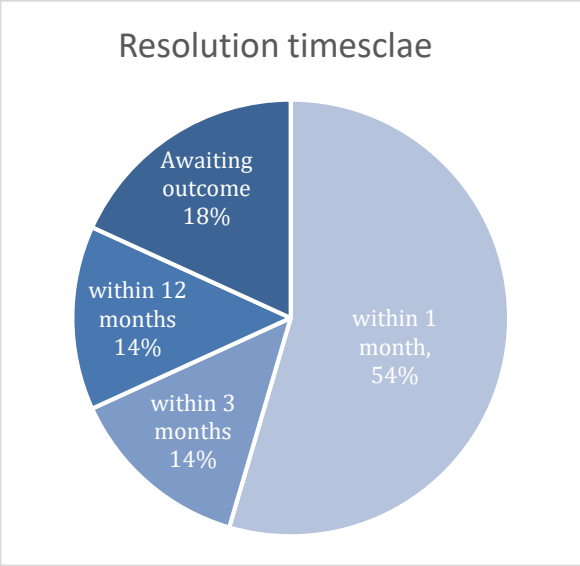
This year, 90% of referrals were made within one working day. This demonstrates good knowledge by agencies of their responsibilities to report swiftly. Where referrals were not made within one working day, this was taken up by Safeguarding Leads for the relevant agency.

In 83% of referrals, the employer was given advice and 22 cases proceeded to an ASV meeting.

The ISCB procedures expect that:

- 80% of cases should be resolved within **one month,**
- 90**% within 3 months**

All, but the most complex investigations, should be completed within 12 months.




As can be seen above, the LA completed 68% (previously 92%) of cases within 3 months.

### *JTAI inspection*

Between 3 December 2018 and 7 December 2018, Ofsted, the Care Quality Commission (CQC), HMI Constabulary and Fire & Rescue Services (HMICFRS) and HMI Probation undertook a joint inspection of the multi-agency response to sexual abuse in the family in Islington. This inspection included a *deep dive* focus on the response to sexual abuse in the family. Inspectors

found that:

***"Islington senior leaders hold a strong strategic commitment to the multi-agency partnership and have made significant investments to improve practice and outcomes for children at risk of abuse, including those children subject to child sexual abuse in the family environment."***

The inspection report[5] found good partnership support of the ISCB, consistent attendance, and ownership. The work of the sub-groups also demonstrated a shared responsibility to improve the outcomes for children and agencies holding each other to account: "ISCB partners have created a learning environment with constructive challenge that drives continues improvements in operational practice"

### *ISCB Away-Day*

The ISCB had its annual away-day to discuss the strategic direction and future priorities. The Board made the following decisions:

1. The multi-agency training offer should continue, focussing on core training and training related to ISCB Priorities
2. A clearer voice for schools through the education sub-group and *Islington Community of Schools*.
3. Transition-points, particularly transition from childhood to adulthood.
4. Board to ensure that partners are hearing the voice of children and partners in the delivery of their services.
5. Improving the Board's data-set to include a dashboard and principle from NICE guidance.
6. Better links with *Adult Safeguarding Board.*
7. A greater focus on Early Help as a "way of working" instead of a service. ISCB agreed the establishment of an Early Help Sub-group as part of the new arrangements.
8. Continuing to explore the relationship between exclusions from school and safeguarding.
9. E-safety
10. Retain *neglect* and *impact of parental factors* (substance abuse, mental ill-health and domestic violence and abuse) as abuse. The current priority relating to sexual exploitation will be widened to include all factors making adolescents more vulnerable e.g. criminal exploitation.
11. Continuing to develop a whole-partnership approach informed by *trauma informed practice.*

### *Changes to CDOP arrangements*.

As part of new safeguarding arrangements

[5] Joint target areas inspection of the multi-agency response to Child Sexual Abuse in the family in Islington

set out in *Working Together to Safeguard Children*, published in July 2018, Child Death Review processes were required to transform. Guidance[6] published by *Department of Education* and *Department of Health and Social Care* recognises that most child deaths are due to medical factors rather than safeguarding or other external factors, and to reflect this, national oversight for child death review processes has moved from the *Department for Education* to the *Department for Health and Social Care*. At a local level, the *Child Death Overview Panels,* first established in 2008, on 1 September 2019 seized as a sub-group of the ISCB and moved under the governance of the London Borough of Islington and Islington Clinical Commissioning Group.

To ensure that any potential safeguarding concerns are followed up the chair of Islington CDOP will continue to be represented on the *LSCB Executive Group* and *LSCB Partnership Board*. The LSCB will continue to receive an annual report from the CDOP Chair.

### *Future Safeguarding Partnership arrangements in Islington*

In May 2017, the *Children and Social Work Act* received Royal ascent requiring *Local Authorities*, *CCGs,* and the *Metropolitan Police* to establish Multi-Agency Safeguarding Arrangements (MASA) and to set out the safeguarding arrangements that will replace LSCBs when they seize to exist on 29 September 2019.

*Working Together 2018* provided further guidance for the three safeguarding partners in setting up local safeguarding arrangements. In Islington, partners have started development of the new arrangements in April 2018 and they published the Islington Multi-Agency Safeguarding Arrangements in July 2019 and the partnership became effective on the 1st September 2019.

### *Co-operation with other strategic boards.*

The Board continues to improve its working relationship with other strategic boards i.e. the *Health and Wellbeing Board*, Islington Children and Families Board, *SIP*, *Corporate Parenting Board* and *Adult Safeguarding Board*. The Chair (or ISCB representative) attends all these boards in order to facilitate co-operation. This report will also be shared with the chairs of those boards.

**Youth Justice Service Management Board (YJSMB)**

In January, the Chief Executive Officer of

[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/777955/Child_death_review_statutory_and_operational_guidance_England.pdf

the Local Authority, and the Director of Youth and Communities attended the LSCB to present a paper relating the work of the YJSMB and the *Islington Youth Justice Plan 2018-2019*, which identified the following priorities areas to improve outcomes for young people whether they are victims or perpetrators:

1. Ensure that there is a strong focus on early intervention and prevention. This also means focussing on issues around trauma, DV, and young victims becoming perpetrators.
2. Increase education, training, and employment. Increasing the number of young people in education, employment, and training to reduce re-offending and improve their outcomes.
3. Hear and listen in respect of young people's voices. Ensuring that service user's voices are influencing service delivery and this includes hearing from them directly at the Board (and in other key forums where the views and perspective of the child/ young person is paramount)
4. Challenge and test ourselves so that learning is built into everything that we do and the learning from Serious Cases is embedded into all our work.
5. Work in partnership and act collectively. Collaboration is key.
6. Address *disproportionality*. Working as services to reduce disproportionality, supporting BME children and young people to decrease their involvement in the criminal justice system and improve their outcomes

The Board welcomed the plan as a whole and in particular for supporting the ISCB priority area of working with vulnerable adolescent at risk of exploitation.

**Safer Islington Partnership**

***"Islington Youth Council recognises the importance of crime and safety; we strongly believe that the youth of today represent a measure of success or failure for every borough. We believe that this plan will significantly help young people as they are the learners of today and the teachers of tomorrow. We need to do more to help young people to have a better future and a better life".***

***- Young Mayor Diana Gomez***

In response to the ISCB challenge that youth crime must be seen within a safeguarding framework, the Local Authority agree a partnership strategy and in January presented their *Working Together for a Safer Islington 2017 -2020 – a partnership response to tackling youth crime in our borough*. This plan is monitored by the ISCB and SIP and sets out the following objectives:

*Objective 1*: Create safer places for our children and young people to grow up in, learn

and enjoy.

*Objectives 2*: Build resilience within individuals, families, and communities.

*Objective 3*: Protect and safeguard young people and support them and their families when they are victims of crime.

*Objective 4*: Prevent young people from getting involved in crime and entering the Youth Justice System for the first time.

*Objective 5*: Tackle gangs, knife-crime and other violence by and against young people and reduce reoffending by young people

These objectives are aligned with the ISCB priorities to develop resilience in young people and the Board welcomed the strategy.

### *ISCB Risk register*

The Board maintains a risk register to ensure risks are identified and plans formulated to mitigate risks.

The Board ensures that arrangements are in place to manage each risk. All risks have ownership at board level and an agency action-plan to reduce / remove the risk.

### *Escalation procedures*

In line with *Working Together to safeguard Children* and The Board's Child Protection Procedures. There is a published protocol to resolve professional disagreements or concerns between professionals.

In 2018/19 the procedure was used on several occasions, with an update given by the Head of safeguarding at each board meeting. Matters were most frequently escalated between the Children Social Care, the Metropolitan Police Service, and Schools.

