



ISCB Annual Report

1st September 2019 – 31 August 2020

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Update from the Independent Scrutineer

Introduction

The *Islington Safeguarding Partners* as part of their arrangements to safeguard children and promote their welfare are required to demonstrate that they are open to independent scrutiny.

I have been appointed to take on the role of independent chair and to offer independent scrutiny of the *Islington safeguarding arrangements*, and this is my assessment of how effective these arrangements have been in practice over the past 12 months. I will highlight where I feel the arrangements are performing well and where I consider further development is required.

Engagement of *relevant agencies*

The *Local Authority*, the *NHS Clinical Commissioning Group*, and the *Metropolitan Police Service* form the three statutory safeguarding partners and have joint and equal responsibility for safeguarding children and young people in Islington.

The safeguarding partners have set out in their published arrangements the organisations that they will be working with to safeguard and promote the welfare of children.

The *Islington Safeguarding Partners* have identified a wide range of agencies, as outlined their published arrangements. These other agencies, called *Relevant Agencies*

should then act in a coordinated way to ensure the effectiveness of the local arrangements. These agencies have been actively involved during and since the development of the arrangements and have demonstrated their commitment to safeguarding by contributing across a range of meetings and activities as both attendees and chairs of various sub-groups.

Whilst all schools, colleges and other educational settings form part of the local arrangements, the system by which the partners can engage with all schools and colleges could be improved. In order to develop this further the Safeguarding Partners have introduced an Education Subgroup to ensure that **all** schools, colleges and other educational settings can be fully involved in the new safeguarding arrangements.

Covid-19

It was during this reporting period that the impact of Covid-19 became apparent. The partnership quickly recognised the detrimental impact that the pandemic would have on vulnerable families and the ability to effectively safeguard and protect children from harm and abuse. A core group comprising of key members of *Islington's safeguarding partnership* was formed during the early stages of the Covid. This group met weekly to discuss how the partners could work more effectively together during the pandemic along with using this forum as a platform to better identify

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gaps in service delivery and develop quick-time solutions to emerging problems. The meeting was seen as being very valuable for the partnership and has continued on a monthly basis.

Learning from *serious case reviews and child safeguarding practice reviews*

The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Such reviews should seek to prevent or reduce the risk of recurrence of similar incidents. It is the responsibility of the *Safeguarding Partners* to identify *serious safeguarding incidents* at a local level and then to review them as appropriate so that improvements can be made.

This report includes the details of three such reviews that were undertaken during this reporting period, referred to as Child P, Child Q, and Child R.

Islington Safeguarding Partners have a well-organised group of multi-agency professionals that oversee reviews and ensure there is a culture of learning and continuous improvement. The group are very keen to see that the recommendations from reviews improve outcomes for children and that lessons learned are embedded into practice. Furthermore, the partners have created a robust audit regime that ensures that the learning is revisited and

embedded. I will closely monitor the audit process to confirm that learning is indeed embedded, and practice is improved.

Voice of children, young people and families

Within Islington, there is a child centred approach which is fundamental to safeguarding and promoting the welfare of children. The partnership is very keen to see that children are involved and participate in child protection conferences where appropriate and that their wishes and feelings are understood when developing safeguarding strategies. Whilst the number of children attending child protection conferences has increased over recent years more work is being undertaken to ensure more children are represented so that their lived experience can be properly understood by professionals managing their care. The annual report highlights the innovative ways that partners across Islington have engaged with children and young people.

Performance monitoring and analysis

The partnership, in order to fulfil its functions, uses a wide range of data. The partnership has developed a multi-agency performance dataset and is developing a *Performance Dashboard* to highlight emerging safeguarding issues or trends that need to be addressed. The data is continually reviewed by the *Quality Assurance Subgroup* and is reported on to the wider strategic board. There is a real desire by the partnership to properly understand the

data and use it effectively to assess the impact of safeguarding. There is good data provided to the partnership from the local authority. The data required from the police and health partners is improving but still needs further development.

Evidence of impact and challenge

The partnership in Islington is mature and well developed; partners do put energy into scrutinising and challenging practice in an appropriate and considered way. A good example of challenge and scrutiny was where the partnership identified improvements in housing registered sex offenders within the community. This came about following local intelligence that indicated that a sex offender was living in the immediate vicinity of his child victim and therefore a considerable safeguarding risk. Although no child was harmed, the partnership quickly came together to review the circumstances and identify any learning they could from this particular incident. As a result, action was taken immediately to rehouse the offender and put in place actions and recommendations in order to prevent or reduce the risk of a similar occurrence.

Partner commitment to Islington safeguarding arrangements

Safeguarding is and will continue to be nuanced in complexity. More so now than at any other time. In order to be effective, the ar-

rangements require resources and strong administration in order to function.

Working Together 2018 highlights that working in partnership means organisations and agencies should collaborate on how they will fund their arrangements. This funding for the arrangements should be equitable and proportionate across the partnership. The funding arrangements of the *Partnership* falls disproportionately on the local authority and should be reviewed.

Conclusion

There are, in my view, many strengths to the safeguarding arrangements in Islington. I have found a strong partnership that is open to scrutiny, challenge, and one that strives to continually learn and improve practice. There is excellent engagement from leaders across the partnership who set a culture that drives improvement activity.

There are excellent examples in the annual report that highlight the breadth and depth of partnership activity across Islington to keep children safe. Such examples include *The Lighthouse project* on page 29, which is a support service for children and young people that have experienced sexual abuse. Work to prevent school exclusions on page 32, the *Keel Project* dealing with domestic abuse on page 25 and the *Disproportionality Project* designed to explore and tackle key issues relating to disproportionate representation of BAME young

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people in the Criminal Justice System and beyond. These are just a few examples of the innovative approach taken by the *Islington partnership* to improve outcomes for children, young people, and families.

The effectiveness of the partnership in Islington was recognised in March 2020 following the Ofsted inspection of children's social care services when they were judged outstanding. Ofsted commenting that:

'Partnership working is strong and well established and has contributed to the development and successful implementation of many creative and innovative services'.

Alan Caton OBE
Independent Chair and Scrutineer
Islington Safeguarding Children Board

Introduction

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PURPOSE OF THIS REPORT

Legislation* requires *local safeguarding arrangements* to ensure that local children are safe, and that agencies work together to promote children's welfare. The statutory safeguarding partners must publish† a report at least once in every 12-month period. The report must set out what they have done as a result of the arrangements, including on child safeguarding practice reviews, and how effective these arrangements have been in practice. The report will also include:

- Evidence of the impact of *safeguarding partners' and relevant agencies' work* including training, on outcomes for children and families ranging from *early help to looked after children and care experienced young people*.
- An analysis of any areas where there has been little or no evidence of progress on agreed priorities, a record of decisions and actions taken by the partners in the reporting period, implementation of the recommendations of any local- and *national child safeguarding practice reviews*, including

any resulting improvements.

- Ways in which the ISCB's partners and *relevant agencies* have sought and utilised feedback from children and families to inform their work and influence service provision.

AUDIENCE OF THIS REPORT

The report will be submitted to:

- The Local Authority's *Chief Executive Officer and Leader of the Council*.
- The *Health and Wellbeing Board*.
- The *local Police and Crime Commissioner / MPS Borough Commander*.
- ICCG Governing Body.
- *National Child Practice Review Panel*.
- *What Works for Children Social Care*.

Individuals and Boards are asked to note the findings of this report, and to inform the Independent Chair / Scrutineer of the actions they intend to take in relation to those findings.

REMIT OF THIS REPORT

This report follows the *ISCB Annual Report 2018/19*† and covers the period from 1st September 2019 to 31st August 2020

* Children Act 2004

† Working Together to Safeguard Children 2018

‡ <https://www.islingtonscb.org.uk/SiteCollectionDocuments/2020.02.15%20ISCB%20Annual%20Report%202018-19.pdf>

METHODOLOGY

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

The report draws 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.

DEMOGRAPHICS

Islington is a small, densely populated inner London borough with a total population of 236,400 in 2020, which is estimated to increase by 5.5% by 2040. The borough is the second smallest in London in terms of area (after the City) and has the highest population density.

The population age profile is on average younger than those for London and England are, with 46% being young adults aged between 20 and 39 years. There are approximately 42,900 children and young people aged 0-19 living in Islington, and around 73,000 0-25 year olds. The proportion of children from a BAME background is relatively high at 66% and a significant proportion of children live in households where English is not the first language.

The borough is one of stark contrasts. In the *2019 Index of Multiple Deprivation* (IMD), Islington was found to be the 53rd most deprived local authority in the country and sixth 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, but the most deprived in London, with 27.5% of children living in income-deprived households. 18.4% of Islington under 16 year olds live in *relative low income* households and 14.0% live in *absolute low income households*, based on the latest data for 2018/19.

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.

Just under 30% of children and young people live in one-parent households (one of the highest proportions in London). 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 91.2% of Islington's schools are *good* or *outstanding* as judged by Ofsted, which is above the national average of 86.2% (as at the end of the 2019/20 academic year). The proportion of young people who were not in *education, employment or training* (NEET) or whose activity was not known was 4.1% in 2019/20 (compared to 5.5% across the country). 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 the professions.

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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* of the Council, the *Executive Member for Children's Services*⁴, *Corporate Director for People* and *Director for Safeguarding and Family Support*. The *Safeguarding Partnership Constitution* makes provision for these meetings to include the accountable persons from the *Clinical Commissioning Group* and the *Metropolitan Police*.

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. The sub-groups of the ISCB also have good attendance from a wide variety of *partners* and *relevant agencies*.

BOARD STRUCTURE

The structure chart on page 17 shows how the functions of the ISCB are organised. Most of the Board's functions are discharged through one of its 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

Chair: Independent Chair of ISCB

Key responsibilities of the sub-group are to:

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

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

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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: 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 legacy *serious case reviews* (SCRs) and *local child safeguarding practice reviews* are disseminated.
- Measure the impact of multi-agency training.

Quality assurance sub-group

Chair: 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.
- Audit and review the progress of the implementation of recommendations of Learning Reviews.

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

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

- Review and monitor ISCB's policies, practice, and procedures, when necessary.

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- Plan the piloting of and / or introduction 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 website.

Missing, child and adolescent exploitation sub-group,

Chair: Detective Superintendent, MPS Central North BCU

Key responsibilities of the sub-group are to:

- Reducing the risk of children going missing or being criminally exploited.
- Improving intervention and diversionary activity for those who go missing, and offend whilst missing, or who are at risk of criminal exploitation.
- Identifying perpetrators who assist children going missing, or aid in their criminal exploitation, and disrupt / prevent their activity.
- Building a problem-profile for both missing children and the criminal exploitation of children / adolescents in Islington.
- Identifying and disrupt peer-on-peer abuse in Islington.
- Using trauma-informed approaches to

problem solve in these areas and safeguard vulnerable children and adolescents from harm.

Case review sub-group,

Chair: Head of safeguarding & Quality Assurance.

Key responsibilities of the sub-group are to:

- Arrange a *rapid review* meeting for a child after notification of a *serious safeguarding incident*.
- Consider all cases that may potentially meet the criteria for a *local child safeguarding reviews*.
- Appoint a suitable panel to carry over-see a *local child safeguarding practice review*.
- Commission, where necessary, a suitable independent reviewer to carry out a *local child safeguarding practice review*.
- To monitor implementation of agencies action plans after a *local child safeguarding practice review*.

Education Sub-group

Chair: Head of Primary School Improvement

- To provide opportunities for the ISCB

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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.
- To ensure that any potential safeguarding concerns are followed up.

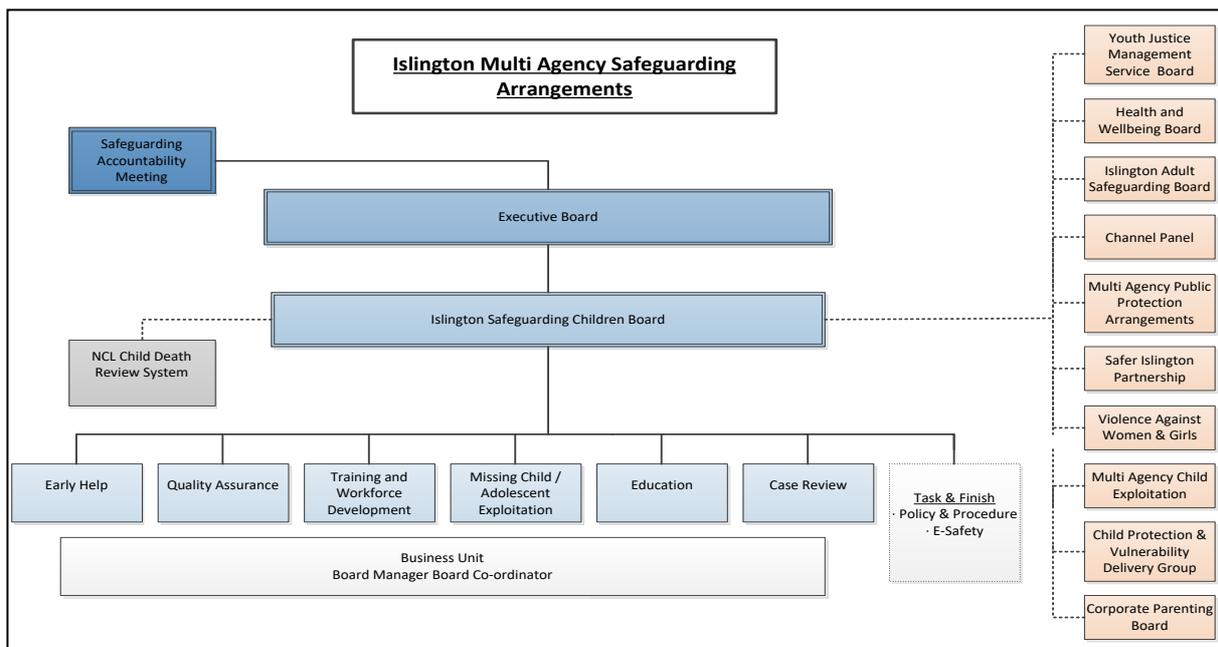
Early Help sub-group

Co-chair: Lay Member of ISCB

Co-Chair: Assistant Director Public Health

Key responsibilities of the sub-group are to:

- Monitor progress by the Partnership against *Islington's multi-agency Children and Families Outcomes Plan*.
- Improve data and information sharing to support the delivery of early help and statutory support to families with multiple needs across children and adults services.
- Agree how and where to deploy resources to ensure they are targeted effectively across the partnership.
- Develop and nurture a children and adult workforce that takes a whole family, relationship-based, and



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trauma-informed approach to assessment, planning, and interventions.

- Ensure continuous improvement in the quality of practice, including assessment, planning, and the quality of interventions.
- Ensure consistent and effective monitoring and evaluation systems are in place across early help and statutory family support services that evidence the impact on children and families' lives.
- Promote and disseminate research findings and good practice in family support, share service developments and information across partners.

Key activities of the ISCB

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In previous reports, The Board set out the rationale for choosing our current priorities, and this is the fourth update on those priorities

ISCB PRIORITIES

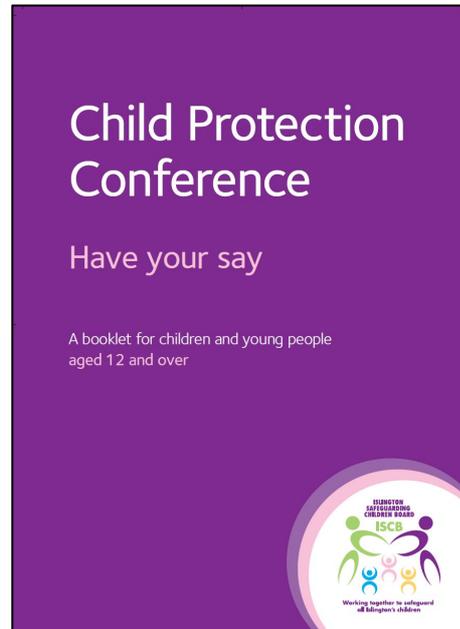
These priorities reflect our desire to improve the collective effectiveness of agencies in three key areas. *Partners and relevant agencies* should:

- Address the *impact of neglect* on children.
- Address the consequences of harm suffered by children because of *domestic violence, parental mental ill health, and substance abuse*, including helping children who have suffered harm to become more resilient.
- Identify and help children who are vulnerable to *sexual exploitation, criminal exploitation, and gangs*.

THE VOICE OF CHILDREN AND FAMILIES IN MULTI-AGENCY PRACTICE

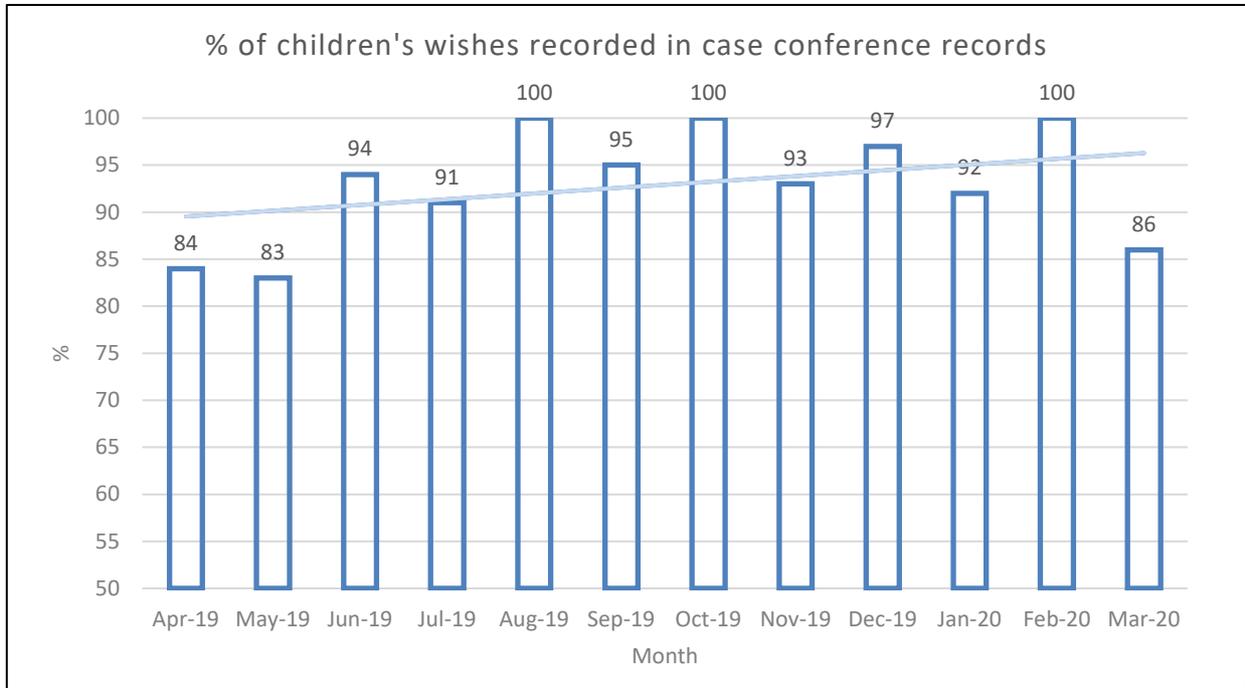
Children's wishes and feeling in Child Protection Conferences

The safeguarding board's procedures require that the child, subject to their level of understanding, needs to be given the opportunity to contribute meaningfully to the conference. Where this is not possible, the social worker should use alternative arrangements to ensure that the



wishes and feelings of the child are properly represented in the case conference. The ISCB has made available a suite of consultation documents for use with parents and children that all professionals can use.

Children and young people's presence may often not be appropriate due to their age and development or it may simply be that adults do not wish them to be present at a conference where parental issues pertaining to neglectful or abusive parenting are discussed. A recent report to the Board shows that participation of children



and young people at child protection conferences is a challenge⁵. Actual attendance of children at child protection conferences remains low. In 2019/20, 68% of children deemed eligible for attendance were invited. This is a significant improvement over the 43% from the previous year. However, only 15% of invited children attended conference this year compared to 31% in 2018/19. In real terms, only half as many children attended conferences compared to last year.

Children's wishes and feelings are represented via consultation forms or other

methods of direct work. Social Work reports to conferences have a separate section for the child's views, as do partner-agency reports. The whiteboard at the child protection conference also has a separate section called *child's wishes, feelings, and experience* to ensure this is fully discussed in the meeting.