All escalated matters were satisfactorily resolved before reaching the Board for resolution.

### *Lay Members*

The Board benefited from having two lay members that actively contributed to the work of the Board. During the year a vacancy was created, which will be filled with the commencements of the new safeguarding arrangements in September 2019.

Lay members consistently challenge the work of the Board where appropriate, and continue to bringing a fresh perspective from Islington's residents.

## EDUCATION SUB-GROUP

The sub-group is coordinated with the *Islington Head Teachers' Forum* to ensure collaboration between the Board and Islington's Schools and Early Years settings. The membership of the group now includes senior manager representing the School Visiting Service and Safe Schools Officers.

**Shared Vision Event**

Several Young People from a local school participated in a joint event between the ISCB, *Shared Vision* and youth drama company. Young people explored the local impact of youth crime.

**Section 175 / 11 Return**

A bi-annual *Section 175 (section 11) self-audit* in schools and early year's settings is co-ordinated by the Principal Officer for Safeguarding in Schools and the Safeguarding Lead for Brightstart and reports to this sub-group. There has been a very good return of audits, and most had appropriately detailed action plans for improvements.

A *Section 11 Overview in Education Report* was presented to the sub-group showing the schools are meeting the required S11 Standards and that they have action plans to address any areas of improvement.

Overall, schools performed well in areas of governance, policy, and procedure, and safeguarding training. Inter-agency working, information sharing, and safer recruitment were areas that required the most remedial action.

**Designated Safeguarding Lead (DSL) Supervision**

In response to ISCB challenge, the *DSL Supervision Pilot* was launched in partnership with the Education Psychology Service in the LA. An update *DSL Supervision Annual Report* was presented to the sub-group outlining that 61 DSL (52 schools) now benefit from monthly supervision and the service is highly valued by DSLs and Schools. This report, and the S175 audits, highlighted that DSLs in schools work under considerable pressures and this matter requires further attention.

Themes emerging from discussions at DSL supervision are:

1. Inter-agency working and difficulties around referrals, follow-up, thresholds, communication, updates, notification of case closures bureaucracy.
2. Home Schooling / schools changes as a response to schools raising safeguarding concerns with parents.
3. Children missing from education
4. Social Media.
5. Parental relationships and parental conflicts.
6. Reliability of external agencies (CAMHS etc.).
7. Level of need and of risk in community for children: poverty, knives, county lines etc.)
8. Multiple expectations and pressure on schools from different sources.
9. Pressure and lack of time to carry out the DSL role.
10. In some schools, lack of team members in DSL role.
11. Discussion around admin (CPOMs etc, transfer of records).

**Youth Violence and Schools Project**

This project was established by the Local Authority to aid schools who were not always able to access the help they needed to recognise and address the issues of gangs and youth violence and effectively support their pupils.

A youth violence tool was developed across the council along with police and after consultation with schools to help identify those at risk. The feedback from schools has been very positive.

**Schools / CSC Communication Report**

The sub-group welcomed the report commissioned by the LA's Head of Safeguarding and Quality Assurance to look at the communication between children social workers and schools. A lack of communication is a frequent discussion-point in the DSL Supervision forums. The report made several recommendations:

1. Better recording of communication on both CSC and Schools records
2. CSC to evidence communication with schools at important transition points: case transfer, closure, step-up/down or change in social worker.
3. Improved communication between DSLs (if not head teachers) and their DSLs.

**Transfer or Records Policy**

In response to the recommendation from the Child K Serious Case Review, the schools *Transfer of Records Policy* was extensively discussed and updated to ensure that information transfers with a child to their next schools. This policy was distributed through the Designated Safeguarding Leads networks.

**Policy Development**

*Model Safeguarding Child Protection Policy*

Schools report that they find the *Model Safeguarding Child Protection Policy* very useful and it is available on the ISCB website for schools to adapt as they deem fit. It was also updated in response to *Keeping Children Safe in Education* and *Working Together 2018*

*Separated Parents Policy*

The area around *parental responsibility* was identified as a need for schools and that area was strengthened in the Separated Parents Policy.

*Gender stereotyping and sexual bullying in Schools: a resource for schools staff.*

An awareness raising resource for primary and secondary school staff to support them in identifying, preventing, and responding to gender stereotyping and sexual bullying (GSSB) in school. In addition, to provide support when working with children, young people, parents and carers so that the entire school community works collec-

tively to implement a whole school approach which prevents sexual bullying and gender stereotyping and creates a gender equality ethos in Islington schools.

**Draft Information-sharing Protocol**

The sub-group looked at the London Board's *Draft Information Sharing Protocol*. The sub-group agreed with the proposal that *legal obligation* and *public task,* instead of *consent*[7] should be relied on as basis for sharing information under the *Data Protection Act 2018.*

## MISSING AND CSE SUB-GROUP

The Board, through the work of its Missing and CSE sub-group, challenges all member agencies to identify, address, and respond to children who were at risk of going missing or who are at risk of sexual exploitation.

**Strategic Development:**

The sub-group agreed four key themes, which forms the basis of the sub-group's action plan for 2018-2019:

1. Harmful Sexual Behaviour
2. Boys and Young Men
3. County Lines
4. Intelligence Gathering and Information Sharing

The sub-group annual report finds that:

***"…data consistently shows that risks to Islington's children and young people to become vulnerable to CSE, HSB, Gangs, SYV, Modern day Slavery and trafficking, are intrinsically linked to peer groups and offending networks, such as gangs. The cohort of children and young people vulnerable to exploitation overlaps significantly with children and young people that go missing from home and care."***

In response, the LA's *Exploitation and Missing Team* have focused on developing a less silo-ed, and more flexible model of *assessment*, *intervention* and *governance*; ensuring that children and young people across the spectrum of risk receive timely and targeted interventions, and that those children at acute risk receive a consistent safeguarding response.

*Analysis* and *mapping* of current risks related to exploitation and missing children remain is an important priority; alongside that the *Safeguarding and Family Support Service* and *Youth and Community Services* have undertaken a number of large pro-

[7] GDPR defines consent narrowly because it was primarily concerned with limitations of data sharing for commercial purposes. It is no longer a satisfactory basis for sharing information for the purposes of promoting the wellbeing of or safeguarding children

jects. This includes embedding *trauma informed* and *motivational practice* models.

A review of children and young people connected to serious youth violence demonstrated that childhood-experiences of domestic violence and abuse was significantly prevalent across all profiles of exploited children.

The Local Authority have in response developed the innovative, co-ordinated multi-disciplinary *Keel-project* for families who experience domestic violence and abuse.

**MASE**

In November 2018 the MASE reviewed its Terms of Reference (TOR) given that the scope of MASE was expanding to consider not only child *sexual exploitation* but other areas of exploitation including *gangs*, *serious youth violence*, *harmful sexual behaviour* and *criminal exploitation*. It was agreed that input from additional partners was required to strategically respond to this broader area of exploitation; as such, *Community Safety* is now part of the MASE.

In the January 2019, the sub-group ratified the decision that the MASE should in future be known at the *Multi Agency Child Exploitation* (MACE) group to reflect all areas of exploitation. The MACE was also asked to prepare an annual report for the sub-group to strengthen the Board's oversight of the MACE work.

**Ofsted inspection**

The LA received an Ofsted inspection in April 2018. The themed visit focusing on *vulnerable adolescents* was very positive: including the following:

'the service provision for vulnerable adolescents in Islington is strong and robust…Risks to vulnerable adolescents…were identified well and comprehensively assessed. Risks are not seen in isolation and the interlinkages between risks are well understood. This leads to the development of effective intervention plans…result in effective targeted interventions and support'

Inspectors also remarked on the "substantive awareness raising and specialist training across the partnership" that have been undertaken by the Exploitation and Missing Team… "The impact of this activity has led to an increased confidence for those working with this vulnerable group in recognising and tackling such forms of exploitation".

### CSE Training and Awareness

Approximately 2,000 professionals from a range of services have received training on Exploitation and Missing risk areas over the past year. Audiences include whole-school staff groups, all Central North Police Officers and training for Special Guardians.

In the last year, we have been able to see the impact of our training and awareness raising on the response to safeguarding children and young people; an example of visible impact is evident in the training delivered to the *British Transport Police*, after which a practice-pathway was set up and a number of children missing and at risk of exploitation have been identified by them at an earlier stage. This is now being used London-wide.

In addition, training was delivered to *Safer Schools Police officers* in January 2019, in relation to Trauma Informed Practice (TIP). This training was well received and provided the opportunity for officers to reflect upon their own thinking and practice when working with vulnerable children and adolescents at risk of exploitation.