Child participation audit

Child's participation has been measured in more depth by looking at all conferences (children aged 5 and older) over a 12 months period. The audit looked at whether:

⁵ Child Protection Annual Report 2019-2020, presented to Quality Assurance sub-group, May 2020.

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- The child attended the conference.
- They completed a consultation booklet.
- There was evidence in the *children and family assessment* of consultation with the child for the conference.
- There was evidence of the child's wishes, feelings and lived experiences were contained in the conference record.

The audit shows that while few young people physically attended *child protection conferences* there has been a continued improvement in terms of children's wishes, feelings and lived experience represented in social work reports.

Moorfields Eye Hospital— Learning from Practice

Moorfields Eye Hospital drew attention to subtle and unusual forms of neglect after participating in an internal multi-agency review (Child O).

Whittington Health Trust

The trust Care Quality Commission (CQC) inspection noted several instances of the trust's ongoing effort to involve children and families in shaping their services:

Social Emotional Mental Health

(SEMH)

The Social Emotional Mental Health (SEMH) service had been designed in true collaboration with a range of local stakeholders. The SEMH model had been a direct result of listening to the local population who said they needed greater access, choice and reduced waiting times for young people who required support for their emotional wellbeing and mental health. The acronym name (SEMH) of the service had been decided by young people during the design process.

Participation and engagement is central to

the *Children's Joint Commissioning Team* and the team has a dedicated Participation Officer who leads on engagement and co-production involving Children and Young People, Parents and Carers and Service Users. This team is jointly funded by the CCG and the London Borough of Islington. Using a range of engagement and participation methods the *Children's Joint Commissioning Team* have

been successful in engaging children, young people (CYP) and their parents and carers in the ongoing development of service provisions across all commissioning areas.

The team worked collaboratively with young people to launch the *Social and Emotional Mental Health service*, where they collaborated with support-staff in delivering the launch for professionals and stakeholders. This also became a platform for them to share their initial experience of the provision and have open discussions to further influence the overall delivery.

In November 2019, CYP were involved in the design of the SEMH-pathways leaflet that has now rolled out to provisions across the borough in both digital and hardcopy form. Due to Covid-19, there was a halt to engagement with young people in face-to-face settings. However, using online platforms CYP had the opportunity to provide key feedback that informed the adaptations to general delivery. This was made possible via the Lead

CYP Group that meets bi-monthly to be informed, and to inform the overall delivery of services pertaining to their health and wellbeing.

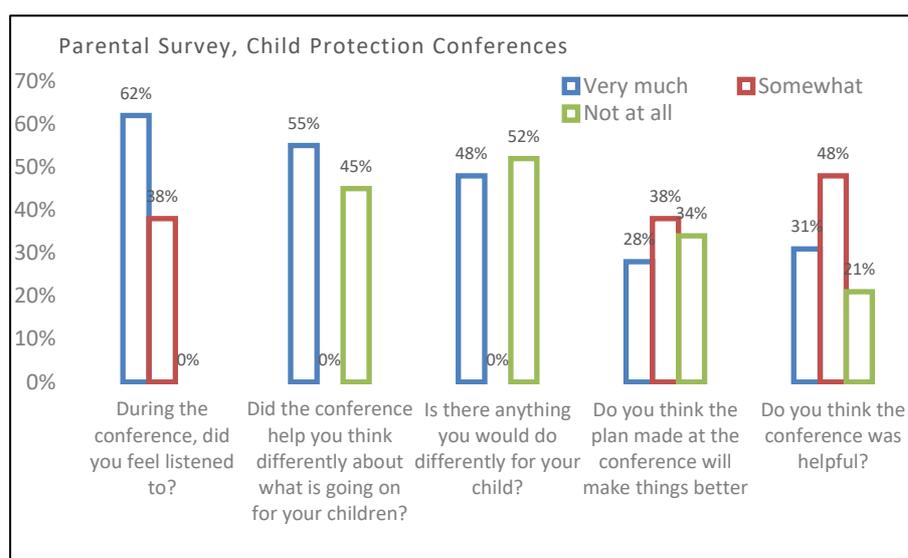
Adverse Childhood Experiences (ACEs)

Through community engagement, clinicians had visited local community settings including schools and nurseries to cascade knowledge of ACEs, and how to better support young people who faced ACEs to minimise the impact of them in adult life.

Youth Board

Young people, families, and carers were fully involved in the planning of their care and the service was accessible to people from a range of cultural backgrounds. The *Youth Board* in place across the service gave young people a clear voice and opportunity to shape decisions about the way in which the service was delivered, and members completed projects that en-

riched the experience of young people.



Parental views about CP conferences

Seeking parental feedback about child protection conferences is difficult. These meetings can be stressful for families and it can be

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hard for parents to feel they have the space to reflect on their experience.

For the last three years, children social care has asked parents to complete an online survey to give anonymous feedback about conference. Parent's uptake has remained very low and was supplemented by telephone surveys. Last year we tripled the number of parents giving feedback, even though the number of parents involved was very low.

Finding of parental views survey

The graph above (*Parental Survey, Child Protection Conferences*) shows the findings of the parental survey. Parents had differing views about the usefulness of case conferences and whether parents needed to change things at home for their children; but conferences made most parents felt listened to.

KEY ACTIVITIES OF THE MAIN BOARD

The Board scrutinised work in the following areas:

Private Fostering arrangements

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

Current Private Fostering Situation

There were **four** notifications in the year 2019-2020. This is down on the number of

notifications in 2018/19 and 2017/18 (9 and 10 respectively). Two of these notifications were not *private fostering arrangements*. The total number of *private fostering arrangements* was 6, involving 6 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 there was one arrangement (involving 1 child) where the initial visit was delayed. The arrangement then ended and the children returned to her mother's care. Overall, 83% of visits were in time.

This year there was an equal divide of female and male children in *private fostering arrangements*. This has equalised slightly as in the past two year there have been more females. These children come from a diverse range of ethnic backgrounds.

Two new notifications this year came from health, one from an *Islington Early Help Service* and the other from another local authority.

At the time of this report, there are two ongoing arrangements, both carried over from previous years.

Reasons for arrangements ending include young people returning to their family or reaching the age of 16.

Recommendations from 2018/19

Recommendation 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

The quality assurance and monitoring is now with the *Permanence Service*. Late visits, although small, continue to be prioritised, managers support practitioners to record outcomes appropriately.

Recommendation 2: ISCB will continue to include Private Fostering as a compulsory

element to safeguarding training.

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

Recommendation 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 better understand the challenges.

This is taking place as evidenced in supervision records and management direction on case files.

Recommendations

1. Team managers and practice managers across the service to review and monitor initial and ongoing visits to ensure that social workers are completing these within timescale and each visit meets the statutory requirement.
2. Fostering Team to appoint a lead to attend the *Private Fostering Consortium* meetings and liaise with the Child in Need (CIN) Service on any new developments.
3. The *North London Consortium* has recently devised the *Private Fostering Website* and this is soon to go live. The newly formed group will continue to review information and documentation and raise awareness. There will be

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a link from the *Safeguarding Board* to this website.

- 4. The COVID-19 pandemic began in March 2020, and next year’s annual report will report on if and how it impacted on *private fostering arrangements*.
- 5. Coram BAAF used to coordinate a national Private Fostering awareness week every July. This has now ceased, however it would be a positive step for Children’s Social Care to initiate this to promote more awareness across the authority.

A 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 against professionals are thoroughly investigated by the LADO, and in accordance with the Board’s procedures.

LADO report

Sources and nature of referrals

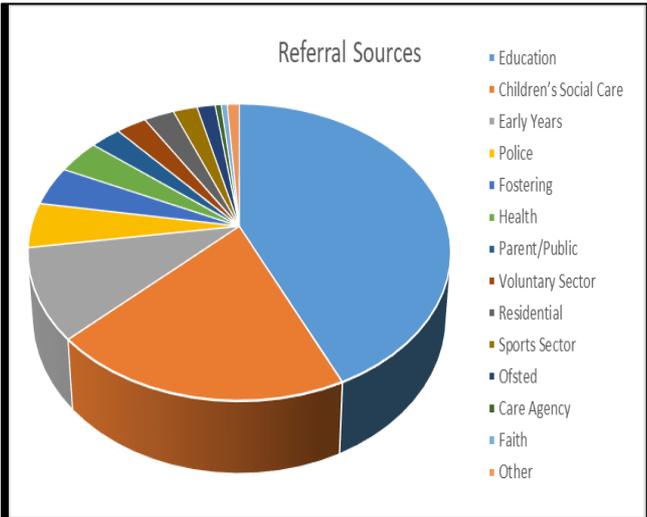
The ISCB received the 2019/20 LADO Annual Report for scrutiny

This report covered the period 1st April

2019 to 31st March 2020 and concerns **189 contacts with the LADO**.

This figure is down from the **202 contacts** in 2018/19. This may be because complaints from Ofsted (that are not safeguarding related) are now recorded and dealt with separately by the *Principal Officer for Safeguarding in Education (PO-SIE)*. There were **16 Ofsted category 3** complaints, which if added to the LADO contacts would bring the total to **205**.

For the period 2019/20, a new tracker for contacts to the LADO was introduced which can now be accessed by safeguarding leads in *Early Years, Education and Fostering*. This has helped in triangulation of enquiries across departments and in providing performance data for each service. The 2020 Ofsted inspection identified this as an example of good practice.



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The vast majority of allegations are about staff in schools and colleges, which is proportionate because they are the biggest employer in the children’s workforce, having the more 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 Lead* 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	81 (82)	43% (41%)
Private-life matters	37 (36)	20% (18%)
Sexual	30 (14)	16% (7%)
Neglect	13 (16)	7% (8%)
Emotional	13 (12)	7% (6%)
Complaints / Care standards	11 (42)	6% (21%)

Nature of referrals

The table (*LADO Referrals*) sets out the nature of referrals that were made to the LADO.

As with previous years, the majority of contacts related to concerns about *physical abuse*.

The second 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.

Complaints about *care standards* have vastly reduced. This may demonstrate an awareness by agencies that such referrals should be dealt with by way of *complaints* or *disciplinary procedures* rather than the ISCB’s *managing allegations procedures*.

Compliance with the ISCB *Child Protection Procedures*, that allegations must be referred within one working day, is fairly similar to last year, 85% (previously 90%). This demonstrates good knowledge by agencies of their responsibilities to report concerns swiftly. Where referrals are not made within one working day, this is taken up by the LADO and safeguarding leads for the relevant agency.

In 87% of referrals, the employer was given advice and 22 cases proceeded to an ASV meeting.

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The ISCB procedures expect that:

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

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

Figures demonstrate that the LA completed 82% (previously 68%) of cases within 3 months.

KEEL PROJECT

The *Keel Project (Keel)* was a prototype project established to test a new way of working with families affected by domestic abuse. The *Keel* evaluation provides a summary of the learning and good practice that have arisen from the *Keel project*.

The *Keel* findings are being used to inform the council's ambitious *VAWG (Violence Against Women and Girls) Service* transformation programme. The council has invested substantial new funding to support this transformation including creating a new post of *VAWG Workforce Development and Practice Manager* who is already in post and will lead on the delivery of the dissemination of learning and good practice from the *Keel*. In particular to support the delivery of the three key findings:

- Supporting victims and moving away from *failure to protect*.

- Engaging men who use violence and abuse.
- A community response to domestic abuse.

The council investment is used to significantly increase *specialist service capacity* to support victims and survivors and their families, as well as developing a new *Intimate Partner Violence* service and monthly panel meeting to reduce the harm caused by people using violence in their relationships. Islington council and its partners is therefore in a unique position to be able to ensure that the *Keel* legacy is delivered and that the good practice and learning is disseminated across the wider workforce to prevent domestic abuse and violence and to ensure that more survivors and their families are protected and able to recover when they have experienced abuse.

An action plan has been developed to deliver the *Keel Project* legacy.

DISPROPORTIONALITY PROJECT

This is the second partnership project involving Islington Borough Council and criminologists at *City University* of London.

The First project, *Enhancing the work of the Islington Integrated Gangs Team*, published in 2019. A third project is being worked on exploring the Andover Estate and youth offending.

The project was designed to explore and tackle key issues and outcomes relating to disproportionate representation of *Black, Asian and minority ethnic* (BAME) young people in the Criminal Justice System and beyond.

The programme was attended by multiple settings from two London Boroughs, Islington, and Haringey and sought to strengthen a multi-agency approach to addressing disproportionality:

- Islington: *Youth Services, Youth Offending Services* and the *Integrated Gangs Team*.
- Haringey: *Youth Justice Service, Early Help, and Youth Service*.
- Police, Probation, education, and health officers also attended sessions.

Service Aims

- To provide training around *Adverse Childhood Experiences* within BAME communities for staff
- Setting up an initiative whereby parents from BAME backgrounds have a safe space to discuss the pressures associated with their children's involvement in ASB and/or offending behaviour and the structural and societal pressures they face.
- Better support young people and their families from the poor outcomes and lack of opportunity which unfortu-

nately is more prevalent in BAME individuals and families e.g. in education, employment, income, health outcomes and treatment. The criminal justice system and Covid-19 are further examples of these pressures.

- Strengthening communities that have been marginalized and helping to influence Islington and Haringey to shape and improve their services so that young people and their families are supported to 'live their best lives'.

Evaluation Approach

- Research team attended all practitioner workshops, Aug-Nov. 2019.
- Interviews with cross-section of the frontline practitioners who attended workshops conducted at YOS sites in Islington and Haringey, respectively, in late 2019.
- Parents' workshops, at neutral venues, recorded to evaluate project and identify parents' lived experiences with regard to disproportionality.
- Young people engaged in criminal youth justice (CYJ) interviewed at YOS sites to capture experiences of criminal offending, victimisation, discrimination, racism, disproportionality.
- Evaluated delivery, outputs and, where possible, outcomes of Disproportionality Project.

Recommendations

1. Structure and Approach

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In any future disproportionality programme involving staff training, consider using full-day rather than half-day sessions, move ice-breaker activities to after the session outline, specify the cumulative nature of learning from session to session, and incorporate 'learning into practice' action planning after each session.

2. Dissemination

Disseminate this project's key findings regarding the challenges and obstacles faced by young people and parents to relevant staff members, including senior leaders, and beyond.

3. Use of academic research

Make fuller use of key social science research insights into implicit bias and the transmission of discrimination, particularly as these relate to race and ethnicity, in future iterations of the programme.

4. Young People's and Parental engagement

Continue capturing the voice of young people in relation to disproportionality and consider offering a more extensive programme of parents' forums, including parent-practitioner sessions moderated by a third party.

5. Responsiveness to local factors

Combine ad-hoc forums in response to

specific incidents and events with more regular outreach programmes that both draw on and share expertise from relevant services.

6. Review the safety and risk implications of YOS procedures

Consider whether the routinisation of young people's movements created by YOS procedures/protocols may increase risk of harm.

7. Reporting on and scrutinising disproportionate court outcomes

Explore the possibility of compiling regular reports for local courts detailing disproportionate outcomes for BAME young people from Haringey and Islington – particularly remand and custodial sentences – and introducing an annual or biannual scrutiny panel, including local court representation, to scrutinise those reports.

8. Replicating an action-orientated training focus

Prioritise the identification and dissemination of good practice, which can have an immediate impact on practitioners' day-to-day work, in future iterations of the programme.

9. Boosting parental trust and engagement

Consider strengthening whole-family

working practices and models, including the creation of parenting worker roles where these do not already exist.

10. Increasing accountability for school exclusions

Consider identifying and collating longer-term outcomes for excluded BAME young people, and disseminating this information on a school-by-school basis.

11. Police relations with young people

Police Borough Command Units should continue working to strengthen relations with BAME young people.

Lighthouse

An update was presented to the Board in November 2019 on the *Lighthouse* service, which is a support service for children, and young people that have experienced sexual abuse. The service is available to:

- Children and young people aged 0-18 years.
- Young people with learning disabilities aged 18-25 years.
- Living in Barnet, Camden, Enfield, Haringey, or Islington.
- Children where there is disclosure or professional suspicion of child sexual abuse.

In its first year, the *Lighthouse* has:

- Trained over 500 frontline staff in police, social care, health and care.
- Referred 363 children and young people – tripling referrals from 118.
- Supported over 200 children, young people and families
- Ran a parent psychoeducation course.
- Hosted regular open days and visits including: *MPS Commissioner*, CEO of *HMCTS*, *Ofsted*, local and national Judiciary and several national/international visits.
- Contributed to national policy and training across the criminal justice system

Child Death Overview Panel (CDOP) and Child Death Review (CDR) process

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: improving 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*, inform changes in policy and practice. The key changes were:

- Oversight of CDR has moved to the *Department for Education* and the *Department of Health and Social Care* with responsibility for the local child

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death review system with the local authorities and CCGs

- Each Child death review footprint to cover at least 60 deaths per year (rather than covering the number of deaths per borough).
- Establish the 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.
- The allocation of a *key worker* for each bereaved family to improve the bereavement process.
- A *Child Death Review Meeting* for every child.
- Where deaths are thought primarily to be caused 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 partners.

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*.

ISCB Risks and Issues register

The Board maintains a *risk / issues register* to ensure risks / issues are identified, and plans formulated to mitigate concerns.

The Board ensures that arrangements are in place to manage each risk / issue. All

risks / issues have ownership at board level and an agency action-plan to reduce or remove the risk / issue.

ISCB Escalation procedures

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

In 2019/20 the procedure was used on several occasions, with an update given by the Head of safeguarding at each board meeting.

In the last year, escalations have been mainly between CSC and MPS. Mainly around the progress around arrests of young people for breach of bail conditions and timelines of when young people were arrested (some in the early hours of the morning). Were there opportunities for more effective partnership working if:

- Social workers were given the chance to plan with police the best time to arrest a young person.
- Young persons were given the opportunity to present themselves to the custody officer, rather than being arrested.

Overall, there was a very good and swift response to any escalations raised. There is a solid working relationship between

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CSC and Police. As well as quarterly partnership meetings so that systemic issues are raised and resolved to limit escalations.

Lay Members

The Board benefits from having a lay member who actively contributes to the work of the Board. During this reporting year, the lay member also took on the co-chair of the Early Help sub-group that helped to establish a productive and well-attended committee.

The lay member consistently challenges the work of the Board where appropriate, and continues to bring 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.

Film Drawn Out

Islington young people, in partnership with Arsenal in the Community have produced a film *Drawn Out* set in Islington about gang and youth violence. It received more than 3 million views on YouTube. As part of a targeted 12-week programme in

conjunction with Solace it will be shown in Islington schools and selected groups.

Sex, Relationships and Education

In September 2020 *sex, relationships, and education* became a statutory requirement in schools. With the support of the *Department of Education*, 5 Islington schools became early adopters of the program. Elsewhere in the UK there has been considerable disagreement by parents about these changes and a lot of work is being done by the LA, including with the Diocese and Islington Faith Forum.

11 x 11 and other school contractors

The ISCB business Unit has done extensive work with LBI colleagues launching the 11x11 project in schools:

- Advising LBI colleagues on S11 requirements for organisations and revising the team's internal safeguarding policies and procedures.
- Provide quality assurance and advice to providers regarding safeguarding policies.
- Commissioned safeguarding training for providers.

The education sub-group received a report from the Local Authority 11x11 service about all the actions that have been taken to enhance safeguarding requirements. The POSIE has also written to schools

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about safeguarding responsibilities in relation to contractors doing work in schools.

Section 11 self-audit in Schools

The 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 0-5*, and reports to this sub-group.

The Partnership Board requested the S11 audit in September 2019 and there has been a very good return (94% for Early Years and over 90% for Islington Schools). Most self-assessments contained appropriately detailed action plans for improvements.

Designated Safeguarding Lead (DSL) Supervision in Early Years and Islington Schools

The ISCB is pleased to see that DSL Supervision in schools and *early years* settings are continuing strongly. There continues to be a lot of pressure on DSLs with the task becoming ever more complex.