### School-based Preventative Education

Specialist Social Workers in the Exploitation and Missing Team have over the last year offered 400 children targeted awareness sessions in their schools, with year-9 children accessing sessions on consent and healthy relationships.

### Missing Children

During the last year, the total number of children missing from home and from care

| **Children *Missing from Care*, *Missing from Home* and *Away from Placement without Authorisation* (APWA)** | | | | |
|---|---|---|---|---|
| **Month** | **N** | **Total** | **Episodes** | **Total** |
| April 2018 | 53 | **101** | 98 | **289** |
| May 2018 | 51 | | 87 | |
| June 2018 | 53 | | 104 | |
| July 2018 | 46 | **85** | 109 | **269** |
| Aug. 2018 | 41 | | 93 | |
| Sept. 2018 | 35 | | 67 | |
| Oct. 2018 | 38 | **74** | 75 | **211** |
| Nov. 2018 | 37 | | 59 | |
| Dec. 2018 | 33 | | 77 | |
| Jan. 2019 | 34 | **72** | 90 | **226** |
| Feb. 2019 | 30 | | 59 | |
| March 2019 | 39 | | 77 | |

Figure 2 Children who went missing

was 332 (this includes away from placement without authorisation).

**Children Missing from Home - Length of Missing Episode**

In total 50% of the missing episodes involved young people going missing for less than 24 hours, and 20% involved children returning the following day.

2% of the missing episodes related to children going missing for more than one month. This data can be related to two individual young people, both of whom were identified as being criminally exploited to run County Lines, and were classified as *wanted* by police. This may have led to these young people believing that staying missing was better for them.

All of these young people have been offered a range of interventions.

**Children Missing from Care - Length of Missing Episode**

In total 56% of the missing episodes involved young people going missing for less than 24 hours, and 20% involved children returning the following day.

1% of episodes involved young people going missing for more than one month. This data is in relation to two individual children, both boys. One of whom was an unaccompanied asylum seeking child (UASC) remanded into the care of the LA and went missing immediately after being placed in supported accommodation. The other child was identified as at risk of gangs and the Local Authority initiated care proceedings due to him continuing to be at significant risk of harm, despite intensive support and intervention.

**Additional Vulnerabilities of Missing Children**

When cross-matched with the risk hazards marker system for CSE, Gangs and Radicalisation we are able to see how many children that go missing from home and care are assessed as being at additional risk.

- **28** children who went missing this year are assessed as a category 1, 2 or 3 risk of CSE (category 3 being the highest level of risk and category 1 being the lowest level of risk)
- **45** children who went missing this year are identified to be either a gang nominal or considered to be at risk of gangs/serious youth violence.
- **0** children who went missing this year were assessed as at risk of radicalisation and referred to Prevent.

This data shows a significant increase from

2017-2018 in terms of the number of children who go missing from care and from home who are identified as at risk of CSE or at risk of gangs/serious youth violence.

### Other Local Authority Missing Children

Over the last year there were **94** children residing in Islington who were *Looked After Children* by another borough[8].

Eight of the 94 children were reported missing from care or away from placement without authorisation. This is a decrease from 11 children in 2017/2018.

All Local Authorities who have placed children in Islington are written to on a quarterly basis and asked to provide an update as to whether their children are still placed and whether they have placed any new children in Islington. Where the LA believes a child to be at risk of exploitation or offending, the placing authority is asked to clarify the risk to their child.

### Return Home Interviews (RHI's)

In the previous annual report, the recommendation was to bring the RHI team into the *Exploitation and Missing Team* to enable closer collaborative working with children who go missing from home and care,

| Return to Home Interviews Status | N | % | % |
|---|---|---|---|
| Completed | 194(129) | 20% | 34% |
| Attempted, Child Refused | 146(117) | 15% | 25% |
| Attempted, Parent(s) Refused | 25(13) | 2% | 4% |
| Not Possible, Unable to make contact | 65(42) | 7% | 11% |
| Not Possible, Other | 0(115) | 0% | 0% |
| Not Required, Authorised Absence | 29(15) | 3% | 5% |
| Not Yet Completed | 118(122) | 12% | 20% |
| **Total (Excluding Still Missing Code)** | **576** | **58%** | **100%** |
| RHI Not Possible - Child is Missing | 418(303) | 35% | - |
| **Grand Total** | **994(856)** | **100%** | **-** |

[8] Their *home* borough remains responsible for their well-being and care planning. However, as the borough in which the children are placed, Islington can challenge the home authority if there are concerns about the children's safety.

and to focus on developing and improving the take-up of RHI's. This has been done, although vacancies have existed in this team. The *Return Safe Team* now contribute to strategy meetings and mapping meetings for young people, and undertake on-going direct work with some children, with a view to decreasing the likelihood they will go missing again.

Over the last year, 458[9] RHI's were offered to Islington children that went missing from home or from care.

The percentage of RHI's offered within 72 hrs is 54%, and this is an improvement from 2017-2018 (35%). Although this number is still relatively low, several factors affect this:

1. The social worker is not notified immediately by a parent or other agency that the child has returned, or a child returns over the weekend period and the Social Worker is not notified until Monday morning.
2. If a child returns over the weekend period, the RHI worker will not be notified until the Monday morning and therefore there is a delay in offering the RHI.

**Child Sexual Exploitation**

The number of contacts Children Services Contact Team (CSCT) received in regards to CSE has quite significantly reduced over the last year; in 2017/2018 there were 115 contacts, decreasing to 65 in 2018/2019 (table below).

It is hypothesized that the extensive training and awareness raising across the partnership has increased the confidence of partner agencies in identifying and working with young people at risk or experiencing CSE.

The majority of children who have been identified as at risk of CSE over the year

| Child Sexual Exploitation | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr 18 | May 18 | Jun 18 | Jul 18 | Aug 18 | Sep 18 | Oct 18 | Nov 18 | Dec 18 | Jan 19 | Feb 19 | Mar 19 | Total |
| **Contacts to CSCT** | 5 | 6 | 6 | 3 | 9 | 4 | 4 | 9 | 4 | 4 | 0 | 11 | 65 |

[9] This number excludes the RHIs that were Not Yet Completed, those that were not required as the episode was actually an Unauthorised Absence, and those where it was not possible to offer an RHI as the child went missing again

2018/2019 are female (53) with 8 males being identified.

In regards to age, in the previous two years the two most common ages were 17 and 14, however in 2018/19 the most common age was 15, followed by 14 and 17 being joint second.

The ethnicity of children categorised as:

- Level 1 risk: 39% White British, 18%, Black British-Caribbean, 13% any other White background, and 8% were Black British-African.
- Level 2 risk: 23% White British, 30% were mixed parentage.
- Level 3 risk: no discernible pattern because of small numbers.

### Harmful Sexual Behaviour (HSB)

The data in relation to the number of contacts CSCT received over the past year in regards to HSB shows that the number of referrals fluctuates month to month and it is not possible to identify a specific pattern.

In response to recognising in last year's report that harmful sexual behaviour may be described in various ways, the Specialist Social Worker for CSE and HSB with CSCT carried out a piece of in relation to coding of referrals.

Seven Complex HSB Strategy meetings took place. The low number of strategy meetings is a reflection of the police involvement with HSB cases. If the child is under 10, there is not a clear victim or offence that would lead to a conviction. Given the limited role of the Police in such cases, a professionals meeting is held rather than a complex strategy meeting.

### County Lines

Referrals received in relation to County Lines would likely be coded as *CSE*, *gangs*, *SYV* or *missing* by CSCT, as there were no specific code on the recording system for County Lines at the current time. Additionally, these factors may be the presenting concern at the time of referral and upon further assessment indicators of County Lines may be identified

In November 2018, a new hazard for county lines were created by Children Social Care allowing better monitoring and identification of children and young people as at risk of county. As of the end of March 2019 a total of 20 children under the age of 18, and 6 young adults had been identified as at risk of county.

### Serious Youth Violence (SYV)

There has been an increase of 39 contacts to CSCT between April 2018 and March 2019 in comparison to 2017/2018. This is likely due to the continued increase in training and awareness raising, promoting better identification, along with an overall

rise in gang related criminal activity and SYV.

A *gangs* and *SYV* contact code has been in place since early 2017, which allows for an accurate picture in terms of number of referrals. Since this contact code has been in use, CSCT have received 211 referrals in relation to gangs and SYV.

Over the year, 125 children were referred to CSCT in relation to gangs or SYV risk.

As of end of March 2019, 55 children were identified as at *risk of gangs / SYV* or identified by Police as a *gang nominal*.