Themes emerging from discussions at Early Years DSL supervision are:

- Working with families with Mental health issues is very complex and difficult for staff to manage;
- Voluntary settings work with Islington families with same complex needs but

with very limited resources;

- Communication with CSC and social workers is sometimes challenging, e.g. lack of information sharing and not keeping settings informed
- Impact of COVID managing and containing children's, parents and staffs heightened anxieties.
- DSL's feeling very over-whelmed with impact of COVID and expectations of government and other agencies
- DSLs feeling the traumatic effect of Racism and the impact of death of George Floyd and BLM movement.
- Parental relationships and conflict

Exclusions Task and Finish Group

The Local Authority has done a lot of work with schools to prevent exclusions and support children at risk of exclusion. A report about exclusions with a 13-point action plan has been agreed that also include recommendation from the Timpson Review about Schools exclusion.

Policies and procedures relating to schools and education

- Metropolitan Police Safeguarding *children from sexual violence, child sexual exploitation, and harmful practices procedure* published. Unfortunately, the policy contradicts the *London*

Child Protection Procedures and the matter was raised with the London Safeguarding Partnership Editorial Board. This guidance has now been withdrawn.

- The ISCB's *Model Safeguarding Child Protection Policy* has been updated and is available on the ISCB website for schools to adapt as they see fit. It was also updated in response to *Keeping Children Safe in Education and Working Together 2018*.

Trauma Informed Training

Trauma Informed Training for schools began 3 years ago and 15 primary and 3 secondary schools have now received training. It will continue to be rolled out with additional 1-2 secondary schools per year, and five additional primary schools per year. There are currently plans to involve the community and parents in *trauma informed training* although funding will need to be found.

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 subgroup'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 an important priority; alongside that the *Safeguarding and Family Support Service* and *Youth and Community Services*

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have undertaken a number of large projects. 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 has 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.

In 2019, the changes in MACE meant that Pre-Mace needed to also expand. Pre-Mace is now attended by Gangs police, Exploitation police, TYS, IGT and chaired by the E&M team.

Ofsted inspection: child sexual exploitation

In March 2020, Ofsted undertook an Inspection of Islington's Children's Social Care Services, the experiences and progress of children who need help and protection was graded as outstanding. In the Inspection report, they commented:

“Children and young people at risk of sexual and criminal exploitation and gang involvement receive a highly effective response. Creative and persistent efforts are made by exceptionally knowledgeable and skilled practitioners in the ‘exploitation and missing’ team and the integrated gangs unit to locate and engage with children who go missing.

The identification and understanding of risk for children facing exploitation are sophisticated and impressive. The quality of return home interviews has improved significantly since the last inspection; they are now of consistently high quality and they are promptly

shared. This informs effective disruption, prevention, and safeguarding activity, which reduces risk for these highly complex and vulnerable children and young people”.

CSE Training and Awareness

The Exploitation and Missing Team provide a significant amount of specialist training across Islington and to partner agencies in relation to CSE, *Harmful Sexual Behaviour* (HSB), *Serious Youth Violence* (SYV) and *Child Criminal Exploitation*. The team pride themselves on being very versatile and flexible in regards to training requests with partner agencies requesting ad hoc training to a varied audience. In the upcoming months there are several new training sessions booked in, including sessions being delivered to young people and staff at local colleges, sessions at the Muslim Welfare House, and, to reflect increased demand, several sessions at primary schools for staff on the signs and risks of exploitation.

School-based preventative education

Children and young people also receive group work and awareness raising sessions across the Exploitation and Missing focus areas. Over the last year, almost 400 children have attended targeted awareness sessions at their schools, with year-9 children accessing sessions on *consent* and

healthy relationships delivered by Specialist Social Workers in the *Exploitation and Missing Team*. The feedback from these sessions has been very positive and the schools involved have requested they continue throughout the next academic year.

Missing Children

From April 2019 – March 2020 245 children were reported *missing from home* and *from care*. This is reduction in number of young people who went missing in 2018-2019 which totalled at 265. These 245 children went missing a total of 972 times, in 2018/2019 the total of missing episodes was 995.

Children Missing from Home - length of missing episode

In total, 49% of the *missing episodes* involved young people going missing for less than 24 hours, and 22% involved children returning the following day.

1% (one child) of the *missing episodes* related to children going missing for more than one month. This young person was considered to be at risk of child sexual and criminal exploitation. During this missing episode, her mother knew where she was but was refusing to give CSC the details of the property. The social work team had regular contact with the young person who stated she was staying with her boyfriend and his family in another borough.

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Children missing from care - length of missing episode

In total 53% of the missing episodes involved young people going missing for less than 24 hours, and 17% involved children returning the following day.

No young people went missing for more than one month.

Other missing children in the Local Authority area

Over the last year, April 2019 to March 2020, there were 67 children residing in Islington who were *Looked After Children* by another borough⁶.

No notification was received that any of the 67 children were reported missing from care or away from placement without authorisation. This is a decrease from 8 children in 2018/2019.

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)

Oversight and management of the *Return Home Interview* (RHI) process was provided by the Exploitation and missing team (moved from the Youth and Community Directorate in July 2018). This was to enable closer collaborative working in regards to children who go missing from home and from care and to focus on developing and improving the take-up of RHI's and engagement with children and young people.

Between April 2019 and March 2020 171 more RHI's were completed than between the same date range in 2018 and 2019.

Since April 2019, the number of RHIs not completed due to whoever completing the RHI not being able to make contact with the child or their family has also significantly dropped, from 65 last year, to 26, which is quite significant. This is a reflection on the individuals completing the RHI's being more embedded in the service and better links being created between them and early help services, the missing police and MASH.

⁶ 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.

There are some clear improvements regarding the number of young people contacted and engaged with the RHI process. When we consider that a third of all missing episodes related to just 10 children it supports the thinking behind the E&M team prioritising trying to build relationships with those who are missing most frequently.

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). From April 2019 – March 2020 there was an increase of young people identified as being at risk of CSE, at the point of referral, from 65 to 81.

Forty six young people have been newly identified as at risk of CSE throughout the year.

Between April 2019 to March 2020 47 young people who were considered to be at risk of CSE received intervention and that CSE level either reduced or they were no longer considered at risk of CSE.

Return to home interviews	
Status	N
Completed	365 (194)
Attempted, Child Refused	88 (146)
Attempted, Parent(s) Refused	29 (25)
Not Possible, Unable to make contact	26 (65)
Not Possible, Other	0 (0)
Not Required, Authorised Absence	28 (29)
Not Yet Completed	127(118)
Total (Excluding Still Missing Code)	663
RHI Not Possible - Child is Missing	309 (418)
Grand Total	972 (994)

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In 2017/2018 the most common ages for a young people to be identified as at risk of CSE was 14 and 17. In 2018/2019 the most common age was 15. In 2019/2020 14 is the most common age with 17 being the second most common.

The majority of children who have been identified as at risk of CSE over the year 2019/2020 are female (39) with 7 males being identified. This gender breakdown is similar that of last year.

The ethnicity break down of young people identified as at risk of CSE has stayed very similar across the year and there is no particular pattern or themes identified in terms of ethnicity. As across the whole service, data is reliant on accurate recording and is open to cross over for example someone choosing “mixed parentage” or “white and black British”.

In Feb 2020 39% of the young people identified as at risk of CSE were white, 43% black, 13% mixed and 1% Asian.

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.

When there are concerns a young person may have displayed HSB, a consultation with the Specialist Social Worker for CSE and HSB is held. Over the last year, 58 HSB consultations were held by the CSE and HSB Specialist Social Worker with front-line practitioners

Child Criminal Exploitation

Between April 2019 and March 2020, 29 young people under the age of 18, were newly identified as being at risk of Child Criminal Exploitation. Only 1 out of those 29 was female, a reduction from 5 last year.

In Feb 2020 50% of the young people identified as at risk of CCE were black, 40%

	April 19	May 19	June 19	July 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Number of young people identified as at risk of CSE, open to ICSC	24	24	23	22	23	25	24	24	23	24	25	23
Child Sexual Exploitation referrals	10	1	5	7	9	5	2	11	3	0	4	3

black, 10% mixed. Please see the more detailed break down below:

Serious Youth Violence (SYV)

There have been 19 fewer contacts to CSCT between April 2019 and March 2020 in comparison to 2018/2019, in relation to Gangs and SYV.

Over the year, 2019/2020 106 children were referred to CSCT in relation to gangs or SYV risk. There were a very similar number of young people referred due to child on child physical harm however, these referrals have not necessarily been identified as gang linked.

From April 2019 – March 2020 29 under 18 year olds have been identified as being at risk of SYV and 38 young people aged between 18 – 24

In Feb 2020 the ethnicity of the young people identified to be at risk of SYV was examined. Thirty one percent (31%) of the young people were white, 25% from mixed parentage and 44% were black.

QUALITY ASSURANCE SUB-GROUP

Attendance at the sub-group is good, and commitment is strong. The meeting is the chaired by the LA's Head of Safeguarding and Quality Assurance.

The sub-group looks at five areas to assess quality assurance in partner organisations:

performance data, audits, inspection reports, quality assurance frameworks, and annual safeguarding reports.



Performance data

ISCB 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.

The sub-group has also discussed what additional data areas to present to the Board to enable a better overview of practice.

Areas discussed included:

- A reported reduction in the number of referrals to Children Social Care – agencies were asked to scrutinise their referral data and no concerns were found.

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- The number of S47 enquiries remains high compared to similar authorities – social work team managers will be more directly involved in authorising enquiries.
- Health Data from Fingertips included in data report.
- The data from the Metropolitan Police remain insufficient although some work is being carried out Pan-London to remedy this.
- The number of children in police custody would be useful.
- County Lines

The ISCB Business Unit has been working with data-analysts' to develop a scorecard that will provide a quick overview of the most important safeguarding metrics. (Although this work has not been completed in the timescale of this report, a draft scorecard is now ready for Board approval).