In addition, 14 of these children have been assessed as likely to be involved in county lines.

## QUALITY ASSURANCE SUB-GROUP

Attendance at the sub-group is good, and commitment is strong and was during this report period chaired by both the Head of Safeguarding and Quality Assurance in the Local Authority and the Independent ISCB Chair.

### *Performance data – Core Business Report*

The sub-group scrutinises the performance report prior to it being presented to the Board. The members assist in the analysis that is written as an accompanying commentary report for each Board. During the year, the ISCB requested that the data should include other areas that would assist the Board to have a better understanding of children's safeguarding and therefore the report was changed to include more data. Repetitive data was removed.

### *Health data*

QA Sub-group receives an annual report from the CCG reflecting on Islington's performance against a wide range of health-related measures related to safeguarding, including some that were specifically requested by sub-group in the previous annual report. The report includes information on:

- Overall levels of hospital activity relating to children and young people in Islington
- Mortality rates
- Specific health issues
- Commissioned health services

This detailed report highlighted that A&E attendance rates are highest amongst children below the age of one. The report showed that there was, on average, an A&E attendance for every Islington child under one-year-old in 2015/16. This is in line with the Statistical Neighbour and London averages, although it is above the England average.

The report provided a wealth of health data and information regarding the service redesign to produce a new Emotional, Health, and Wellbeing model. The report

also highlighted the current and ongoing issues in staffing, particularly around recruitment and retention of specialist staff namely health visitors and school nurses.

The CCG agreed to develop a Dashboard for future reporting which would highlight areas of concern and analysis for scrutiny by the ISCB; this work is ongoing.

### *Learning from audits*

**Joint Targeted Area Inspection (JTAI) – Child Sexual Abuse (CSA) in the Family Environment**

The ISCB developed an audit tool to carry out the multi-agency audit in relation to CSA. The finding of the JTAI is reported elsewhere in this report and will not be repeated here. Key findings include the lack of an agreed data-set for senior leaders to review and oversee work in this area. The sub-group is in the process of agreeing how multi-agency CSA data can be obtained for inclusion in the *ISCB Core Business Report.*

In the multi-agency audit report, partners drew the following conclusions:

1. It is hoped that utilising *the Lighthouse* for all Child Sexual Abuse cases will provide more timely support to post abuse therapy, the criminal justice system, and intermediaries.
2. Where cases are taking a lengthy time to progress from arrest to charge, the police, social care and other agencies should discuss the impact of the harm the wait is causing to the child and their family and escalate to senior managers using the *Islington Safeguarding Children Board Escalation procedure.*
3. The Chair of the ISCB should raise with the London SCB the time that children wait for their alleged abusers to be tried to ascertain whether cases involving sexual abuse and children could be prioritised with the court.
4. In cases where there are abuse and neglect features and past parental issues such as mental health, reflective supervision should take place with staff to consider how this affects the parent's ability to identify and respond to the abuse.
5. Direct work with children who have been sexually abused, are at risk of sexual abuse of have displayed harmful sexual behaviour should cover interventions to help the child comes to terms with the loss they have suffered. All professionals should be attuned to this loss and approach this through a trauma informed lens including where the loss involves the perpetrator of the abuse.
6. In cases where children have displayed harmful sexual behaviour and are being interviewed under caution the police and social care should work together to develop a system whereby such children are offered an ABE

trained social worker to facilitate disclosures of abuse as well as the interview of the child.
7. Social Care training to consider specific training for managers on secondary trauma, given the emotional impact of this work.
8. Named GP to complete an article in the GP newsletter of the need to stay proactively involved with Children's Social Care where needed.

**JTAI Task and Finish Group**

A task and finish group, with governance to the QA sub-group, was established to monitor the implementation of the *JTAI Multi-Agency Action Plan*. Implementation of the recommendations are progressing well but issues of agreeing a data-set for leadership oversight has not yet been fully completed.

**PACE Audit on Children in Custody**

This audit reviewed 18 incidences of young people in police custody within a 6-month period. Most young people were male, 16-17 years old, overwhelmingly from a BME background and over half of the children were Looked After.

It is clear that since the *PACE Case Review* commissioned by the ISCB, there is evidence of more joined-up thinking and planning between social care and the police when children come into custody. Most (83%) children, however, who were arrested, charged and then have their bail refused remained in police custody until a court hearing. This can be anything up to 48 hours.

In some cases, police and social care worked hard to prevent young people from being in custody overnight. In other cases, more could have been done to improve the timeliness of charging and earlier liaison with social care so that if in the event a placement was needed, a search had already started for that placement.

*Recommendations*

1. Disseminate London Board PACE procedure when agreed. (The procedure has since been published)
2. Raise awareness about the PACE-champion role throughout the police and children's social care.
3. Encouraging MPS officers to notify the LA of a possible PACE transfer when it looks likely that a young person will be charge, instead of waiting for the charging decision.

There is ongoing good practice in this area, and CSC and MPS endeavour to avoid any child being held in custody overnight. The Head of Quality Assurance reviews the monthly *Islington Custody Data* shared by the MPS to ensure that practice in this area remain of a high standard.

**Analysis of Sec 47 Investigations following an increase in Islington compared to Statistical Neighbours**

Through performance data, CSC detected an increase across the service of S47 Enquiries, exceeding that of comparator Local Authorities as well as an increase in Islington compared to previous years.

Twenty-seven *Section 47 enquiries* were reviewed, and the auditor examined strategy discussion decisions to undertake either a single or a joint investigation. It was found that in most instances, the correct decision was taken and in 7 cases (5 of these being single agency) an assessment under section 17 may have been more appropriate.

*Threshold*

In strategy meetings where the police decided not to initiate a criminal investigation (joint s.47 enquiry) there was sometimes an assumption that the enquiry must continue as single agency when it might have been more appropriate to undertake a child and family assessment under s17.

Out of 1181 *child protection enquiries*, 450 were *joint-agency* with the police and 715 were *single-agency*. The number single-agency enquiries were striking.

The review also found that children were not routinely seen before decisions about child protection enquiries were made, which needed to be addressed.

Practitioners found the threshold table that used to be in the London Procedures useful and that is now part of the ISCB's threshold document[10].

**Practice Week**

The scope was extended from previous Practice Weeks to include *Targeted Youth Support*, *Youth Offending Service,* and the *Integrated Gangs Teams*. As in previous Practice Weeks, it included managers and teams across *Early Help*, *CSCT*, Children in Need (including Disabled Children's Team) *Children Looked After* (including *Fostering and Adoption*) and *Independent Futures*.

*Aims of practice week*

- Observing practice helps senior managers to hold the experience of practitioners in mind, by walking in their shoes and gaining a richer understanding of the current frontline practice experience.
- It increases the visibility and approachability of senior leaders. Social workers learn that their senior leaders have a depth of knowledge around practice and the ability to build relationships

[10] https://www.islingtonscb.org.uk/SiteCollectionDocuments/2018.11.20%20%20ISCB%20Threshold%20Document.pdf, p35

with families.
- It is a chance for senior managers to role model the behaviours that they expect from social workers and practice managers.
- It provides a huge and thorough audit of practice, helping us understand our strengths and weaknesses, and can be focused around a specific theme.

*Findings and recommendation*

- Continue to develop use of group supervision 'team around the child' particularly where planning for children involves several different teams e.g. Fostering and CLA.
- Develop advanced training around engaging other professionals in risk management through collaboration. Develop training for social workers on using Motivational Practice skills to build participation and ownership in a professional network, regardless of threshold level.
- Link trauma-informed training and narratives to a clearer understanding of adult-child attachments
- Create a tracking system for fostering and adoption family finding.
- Include trauma-informed language on case recording e.g. placement breakdown, disruption meeting.
- Children's lived experiences should form part of all updated case summaries.
- To further develop supervision training for Managers.
- Collaborate with social workers to develop more guidance / best practice around supporting parenting / caring, using specific case studies of situations where carers may take a variety of approaches
- Team managers training – building a trauma-informed culture in teams.
- Develop training on assessment of a home environment.
- Develop a system of Serious Success Reviews.

**Radicalisation**

During this reporting period, the QA Subgroup received a report relating to children referred to the *Children's Services Contact Team* (CSCT) under the category *Vulnerable to being drawn into terrorism (radicalisation/extremism)* during the period April 2017 to March 2018.

CSCT received 24 contacts during the 12 months audited, involved 20 children from 10 families. Four children were referred twice. The sibling groups ranged from one to four children. 12 females and 8 males made up the sample group. The *index child* in 10 families was male on 6 occasions, and out of the 4 female children, 2 were from one child families. The ages of the children, at the point of contact, ranged from one month to 17½ years old.

In 7 out of the 10 referred families there was a school connection. Four contacts

(eight children) were received after children researched concerning topics online at school/college. In other instances, children researched topics online but shared information in school.

*Finding and Recommendations*

- All of the contacts made to CSCT were, in the view of the auditor, appropriate.
- Referral frequency compares favourably with statistical neighbours and national figures.
- The audit evidenced outstanding partnership working between the Police, Education and Safeguarding and Family Support.
- The guidance and protocols between the three agencies are effective and swift action is taken once a concern is identified.
- As part of MASH-checks health, probation and housing were consulted as part of decision-making.

**Trafficking**

QA Sub-group received a report giving a brief overview of all children[11] and young people referred to the CSCT under the category *trafficking* during a 12-month period.

Only four contacts were received by CSCT during this 12-month period, involving one sibling group of three children, and one other contact in respect of a 16 years old (the age was in dispute).

With such a low number, it is reasonable to assume there may be hidden cases that have not come to the attention of agencies. It is not clear how well Islington compares to neighbouring authorities or the national picture.

*Findings and recommendations*

- Peer review with neighbours to ascertain how Islington compares statistically in relation to trafficking.
- Inclusion in the ISCB Missing and Exploitation Action Plan (This was included in the action plan)
- Implement guidance provided within the Human Trafficking and Modern Slavery Briefing, dated March 2018. (Included in all *ISCB Refresher Safeguarding Training* course).

### *Quality Assurance Frameworks*

The QA Sub-group received a report outlining the newly produced *Youth Offending Service, Quality Assurance Framework*. The Framework delivers an evidence-based approach which offers a 'Good Lives' model and a strengths-based approach to rehabilitation from offending which is fairly new to the service and to which all staff have

[11] Referrals not include cases of internal trafficking / county lines which are dealt with elsewhere.

been trained.

The sub-group requested that other partners also provide updates on their own Quality Assurance Frameworks / Arrangements. The *Designated Nurse* for Islington CCG provided an update on quality assurance arrangements on behalf the health economy.

The ISCB also presented its own *Learning and Improvement Framework*.

Updates from other partners have been added to the forward plan for the sub-group.

### *The role of Lead Professionals / Early Help*

Islington CCG challenged the partnership on oversight regarding *early help* and in particular, how agencies fulfil the role of the *lead professional* in their organisations.

It was greed that the Board does not currently have sufficient oversight of early help, and the local *early help* model that was agreed by the partnership in 2012 centres around targeted family support needs to be reviewed. There is a question about how partners support *Team Around the Family* meetings.

It was also acknowledged that some agencies, like school, do act as *lead professionals* calling multi-professional meetings but that other organisations may not necessarily be aware of it. These efforts need to be mapped so that there is a shared understanding of the impact of those efforts.

The ISCB agreed that an Early Help Sub-group should be established under the governance of the ISCB and this issue will be pursued as part of a refreshed Early Help Strategy.

### *Annual Reports from partner agencies.*

The sub-group scrutinises Annual Safeguarding Reports of agencies, where these are available. It is proposed that the sub-group requests safeguarding annual reports from *all partners* in future, particularly from the three local safeguarding partners: Local Authority, Islington CCG and North Central London Borough Command Unit.

#### Whittington Health NHS Trust

The Trust's *Quality Committee* receives a twice-yearly report from the Head of Safeguarding on the child and adults safeguarding arrangements in the trust relating to:

- staff training compliance,
- supervision,
- serious case reviews,
- LADO allegations,
- serious incidents and
- Inspections.

The Safeguarding report was comprehensive and informative.

**Moorfields Eye Hospital NHS Foundation Trust**

The Designated Director and Nurse for safeguarding leads on presenting a *Safeguarding and Promoting the Welfare of Children and Young People Annual Report* to:

- Safeguarding Children and Young People Group Meeting
- Trust Board
- Quality and Safety Committee
- Clinical Governance Committee

Key Achievements noted by the QA subgroup.

- Continued to increase both the cohort of staff and the departments/services across the trust who have completed level 3 training.
- Held a safeguarding awareness stand at the clinical governance half-day in November 2018.
- Further developed the safeguarding champions including training another two cohorts.
- Took part in the Domestic Violence and Abuse Bill consultation.
- Worked collaboratively with Solace Woman's Aid and Mankind to promote awareness of domestic violence and abuse including supporting the international "16 Days of Action".
- Extended the distribution of the internal Safeguarding Snippets newsletter.
- Contributed to the review of and had our feedback included in the Safeguarding Children and Young
- People Roles and Competencies for Healthcare Staff Intercollegiate Document (2019).
- Hosted the inaugural pan London Band 7 safeguarding children & young people acute trusts professionals network meeting.
- Been compliant with National Institute for Clinical Excellence (NICE) quality standards relating to safeguarding children and young people.
- Commenced question and answer sessions at Moorfields south network sites

The sub-group welcomed the comprehensiveness of the safeguarding report and the clear alignment with ISCB priority areas.

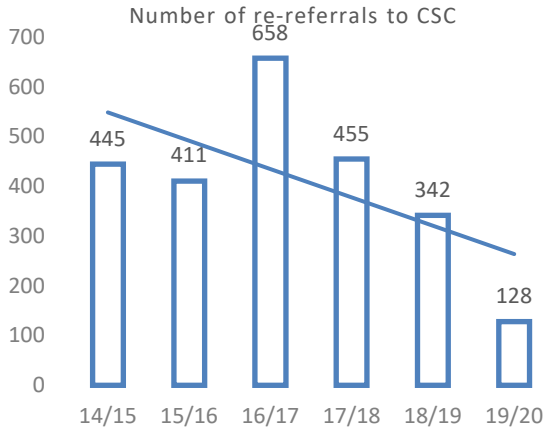
**Camden and Islington NHS Foundation Trust**

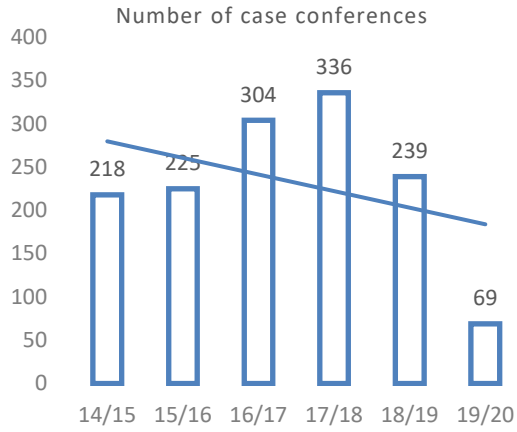
The Director of Nursing and Safeguarding Manager presents an annual safeguarding report to the Trust's *Quality Committee* and the ISCB sub-group covering:

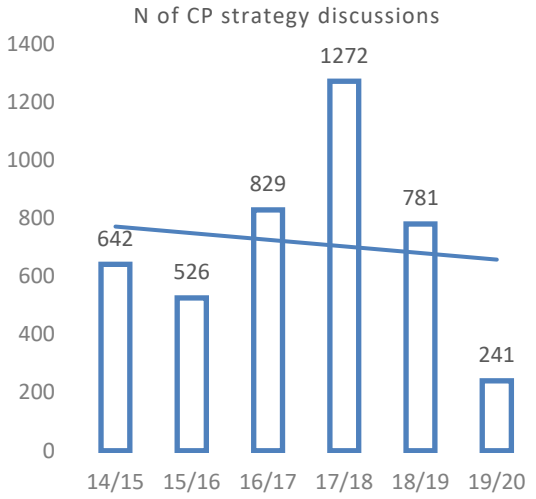
- Training compliance
- Safeguarding reporting data
- Supervision

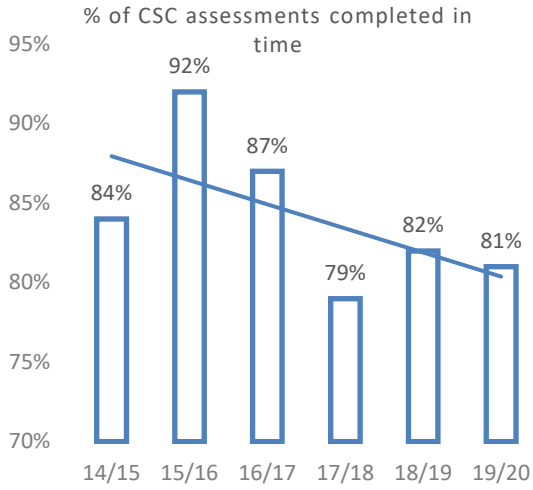
- Local Safeguarding Policies and procedures
- Prevent
- Serious Case Reviews and Multi-Agency reviews / DHRs / SARs
- LADO
- Domestic Abuse and Violence
- FGM
- Modern slavery and Trafficking
- MAPPA / MARAC / Channel
- JTAI
- S11 Audit

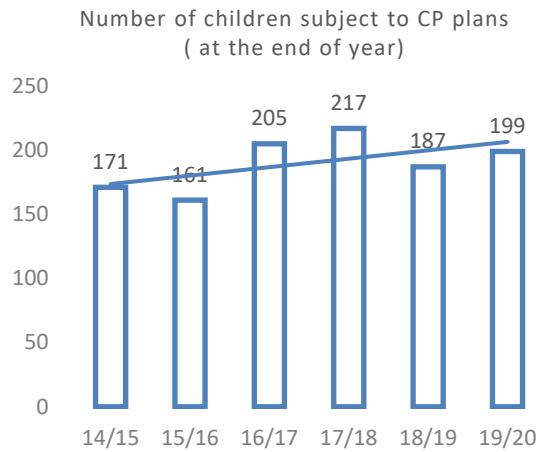
The annual report is very comprehensive and highlights areas of good practice and improvement, giving assurance to the sub-group that safeguarding in the trust is a high priority and that children are safe.