Data Highlights⁷

- Islington received 10,948 contacts requesting a service for children in 2018/19, a decrease from 2016/17 and 2017/18. The most common source of contacts is the police (33%), followed by schools (13%)
- The most common reasons for contacts were *domestic violence, parenting capacity, physical abuse, and child mental health*.
- 3,542 (32%) went on to receive an early help service and 2,509 (23%) went onto receive a social care service
- Islington had the 18th highest rate of assessed *Children in Need* in the country in 2017/18
- Islington had a slightly higher rate of children with child protection plans per 10,000 compared to our statistical neighbours.
- Islington carries out a much higher rate of child protection enquiries than statistical neighbours do.
- We had a lower proportion of repeat child protection plans compared to statistical neighbours.
- Children do not have child protection plans for lengthy periods of time, this means that the harm they suffered is resolved as quickly as it can be.
- Islington applies to court for orders to protect children more than most other boroughs
- The number of children subject to court orders has risen.
- Islington has more children looked after per 10,000 than statistical neighbours.
- The proportion of Looked After children who had to move more than

⁷ LBI Child Protection Annual Report, 17 September 2020

three times during a year is slightly higher than our SN

Children and Families Outcome Framework Measures

A *Children and families outcomes framework* has been agreed by CSC that reports to the Local Authorities *Practice and Outcomes Board*. The sub-group agreed that the outcomes framework is also useful for the Board to note and it was agreed that it would in future be included in the *ISCB's Core Business Report*.

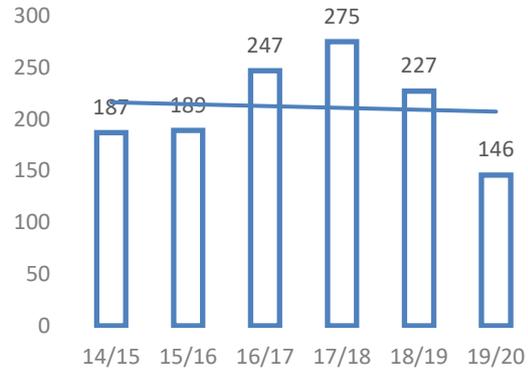
Data from the Health Economy

The 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:

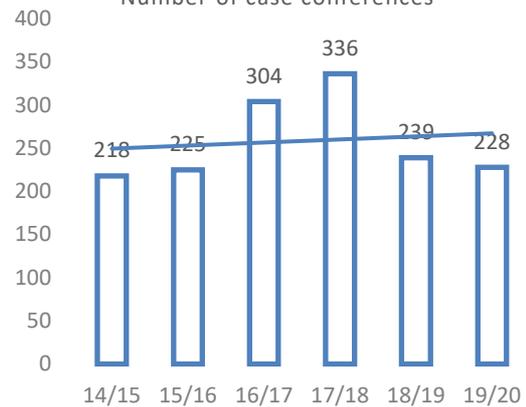
- Overall levels of hospital activity relating to children and young people in Islington.
- Mortality rates.
- Specific health issues.
- Commissioned health services.

Note: The graphs following are projected totals for 19/20 using data as of December 2019, for the year ending March 31st2020.

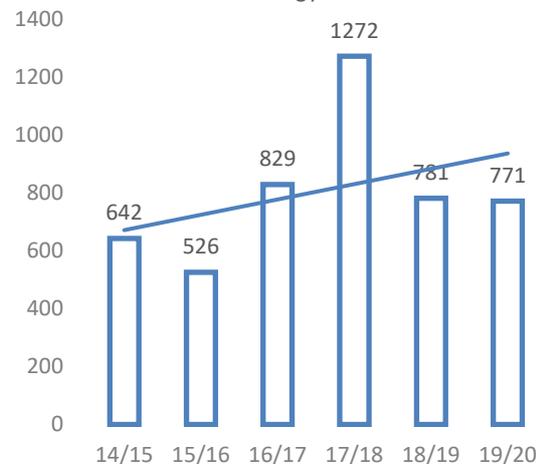
Number of children who became subject to CP plans during the year



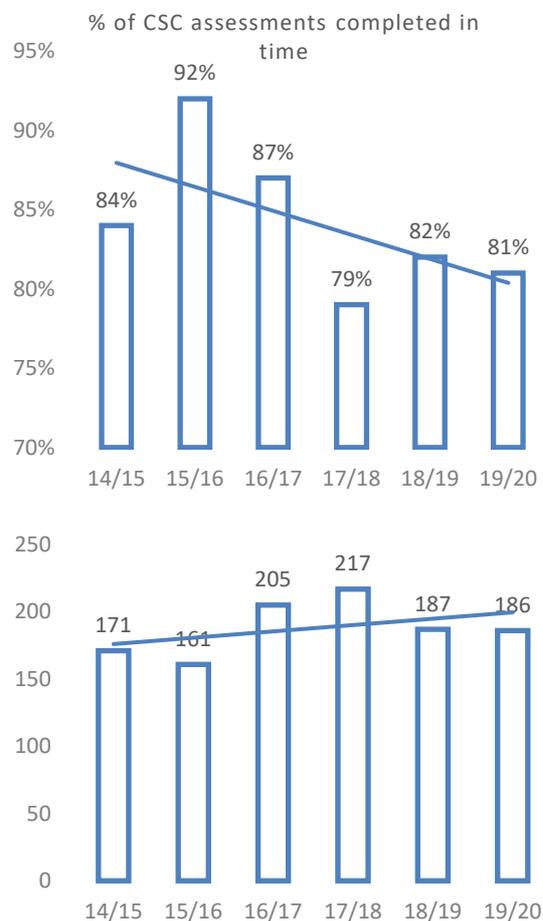
Number of case conferences



N of CP strategy discussions



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Inspections

Islington Children Social Care

The Local Authority's Children Social Care services were inspected in March 2020 and Ofsted⁸ found:

“Children in Islington benefit from services that have gone from strength to strength since the last inspection in 2017, when

they were judged good overall, and outstanding for leadership, management and governance. Senior leaders and members of the council demonstrate an unwavering commitment to improving and enriching the lives of children and their families. This is evidenced by the significant and sustained investment in children's services, and by the wide range of highly successful initiatives that are having a positive impact on children and their families, whatever their level of need. Highly skilled and experienced staff listen carefully to children to understand their needs and ensure that plans are effective.”

Overall, CSC services were rated *Outstanding*.

The sub-group noted the LA's action plan to address points of improvement:

- The timeliness and quality of planning for children at high risk in the community, when they are placed back with their parents while alternative accommodation is sought.
- The engagement of care leavers in pathway planning and the consistent provision of health histories.

A multi-agency protocol was drawn up in

⁸ London Borough of Islington: Inspection of Children Social Care Services

response to high-risk children in the community.

A *high-risk panel* will in future take place between CSC and the Police once a month to have robust oversight over cases such as these. The sub-group will review the impact of the policies in future meetings.

Whittington Health CQC Inspection

Head of Safeguarding / Named nurse presented findings from their most recent CQC inspection. In relation to children, the report mentioned several excellent achievements:

- The new Social Emotional Mental Health (SEMH) service.
- The service had raised awareness of *Adverse Childhood Experiences (ACEs)* with local stakeholders to help support the most vulnerable children and young people in the local area.
- Support teams provided for children aged under five took a truly preventative, family-based approach to empower parents to support their own children by teaching them new skills and building peer support networks.

Learning from Audits

Multi-agency Audit – Child Sexual Abuse

Good practice:

- Professionals understand that not all children disclose and that they need to feel safe and be given opportunities to express what life is like for them.
- Management of uncertainty is a particular challenge for practitioners and managers in this area of work.
- Response to disclosure were found to be robust, timely, well thought through and managed.
- Assessments were found to be thorough, involving the network, appropriately highlighting risk and evidenced the child's voice and lived experience.
- Good quality supervision and reflection on complex situations.
- Designated leads and named professionals are well utilised in Islington.
- Adherence to the Safeguarding Board's escalation policy where necessary.

Practice that can be improvement:

- The impact of a family's culture was not always considered
- Social workers found navigating the complex health systems difficult.
- Better consideration of the impact of

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the mental health of the parent on the disclosure.

- More consideration for what is was like for practitioners, working with perpetrators who may be threatening and intimidating (and how difficult it was to practice within a trauma informed approach.)
- ISCB should raise with the *London SCB* the time that children wait for their alleged abusers to be tried.

Repeat Child Protection Plans

Fewer children had a repeat plan in 2019/2020 than the previous year. In 2018/2019 the service saw 47 children from 30 families experience a repeat plan. In 2019/2020, this has reduced to 37 children from 21 families. While the percentage has reduced from 20.7% to 18.3%, it remains above the Islington target of 15%.

One hypothesis for this could be that we have CP plans for a smaller population of children but from families with more complex and chronic needs. The challenge remains helping such families make sustainable change for their children.

From the 21 repeat plans made we can see the following:

- Nine previous CP plans were of only a few months in duration although the vast majority continued to receive a

service even after the plan ended.

- 40% of current plans were repeated within a two year period, which marks a welcome reduction from previous years 50%.
- Domestic abuse remains a significant factor in such plans.
- Nearly half of repeat plans were made with the support of most, but not all, agencies.
- Safety scales viewed in these and other conferences did not always suggest critical risk. This raises a question in terms of how we use the child protection process with families with chronic problems and how we help families manage the risk of relapse. However, for other children the continuing risk of harm has been clear and for a third this has resulted in escalation to a legal framework.

Strategy discussion audit

Examined the thresholds across *Child in Need services* (CIN) management teams and the impact on numbers of strategy discussions across the *children in need service*. In teams where fewer strategy discussions took place, there was a better conversion of s47 enquiries to *initial child protection conferences*.

An action plan was drawn up to address

the discrepancies.

Physical abuse audit

CSC Quality Assurance Service carried an audit on 30 children to consider:

- If responses were proportionate to risk.
- Whether the safeguarding Board's procedures were followed.
- Whether health professionals were included in strategy discussions.

Auditors found that responses were proportionate in 28 of the 30 cases audited but that health professionals were only included in about half (55%) of strategy discussions. More than a quarter of referrals passed to CIN teams (from the CSC front door) were not progressed to assessment.

An action-plan was put in place for Team Managers to ensure full implementation of *strategy discussion* procedures.

Core Group meeting and CP Plans

The practice around *Core Group Meetings* (CGM) and Child Protection (CP) Plans were explored in a CSC audit that found:

- Core groups were well attended by the family and by health and education professionals.

- The first core group meeting was often held within time but practice varies with subsequent CG meetings (this may be a recording issue).
- There were examples of good practice but overall there was a lack of consistency with social workers doing different things.
- There appeared to be a lack of purpose in meetings and CP plans were not being reviewed.
- It was not always clear who was chairing CG meetings.
- The voice of the child was lacking in CG meetings, even with older children.
- Progress of CP plans was only discussed in 12% of supervisions.

Practice guidance has been formulated for social workers to address these concerns.