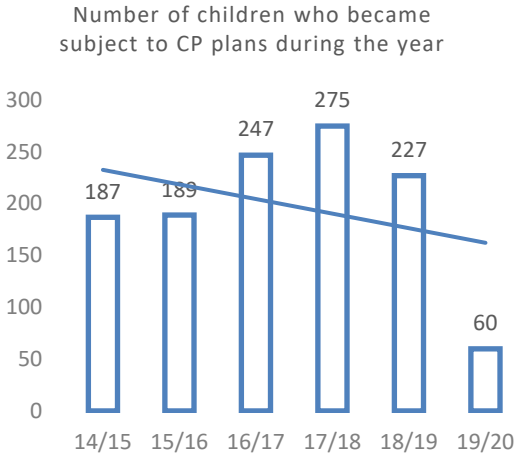

Number of re-referrals to CSC
700
600
500
400
300
200
100
0
445
411
658
455
342
128
14/15
15/16
16/17
17/18
18/19
19/20


Number of case conferences
400
350
300
250
200
150
100
50
0
218
225
304
336
239
69
14/15
15/16
16/17
17/18
18/19
19/20


N of CP strategy discussions
1400
1200
1000
800
600
400
200
0
642
526
829
1272
781
241
14/15
15/16
16/17
17/18
18/19
19/20


% of CSC assessments completed in time
95%
90%
85%
80%
75%
70%
84%
92%
87%
79%
82%
81%
14/15
15/16
16/17
17/18
18/19
19/20


Number of children subject to CP plans ( at the end of year)
250
200
150
100
50
0
171
161
205
217
187
199
14/15
15/16
16/17
17/18
18/19
19/20


Number of children who became subject to CP plans during the year
300
250
200
150
100
50
0
187
189
247
275
227
60
14/15
15/16
16/17
17/18
18/19
19/20

## TRAINING AND WORKFORCE DEVELOPMENT SUB-GROUP

The ISCB sub-group is chaired by the *Named Nurse for Safeguarding* in Whittington NHS and attended by a wide variety of agencies, including representatives from the private and voluntary sector.

The ISCB has commissioned a comprehensive training offer in line with its training strategy, *Competence Still Matters* and the *ISCB Business Plan*.

### *ISCB Training Strategy*

The training strategy[12] was reviewed and the following requirements were inserted in light of Board's decision to embrace a *trauma informed approach* and findings from the JTAI inspection:

- All agencies to ensure that staff receive at least introductory training in *Trauma Informed Practice*
- All agencies to ensure that staff receive training in *Child Sexual Abuse in the Family Environmen*t as part of agency training

Amendments were made to the *ISCB S11 Audit Tool* to reflect these two requirements. The S11 analysis will be included in the next annual report.

### *Amendments to Core Training*

The ISCB have made the following amendments:

- Reviewed and incorporated learning from the serious case reviews for *Child K*, *Child EML*, *MAMR Child O*, *Pathways to Harm* and JTAI *CSA in Family Environment*
- Changes in *Working Together 2018*
- Changes in *Keeping Children Safe in Education 2018 and 2019*
- Learning from London Borough of Islington *Practice Week*
- *London Child Protection Procedures*, 6 monthly updates
- *General Data Protection Regulations* and *Data Protection Act 2018*
- Focus on *contextual safeguarding* and *Trauma Informed Practice* on all ISCB courses, including *criminal exploitation*.
- NICE Guideline NG76: *Child Abuse and Neglect, recognising, assessing and responding to abuse and neglect of children and young people*

### *Core Training Offer*

At the ISCB away-day the Board agreed that the core training offer will remain unchanged, and that the Board will continue to offer multi-agency training as part of its

[12] Competence Still Matters

core function. During the JTAI inspection, inspector remarked that:

***"Staff across the partnership have opportunities to attend a wide range of core and specialist training programmes offered from the ISCB"***

The core-training offer to multi-agency staff includes:

- *Child Sexual Exploitation (all groups)*
- *Designated Safeguarding Lead - Role and Responsibilities (group 5)*
- *Safeguarding and Child Protection Refresher/Update (Groups 2-5)*
- *Safeguarding and Information Sharing Foundation (Group 2)*
- *Serious Case Review Briefing (All Groups)*
- *Working Together to Safeguard Children Induction (Group 1, voluntary sector)*
- *Working Together: from referral to child protection conference - Part One*
- *Working Together: core group to child protection planning - Part Two*

### *Key Training data*

This year, the ISCB trained in excess of 1125 members of staff. This is a 10.7% decline since last year (1260) despite the Board offering more training opportunities than last year and a steady demand for training places. Only 70% of training requests resulted in training.

The reasons for this are multi-factorial:

- *The learner or organisations withdrew their application.*
- *The Board declined the application.*
- *The learner failed to arrive for training.*

*Training cancellations*

It is expected that some learners will need to withdraw from courses because of sickness, operational pressures, or staff changes. The number of cancellations was not remarkable.

*Non-attendance*

As in previous years, some course places were wasted because of staff not attending booked courses - despite allowing course to be overbooked by 10-15%. Empty seats on training courses lead to complaints and unhappiness from partners who wanted to book their own staff on courses, and it is costly.

On average 14% of learners did not arrive for training, although it did vary considerably from course to course, e.g. *Designated Safeguarding Lead* training achieved 92% attendance, which is better than expected and because of overbooking effectively resulted in a full course. By contrast, attendance at *Gangs and CSE training* was more than twice as poor at 20%. Despite overbooking, courses were on average only 90% full.

In response to learner feedback, the ISCB

invested in the development of *system reminders* and *automated calendar invites* to diaries, but these measures have not made any difference suggesting that the lack of a system reminder, frequently sighted as the reason for non-attendance, is not the root cause of the problem.

It might be a factor that staff who attend *Designated Safeguarding Training* are more likely to be senior members of staff and failure to engage with training would result in potentially serious repercussions for their agency during safeguarding inspections.

*Places withdrawn by the ISCB*

Leaners apply for courses on-line using the multi-agency training portal. Line managers in partner agencies have oversight of applications and they approve all their own staff's training to ensure that staff are available, operational demand can be met, that the course is appropriate, and that staff meet the course requirement.

An audit of course bookings have shown that despite line manager approvals a significant proportion of approved bookings did not meet the course requirements. The most likely reasons are:

- Learners requesting a place on the Designated Safeguarding Course but they have not completed the foundation course in safeguarding.
- They have already done the same course within the last three years (or two years for schools).
- Learners apply for courses that are not appropriate for their role and the organisation does not intend to utilise the member of staff in that role.
- Organisations booking entire staff-teams on one course, effectively using ISCB training as internal single-agency training.
- Learners booking themselves on several instances of the same course.

Responding to these issues are very time-consuming requiring significant administrative oversight, correspondence and management of enquiries.

The ISCB Business Unit is doing further analysis to see how these issues can be addressed, including a charging-model for partners who are not core financial contributors to the ISCB.