No further action after a child protection enquiry

An audit showed that 23% of S47 enquiries had an outcome of concerns *not being substantiated*. The findings were that:

- The decision to begin a child protection enquiry was considered appropriate in 86% of cases.

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- The decision for *no further action* appropriate in 100% of cases audited
- Management oversight was evident in 73%.

An action-plan was put in place to remedy issues requiring attention.

Joint working between Targeted Youth Support and Children Social Care

The focus of the audit was to examine the quality of joint work between *Targeted Youth Support (TYS)* and *Children's Social Care (CSC)*. Findings were:

- Joint-supervision between services was seen as useful and needs to be embedded in practice.
- There was evidence of a shared understanding of young people's needs, and the purpose of intervention.
- There were good examples of joint working; both with young people, and with the wider professional network.
- Communication between TYS and CSC is generally frequent and good but could be better evidenced.

- Young people can be subject to multiple intervention plans.

It was recommended that the *Joint Protocol between Children's Social Care and Targeted Youth Support/Youth Offending Service* be revised.

Supervision Order (SO) Audit

Supervision Orders (SOs) do not have the same level of multiagency scrutiny as children on child protection plans. There has been concern about SOs both in Islington and nationwide. Research also showed that children subject to supervision orders were most likely to have further proceedings. SOs also came under scrutiny in the Serious Case Review of *Polly*⁹, who was murdered by her mother in May 2014 while under an SO. The ISCB welcomed the audit in light of a *Rapid Review*¹⁰ carried out by the Board in May 2020.

Positive Findings:

- Chronologies were largely up-to-date.
- There was a consistency of social workers.
- Good rapport with children and families and a good understanding of children's lived experience, wishes and feelings.

⁹ <https://www.ddscp.org.uk/media/derby-scb/content-assets/documents/serious-case-reviews/Final--ADS14---31082015.pdf>

¹⁰ Rapid Review Child CK (unpublished)

- Supervision was in line with Islington's policy

What needed improvement?

- Identifying children with SOs on management systems are problematic.
- Assessments often did not reflect the child's current circumstances.
- Improve information-sharing procedures (including court assessments) with professionals—especially where children and family assessments are not appropriate.
- Improve management oversight.
- Professionals from partnership lacked understanding about the SOs and their status.

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.

CSC Safeguarding and Quality Assurance Child Protection Annual Report

The Service Manager for Safeguarding attended the sub-group in May 2020 to present annual report. The report highlighted

key safeguarding data e.g. CP investigations, referral, children subject to CP plan.

The report also summarised key quality assurance activity during the year, which is reflected elsewhere in this section.

Child Protection Report to Scrutiny Committee – September 2019

The report presented by the statutory Director of Children Services to the LA's scrutiny committee showed good governance over safeguarding in Islington.

It showed that *Islington Safeguarding and Family Support Service (SFSS)* is currently working with 1100 children in need, 313 children who are looked after, of which 24 are disabled children and 41 are *Unaccompanied Asylum Seeking Children (UASC)*, 400 care leavers and 200 children with child protection plans. The majority of child protection plans are due to *emotional abuse or neglect*.

Characteristics of parents whose children have *child protection plans* include *domestic violence and abuse (45%)*, *adult mental health (31%)* and *adult substance misuse (24%)*.

Sixteen children were living in a *Private Fostering arrangement* at some point during the year.

Islington's *Youth and Community Service* is

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working with 66 Youth Offending interventions. This includes seven custodial interventions, four remand interventions and 55 community interventions.

The report covered services, interventions, outcomes, and governance arrangements in the People Directorate very well

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.
- Inspections.

The Safeguarding report was comprehensive and informative.

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.

Moorfields Eye Hospital Safeguarding Children and Young People Annual report 2019/20

Moorefields Eye Hospital presented their annual report providing assurance of safeguarding activity in the health trust. The safeguarding report is always of a high standard and this year was no exception.

The S11¹¹ duty of organisations are specif-

¹¹ Section 11, Children Act 2004

ically, and helpfully, addressed in the report, as are the *ISCB Priority* areas.

The report shows clear governance arrangements for safeguarding in the trust with excellent oversight by the *Director of Nursing* and the *Head of Safeguarding*.

During the reporting period, the following learning and improvement outcomes have been achieved:

- Queries to the safeguarding children and young people team rose again by 27% compared to 2018 – 2019, demonstrating staff are continuing to have a greater awareness and understanding of safeguarding and child protection and safeguarding is becoming a more integral part of practice.
- Mandatory safeguarding children training compliance at Levels 1, 2, 3 and 4 remained above the 80% target throughout the year.
- Incident reporting by staff from a wide range of roles and responsibilities rose by 7% and identified no acts or omissions. There were no SI's relating to safeguarding during this reporting period.
- Referrals to children's social care rose by 6% and as in previous reporting, a third of which were related to children and young people of adult patients, which demonstrates engagement with the *Think Family / Child Behind The Adult* agenda in safeguarding the children of adult patients.
- A fourth cohort of staff completed their initial Safeguarding Champions training.
- Eight Trust documents, including policies, with a safeguarding focus or section were developed or reviewed and updated. This included in relation to the Covid-19 pandemic to ensure staff have access to and are working with best practice policies and processes.
- The safeguarding team supported managers to review 10 complaints of which 2 had a SGC&YP feature. This process ensures a high-quality response and understanding of the Trusts legal obligation to safeguard.
- The Trust was involved in the Child O Learning Review convened by Islington Safeguarding Children Board. A known patient of Moorfields, the issue of subtle neglect and how it might present in an ophthalmic setting was identified by the review.
- Systemic learning is supported through a variety of activities including face-to-face training, via team meetings and briefings, disseminated via SGC&YP group members, distribution of the internal safeguarding

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newsletters, attendance at meetings, and presentations at clinical governance sessions, via staff question and answer sessions and comprehensive feedback through incident reporting.

Islington CCG Safeguarding Children and Adults Annual Report

The *designated nurse* presented their annual safeguarding report and noted the following actions for the year:

- To achieve $\geq 80\%$ compliance with mandatory safeguarding training in ICCG,
- To achieve $\geq 80\%$ compliance with mandatory safeguarding training across all trusts,
- Areas of weakness in providers as identified in the JTAI inspection,
- Roll out of *CPIS* in Moorfields Eye Hospital NHS Foundation Trust,
- Meeting the requirements of the Mental Capacity (amendment act) 2019.

Quality Assurance Frameworks

Islington CCG

The CCG presented the updated Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework.

The purpose of framework is to set out clearly the safeguarding roles, duties, and responsibilities of all organisations commissioning NHS health and social care. It has been refreshed in partnership with colleagues from across the health and social care system, the *Department of Health* (DH) and the *Department for Education* (DfE).

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 strategy¹² 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:

¹² [Competence Still Matters](#)

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- 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 Environment* as part of agency training

Amendments to Core Training

The ISCB have made the following amendments:

- Reviewed and incorporated learning from the serious case reviews for *Child P* and Rapid Reviews.
- Changes in *Working Together 2018*, information sharing
- Changes in *Keeping Children Safe in Education September 2019* and *Keeping Children Safe in Education 2020*.
- Learning from London Borough of Islington *Practice Week*
- *London Child Protection Procedures*, 6 monthly updates
- *General Data Protection Regulations and Data Protection Act 2018*

Core Training Offer

The core training offer has remained unchanged, and the Board will continue to offer multi-agency training as part of its core function.

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

Due to the impact of Covid -19, ISCB's face to face training offer was paused and a virtual offer was developed to supplement.

The ISCB trained 793 members of staff throughout the reporting period. This is significantly lower than the previous year (1125) but can be explained due to the pause in training program. Since the intro-

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duction of the virtual offer, uptake has remained high if not higher than in previous years due to the more accessible nature. At the current rate, training that was lost due to Covid-19 will be eradicated.

Training cancellations

It is expected that some learners will need to withdraw from courses because of sickness, operational pressures, or staff changes. On advantage of online training is a much lower cancellation rate.

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.

Places withdrawn by the ISCB

Learners 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 a significant proportion of approved bookings do 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 managing complaints.

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 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 Quality Assurance and impact

Of the 793 who attended training 74.8% completed the course evaluation. ISCB training is very well regarded by attendees and 97% reported that the course met their training needs very well, 99% thought ISCB courses fulfilled their published objectives and 100% of participants stated that ISCB courses enhanced their learning and knowledge about safeguarding children and associated procedures.

“I have always felt that Islington offers excellent courses. They are very thorough and well presented. I have been attending since 2002 and have experienced some superb interactive presentations.”

Only 10% 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. 99.7% of attendees will recommend ISCB course to their colleagues.

EARLY HELP (EH) SUB-GROUP

The Early Help sub-group held its first meeting on 24 September 2019 and has been well attended by a wide variety of partners.

Children and Families Outcomes Framework

The framework was agreed at the *Quality Assurance sub-group* after consultations with partners at EH sub-group. The governance / accountability of the framework is held with the local authority but it will inform work in the EH sub-group.

Liquidlogic EHM Portal

The Service Manager for Early Help consulted with partners about the development of an online portal to facilitate referrals and early help assessment. A task and finish group was arranged to agree the specification of the system.

The project lead provided regular updates to the sub-group but in July, the LA reported that *user acceptance testing* showed serious drawbacks about the portal usability. These concerns were shared by other Local Authorities. These issues will only be ironed out when version 5 of the system is launched and the rollout of V5 is itself delayed.

A separate work stream within the project was to decide which one of the four options partners wish to specify. This will require significant input from partners, which is impossible because of the demands already placed on partners by Covid-19. The partnership therefore agreed to pause this work stream until 2021.

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Early Help Strategy

The early help strategy¹³, *Giving children the best start in life*, was considered at the sub-group. The LA's Head of Early help was mindful that it could benefit from an update, and perhaps could be less LA focussed. This work was progressed by means of a *Hot House methodology* to establish the basis of a new strategy so that it could be commissioned. Partners agreed that school, early years and the private and voluntary sector should be better represented within the document.

When Covid-19 broke out in early 2020, the sub-group agreed that revision of the strategy was not a priority and agencies were rightly focussing on business continuity.

Troubled Families Performance

The LA is undertaking work with the *Ministry of Housing Communities and Local Government* looking at the *Troubled Families* agenda. Data-collection did not allow the LA to evidence the outcomes of the Troubled Families programme effectively.