*Training audience*

There is an excellent variety of staff from all sectors (see table) attending ISCB training, representing more than 290 individual settings. Attendance from schools (notably Primary Schools), early years, children's centres, child minders, and the local authority is good.

| Training attendance by sector (n) | |
|---|---|
| Academy - Primary | 3 |
| Academy - Secondary | 13 |
| Adventure Playground | 11 |
| Alternative Provision | 6 |
| Chaperone Service | 15 |
| Charity | 116 |
| Childcare on Domestic Premises | 1 |
| Childminder | 15 |
| Children's Centre | 71 |
| Children's home / residential set | 16 |
| College Nursery | 14 |
| Community Centre | 4 |
| Company | 8 |
| Criminal Justice | 1 |
| Free School | 11 |
| GP Practice | 30 |
| Independent (PVI) | 10 |
| Independent School | 42 |
| Justice - Criminal | 11 |
| Local Authority | 271 |
| NHS Trust | 43 |
| Other | 3 |
| Out of School Club | 27 |
| Post-16 Learning | 1 |
| Primary School | 134 |
| Private (PVI) | 94 |
| PRU | 9 |
| Secondary School | 40 |
| SEN School | 18 |
| Social Enterprise | 2 |
| Supplementary school | 13 |
| Tertiary education | 10 |
| Voluntary (PVI) | 89 |
| Voluntary Children's Centre | 42 |
| Voluntary Sector | 48 |
| Youth Service | 17 |

| Grand Total | 1259 |
|---|---|

### *Training Quality Assurance and impact*

ISCB training is very well regarded by attendees and 98% reported that the course met their training needs very well. 98.4% thought ISCB courses fulfilled their published objectives. Nearly all (99%) participants stated that ISCB courses enhanced their learning and knowledge about safeguarding children and associated procedures. Only 9% of participants claimed that they would not do anything differently as a result of attending the course and in all instances those participants explained that they are already very experienced in the field and attended only to refresh their knowledge. 99.2% of attendees will recommend ISCB course to their colleagues.

### *2019 /20 Training priorities*

The Training and Professional Development sub group will focus on the following work streams:

- Core ISCB training
- Support and train the partnership in recognising the impact of early childhood trauma and domestic abuse as important predisposing factors that may contribute to vulnerability.
- Training needs analysis of skills supporting early help (once the Early Help Strategy has been revised and agreed
- Inclusion of quarterly agency and ISCB training data in the ISCB core-business

report.

- Analysing the *Training Standard* in the Section 11 / 175 audit.
- Parental Conflict Training and Conference
- ISCB Summer Conference – Lessons from serious case reviews.
- *Train the trainer* training to enhance confidence in training multi-agency audiences and increasing ISCB training capacity.
- *Safer Recruitment training* (not for schools).

## CASE REVIEW SUB-GROUP

In June 2018, the Board agreed a serious case review in relation to EML, a young person with significant and enduring mental health concerns who died by suicide. This review was published on 6 December 2019 and the case review sub-group is overseeing the implementation of the action plan.

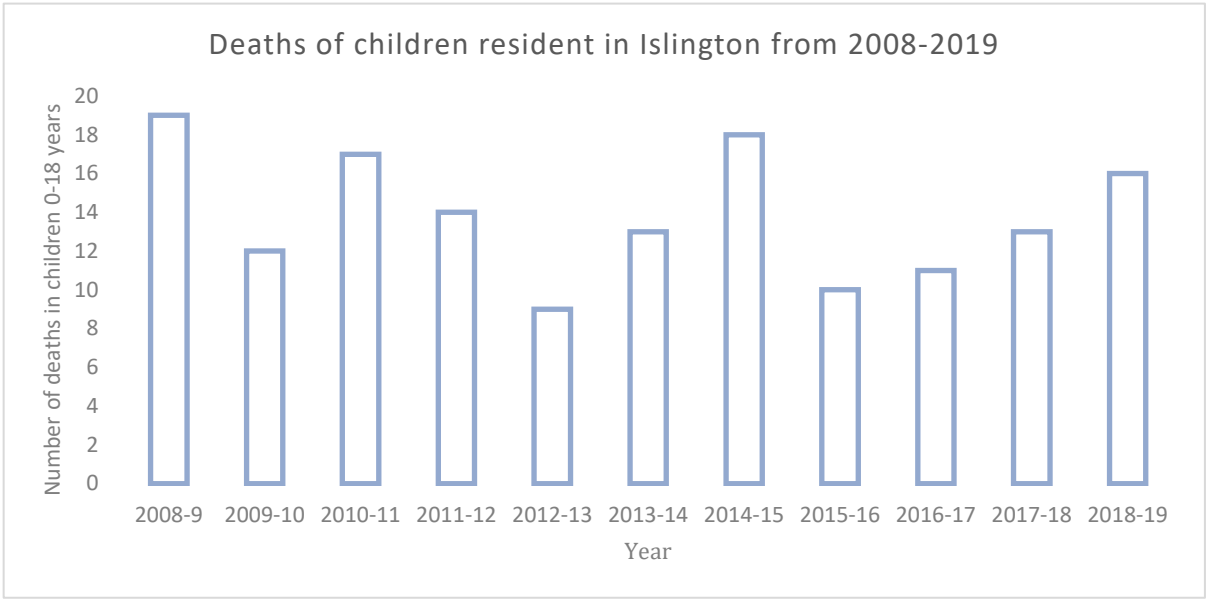
In February 2019 the Board agreed that a Serious Case Review should be carried out in relation to an Islington child, P. This review is nearing completion and will be published in the spring of 2020.

A review has also been agreed after the unexpected death of a child, Q. This review is progressing well and is likely to be published in late Spring 2020;

Learning from these reviews has been taken forward by the training sub-group and is included on all ISCB courses.

## CHILD DEATH OVERVIEW PANEL

The panel is constituted as a subgroup of the Islington Safeguarding Board. The core membership of the ICDOP draws in members from health, the local authority, and the police. Dr Leonora Weil is currently the Chair of the ICDOP. Dr Andrew Robins, a Consultant Paediatrician at Whittington



Health is the Designated Doctor for Child Death.

The work of the ICDOP is to review all child deaths through a systematic collection of information about the circumstances of the death. In doing this work, the aim is to identify if there were any modifiable factors contributing to the death, and to determine if there are any lessons that could be learned to reduce future child deaths and to improve practice and service delivery.

During the year, the ICDOP met on four occasions. This includes 2 joint neonatal meetings with Camden CDOP that were held on Sept 2018 and March 2019 and which were attended by Dr Mark Sellwood, Consultant Neonatologist, UCLH and by Mr Ruwan Wimalasundera, Obstetrics Lead, NCL (when available).

As in previous years, there were a number of cases discussed at meetings that had to be brought back to later meetings with additional information. There is always a period of time between when a child dies and when their case comes to the Panel for discussion. When there are criminal proceedings or a Serious Case Review (SCR), the Panel cannot formally complete its work until these other processes are finalised

Over the eleven years of its operation, there have been an average of 14 deaths per year.

During the year April 2018 to September 2019, there were 22 deaths of children who were residents in Islington (16 between April 2018-March 2019, and 6 between April-29th September 2019). The graph shows the number of deaths in children under 18 between April 2008 and March 2019. It should be noted that the numbers are small, and that conclusions cannot be drawn from the year-to-year fluctuations.

*Deaths by gender and age*

Of the 16 cases from April 2018-March 2019, more males died than females and more than 60% died in the first year of life (25% under one month, 37% at 1-12 months). This was a similar pattern for the total deaths between April 2008-Sept 2019 with over 60% in males and nearly 60% of deaths in the first year of life.

*Cause of death*

The panel is asked to categorise the deaths according to the list below[13]:

- Deliberately inflicted injury, abuse or neglect
- Suicide or deliberate self-inflicted harm
- Trauma and other external factors

[13] Actual numbers are very small and not published in this report to protect the privacy of families.

- Malignancy
- Acute medical or surgical condition
- Chronic medical condition
- Chromosomal, genetic and congenital anomalies
- Perinatal/neonatal event
- Infection
- Sudden unexplained death

As in previous years, the highest numbers of deaths are related to congenital and genetic anomalies. Otherwise, there are no factors that emerge as trends, which warrant particular consideration. The numbers within the borough are too small to draw useful conclusions around trends in cause of death. They therefore need to be considered in the context of London-wide and national data. The NCL CDOP and national mortality database information will be helpful for this purpose.

*Ethnicity and consanguinity*

Ethnicity and consanguinity were not very reliably recorded. Consanguinity was not recoded in 15 cases, not present in 6 and present for one death. This death was the second death of a similarly affected son however there was no positive genetic diagnosis despite extensive GOSH investigation.

*Learning*

The CDOP process asks the panel to consider whether, through the assessment, one or more factors are identified in any domain which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths. The presence of modifiable factors is taken to be associated with preventability.

These discussions have highlighted the following important areas for learning:

Of the 16 cases from April 2018-March 2019 there were two SUDI deaths, one accidental death from a window fall and one from suicide. One 17-year-old young man was stabbed.

Of the 6 cases from April 2019-29th September 2019: one death was in a 3yr old-inpatient for presumed infection. One died from fulminant Group B meningococcal sepsis and there was one SUDI death.

*Future of Child Death review / CDOP*

New Statutory operational guidance around child death was published in October 2018 and put into place as per the national guidance on 29th September 2019. The rationale for the new model was based on numerous factors: including to improve the experience of bereaved families and professionals and to ensure information would be systematically captured to enable local learning and, through the National Child Mortality Database to inform changes

in policy and practice. The key changes were:

- Oversight of CDR has moved to Department for Education to the Department of Health and Social Care with responsibility for the local child death review system with the local authorities and CCGs
- Each Child death review footprint to cover minimum number of 60 deaths per year (rather than covering the number of deaths per borough) to be included under a North Central London (NCL) wide Child Death Overview Panel that includes London Boroughs of Barnet, Enfield, Haringey, Camden and Islington with a focus on thematic learning. Furthermore, the deaths may be discussed in the NCL CDOP even if the child was not resident in the area, but if it is considered that the most learning would be had in that area. The responsibility for ensuring that the death is discussed in a CDOP is responsibility of the CDOP where that child is resident.
- Allocation of Key Worker for each bereaved family to improve the bereavement process.
- Child Death Review Meeting for every child
- Where deaths are thought to be caused primarily by not natural causes, a Joint Agency Repose will, occur similar to current rapid response meetings, followed by a child death review meeting involving the same partner

# Budget and resources

**Funding of LSCBs continues to be challenging, and collectively the London LSCB chairs are disappointed, as they were last year, that the MPS continues to choose to fund partnership safeguarding in London at a level which is 45% less than all the other large urban Metropolitan Police Forces in England.**

Safeguarding is a complicated and demanding partnership arrangement that needs appropriate resourcing if it is to be effective. If the ISCB is to carry out its statutory duties, it needs to be properly supported.

The guidelines which we adhere to (*Working Together to Safeguard Children (2018)* makes it clear that funding arrangements for Safeguarding should not fall disproportionately and unfairly on one or more partner to the benefit of others.

In London, this burden continues to fall unfairly on Local Authorities. MOPAC have been approached to provide reasonable and proportionate levels of funding to the Local Safeguarding Boards. As yet we have not seen an increase in funding.

| INCOME | 2017/18 | 2018/19 |
|---|---|---|
| **Agency contributions** | | |
| London Borough of Islington | £132,200.00 | £132,200.00 |
| DSG Grant | £50,000.00 | £50,000.00 |
| Islington CCG | £10,000.00 | £10,000.00 |
| NHS England (London) | £0.00 | £0.00 |
| Camden & Islington NHS Trust | £7,500.00 | £7,500.00 |
| Whittington NHS Trust | £15,000.00 | £15,000.00 |
| Moorfields NHS Trust | £7,500.00 | £7,500.00 |
| National Probation Trust | £1,500.00 | £1,500.00 |
| Community Rehabilitation Company | £1,000.00 | £1,000.00 |
| MPS (MOPAC) | £5,000.00 | £5,000.00 |
| Cafcass | £550.00 | £550.00 |
| Fire Brigade | £550.00 | £550.00 |
| **Subtotal** | **£230,800.00** | **£230,800.00** |
| | | |
| **Other income** | | |
| None | £0.00 | £0.00 |
| **Subtotal** | **£0.00** | **£0.00** |
| | | |

| | | |
|---|---|---|
| **Total income** | **£230,800.00** | **£230,800.00** |
| | | |
| **EXPENDITURE** | | |
| **Staff** | | |
| Salaries, 2.5 staff | 109,856.00 | 111,248.77 |
| Chair | 27,073.00 | 24,197.12 |
| Agency (training) | £0.00 | £0.0 |
| Sessional worker | 11,012.16 | 15,760.00 |
| SaferLondon Post | £9,800.00 | 0 |
| **Subtotal** | **£157,741.16** | **£151,205.89** |
| | | |
| **Board training** | | |
| Facilities & refreshments | £4,810.00 | £4,092.75 |
| ISCB Conference | £0.00 | £0.00 |
| Trainers | £0.0 | £0.00 |
| **Subtotal** | **£4,810.00** | **£4,092.75** |
| | | |
| **Other expenses** | | |
| SCRs | 12,245.70 | £12,490.00 |
| Training portal license | £0.00 | £276.00 |

| | | |
|---|---|---|
| Legal costs | £0.00 | |
| Board activities | £2194.50 | £2,170.50 |
| Stationery + phones | £47.75 | £319.00 |
| Printing | £1,149.00 | £124.40 |
| Travel | £133.50 | £90.00 |
| **Subtotal** | **£15,770.45** | **£15,469.90** |
| | | |
| **Total expenditure** | **£178,321.61** | **£170,768.54** |
| | | |
| Income | £230,800.00 | £230,800.00 |
| Expenses | £178,321,61 | **£170,768.54** |
| **Balance** | **£52,478.39** | **£60,031.46** |

# Conclusions and key messages

**Our aim year on year is to make sure that children in Islington are best protected from harm. This can only be achieved through ensuring the right systems are in place, that agencies work well together for each individual child and family and we develop our learning culture.**

We need to be constantly reflecting whether children in Islington are safe and, if not, what more can be done to reduce incidents of child maltreatment and intervene quickly when children are at risk of suffering significant harm. We will continue to raise awareness within our local community that safeguarding children is everybody's business.

### *Key Messages for all partner agencies and strategic partners.*

Partner agencies and strategic partners should:

- Support and champion staff to share and record information at the earliest opportunity, and proactively challenge decisions that fail to adequately address the needs of children and young people and their parents or carers.
- Make sure that help for parents and children is provided early in life and as soon as problems emerge so that children get the right help, at the right time.
- Ensure that the priority given to child sexual exploitation by the Safeguarding Board is reflected in organisational plans, and that partners play their part in the work of The Board's sub-groups.
- Ensure that work continues to address domestic abuse and that the evaluation of the local approach recognises the needs and risks to children and young people.
- Ensure work being undertaken to tackle neglect is evaluated and evidence of its impact on children and young people informs both strategic planning and service delivery.
- Ensure that substance misuse services continue to develop their role in respect of safeguarding children and young people and that greater evaluation is undertaken about the links between parents and carers' substance misuse and the high number of children and young people at risk of significant harm.
- Focus on young people who may be at

risk and vulnerable as a result of disabilities, caring responsibilities, radicalisation and female genital mutilation.
- Make sure that young people going into Adult Services for the first time get the help they need and that there is clarity about the different processes and timescales involved.
- Ensure that agencies commissioning and delivering services to adults with mental health issues need to ensure mechanisms are in place for the monitoring and reporting of their performance in respect of safeguarding children and young people.
- Ensure that performance information is developed, collected and monitored and that this is provided with a narrative that helps everyone understand how effective safeguarding services are.

### *Key Messages for Politicians, Chief Executives, Directors*

Politicians, Chief executives and Directors should:

- Ensure their agency is contributing to the work of the Safeguarding Children Board and that it is given a high priority that is evident in the allocation of time and resources.
- Ensure that the protection of children and young people is consistently considered in developing and implementing key plans and strategies.
- Ensure the workforce is aware of their individual safeguarding responsibilities and that they can access LSCB safeguarding training and learning events as well as appropriate agency safeguarding learning.
- Ask how the voice of children and young people is shaping services and what evidence they have in relation to the impact it is having.
- Ensure the agency is meeting its duties under Sections 10 and 11 of the Children Act 2004 and that these duties are clearly understood and evaluated.
- Keep the Safeguarding Children Board informed of any organisational restructures so that partners can understand the impacts on their capacity to safeguard children and young people in Islington.
- Ask questions about ethnicity, disability, gender to ensure strategic planning and that commissioning arrangements are sensitive to these issues.

### *Key Messages for the children and adult's workforce*

Everyone who works with children, in a paid or voluntary capacity, should:

- Use safeguarding courses and learning events to keep themselves up to date with lessons learnt from research and serious case reviews to improve their practice.
- Should familiarise themselves with the role of the ISCB and *London's Child Protection Procedures*.

- Should subscribe to the Islington Safeguarding Board website and visit it regularly to keep up to date at www.islingtonscb.org.uk
- Ensure that they are familiar with and routinely refer to The Board's Threshold document and assessment procedures so that the right help and support is provided and that children and young people are kept safe.
- Should be clear about who their representative is on the Islington Safeguarding Children Board and use them to make sure the voices of children and young people and front-line practitioners are heard at The Board.