In the summer, the sub-group assisted in completing the *community, workforce and leadership* section of a questionnaire for

Ministry for Housing, Communities and Local Government that they have shared as a condition of the *troubled families earned autonomy* funding.

Early Help Targeted Family Support Review

In September 2019, the sub-group was informed that a review of these services were underway in the Local Authority. A new model is being developed that will be influenced by Islington's resident, including children and parents.

In June, the Head of Early help provided a further update on service development, outlining the five principles of the service:

1. **Responsiveness and flexible** – a front-door service with a team around the family/worker approach. Universal services for families who require targeted support.
2. **Graduated and enabling approach** – that builds on resilience and empowers families.
3. **Outcomes focused** – for the whole family, whole population, and individual family level outcomes.
4. **Consistent** – this will include whole

¹³ Giving Children the Best Start in Life—Islington Children and Families Prevention and Early Intervention Strategy 2015-2025

family, family-led, motivational practice that is trauma informed, and relational.

5. **Accessible** – ensuring services are community based, where families are and based in localities. Messaging about the service that normalises, rather than stigmatises, access to help ensuring that advertising makes the services visible and accessible.

The first three values are particularly impact in responding to the needs created by COVID. It will encompass two services: one that is *case-holding* and the other *out-reach*.

From the 1st of July 2020, the service will have a new telephone number and will be known as Bright Start 5-19.

Staff recruitment and assimilations are taking place during the next phase to align with the *Fair Futures* project.

Public Health Priorities

The Assistant Director for Public Health presented a model and priorities areas to the sub-group.

Main areas of work

- Maternity and Early Years
- School-age and beyond
- Vulnerable children.

The sub-group agreed that these are the main areas that need to be considered, and that they were well aligned with the ISCB priorities.

Maternity & Early Childhood	School age	Progression to adulthood
<ul style="list-style-type: none"> ▪ Families are resilient and empowered to manage problems, develop skills & tools and to help themselves and support each other ▪ Families can access information and / or services at point of help or need ▪ Children and families grow up feeling safe ▪ Ensuring all children have the best possible start by identifying needs from pre-birth, promoting positive attachments, and children grow up in a in a stable home 	<ul style="list-style-type: none"> ▪ Encouraging healthy eating to prevent and reduce childhood obesity and improve oral health ▪ Supporting families to improve their relationships, reduce conflict and improve prospects for their children ▪ Young people being healthy & happy at home, in school and in the community ▪ Every child is happy at school and feel they belong to the school family ▪ Children & young people have good self esteem ▪ Increase in youth provision to identify much earlier young people at risk and children with additional needs ▪ 11:11 all children and young people have outstanding cultural experiences by year 11 in school. 	<ul style="list-style-type: none"> ▪ Helping families and young adults who are out of work find the right job ▪ Support children and young people through key transition points that occur during their lives that may cause disruption to their well-being, such as transitions between schools, between education into employment, between services, between professionals and between localities. ▪ Support on estates to tackle loneliness & isolation, build community networks and reduce child poverty ▪ Communities, children & young people and partners work together to reduce youth violence in the borough ▪ A relationship with a trusted 'lead professional' to coordinate the support needed from other agencies or the community and voluntary sector

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The area of *vulnerable children*, in particular, was well aligned with the ISCB priorities and included:

- **Safeguarding:** Implementing learning from unexpected child deaths and establishing new arrangements under CDOP.
- **Mental Health:** Supporting good parental mental health, support student mental health, and improve pathways for those who self-harm.
- **Youth safety:** implement a public health approach to reduce youth violence
- **Poverty and inequality:** targeted provision to reach those with the highest need.

Pre-vulnerable children and families

As the impact of Covid-19 became clearer, the partnership re-considered the group of vulnerable children and families and identified a group that could be considered *pre-vulnerable*. This may include an increased need from families who may not traditionally work with early help services. This would place additional need on services that are already stretched.

Principles

- Good quality, integrated, universal services
- Reducing inequalities
- Think family
- From participation to co-production,

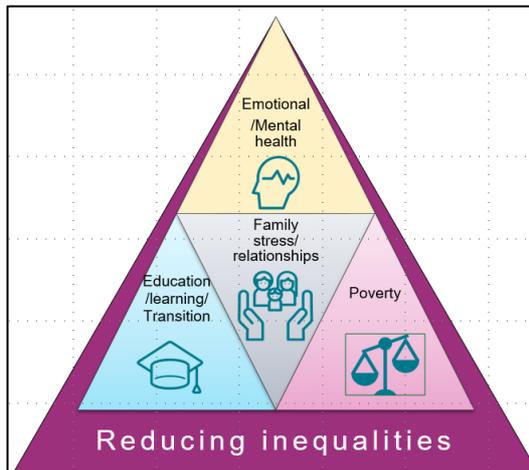
Universal	Pre-Vulnerable	Vulnerable
<ul style="list-style-type: none"> • Physical wellbeing <ul style="list-style-type: none"> • Food- obtaining and eating well • Lack of exercise • Sexual health support • Reduced health services • Mental wellbeing <ul style="list-style-type: none"> • Stress/ Routines/Family conflict • Social isolation • Transition difficult for YR6, YR11, YR13 • Loss of early learning • Bereavement support • Not understanding guidance and how to find support • How to support young people • Safety <ul style="list-style-type: none"> • Online safety • Workforce <ul style="list-style-type: none"> • Staff concerns of exposure • Reduced workforce- staff sickness • Anxiety around PPE 	<ul style="list-style-type: none"> • Risks and safeguarding <ul style="list-style-type: none"> • Domestic abuse/violence • Substance misuse • Youth violence/gangs • FGM • Family conflict • Mental health conditions exacerbated • Children who are carers • Children left alone at home • Families not asking for help- how do we know who they are • Poverty and inequality <ul style="list-style-type: none"> • Overcrowding • No place for respite from isolation • Increasing inequalities • London already has a number of deprived areas • Food poverty • Scarcity of essential items • Digital divide- lack of IT resources and connectivity • Health <ul style="list-style-type: none"> • Less access for advice and triage • Workforce <ul style="list-style-type: none"> • Overwhelming workforce with increased referrals 	<ul style="list-style-type: none"> • Risks and safeguarding <ul style="list-style-type: none"> • Vulnerable families not attending school or nursery • Refusing contact- claiming self isolation • Respite/care reduced or unavailable • Reduced F2F interactions • Families awaiting referrals into services • Youth crime and SYV figures have not been high so far during the pandemic and have fallen • VAWG reports are lower than the same period a year ago but the severity of recent incidents more concerning • Poverty and inequality <ul style="list-style-type: none"> • As for pre-vulnerable • Health <ul style="list-style-type: none"> • Health conditions preventing children who could be in school from going • going due to shielding • EHCP criteria (as vulnerable) not usually available for children aged <5 – need adapted criteria • Autism – high percentage of EHCP and families might be finding circumstances difficult • Workforce <ul style="list-style-type: none"> • Overwhelmed by increased referrals • Staff sickness

the voice of children and parents.

- Connecting socially for a stronger community
- Innovation and evidence

Priority areas of work

Agreed priority areas for work in light of need, and in particular in response to COVID-19: emotional and mental health,



education and learning, transitions, poverty, family stress and relations with reducing inequality throughout all priority areas.

Targeted Early Help Systems and Outcomes Report

The annual report has been produced and circulated. Although *IFIT* and *Families First* have now been reorganised into a new *Early Help 5-19 service*, it gives a good sense of outcomes.

Across all targeted services, 1,600 families received an intervention, about the same as the previous year. *Families First* worked with 711 families, *IFIT* with 89 intensively, *Bright Start* worked with 455. Overall 72% of families were from a Black or minority ethnic background, 219 family members out of the 2452 had two or more episodes of intervention.

The main referral sources were *education, health* and the *police*. One in ten referrals was from families themselves, which is fewer than preceding years.

Presentations to the sub-group relating to services

During the year, several organisations presented to the sub-group about the work they are doing in the community, including:

North London Partners in Health

NCL STP is made up of 28 health and care organisations across five north London boroughs, delivering transformation and improvement work across a number of areas, including children and young people.

The *NHS Long Term Plan*, published in January 2019 provides the ambition and mandate across the system to work in partnership to deliver improvements for our population.

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The CYP Programme has three key priorities:

- Asthma
- Paediatric admissions
- Complex needs

Fairer Together

The LA presented the outline of their work under the Fairer Together programme, which includes:

- **Strong Foundations** - effective partnership and successful multi-agency delivery – shared language and set of principles
- **Shared vision and strategy** – using collaborative resources to move forward
- **Target operating model** – how we are going to use our resources
- **Start well / live well / age well** - what could our shared ambitions look like?

The sub-group noted these developments and asked that the LA bring regular updates to the *ISCB Partnership Board* to ensure the work around targeted early provision and safeguarding are well co-ordinated. In particular, the sub-group would like to see that the project develops an even stronger children focus and felt it

might be in danger of becoming adult-focused. It is also essential that schools are partners in the process. The role of the MPS in *early intervention* needs to be clarified and included. The ISCB would like to see that its priority areas are reflected in the strategy.

Youth Violence Strategy

The LA consulted with the sub-group and the priorities for the new *youth safety plan*. The priorities proposed:

- Public Health approach.
- Impact of trauma.
- Education and school inclusion.
- Impact and links with *violence against women and girls*.
- The role of *social media*.
- Impact and changes to drug markets and growth of *county lines*.

These priorities were well received and strongly supported. In addition, the group suggested that *unsafe places* in the community should specifically addressed in the strategy. They recognised that trauma is a huge factor but that not every children can or should be seen through that lens; the approach / model of working should accommodate that. The strategy should definitely address the antecedents leading

to youth violence including poverty and domestic violence and abuse.

Presentation about Family, stress and relationships

(Family stress and relationships is one of the four priorities agreed by the sub-group)

The Head of *Bright Start and Early Help 5-19* provided an overview of the model, and how the service sets out to reduce family stress/ support strong relationships.

(The principles of the service are set out earlier in this chapter.)

The service has set up *Twitter* and *Facebook* accounts for early help and is developing a social media strategy. The aim is to link the service directly to families and community networks.

Recruiting to all outreach posts is ongoing which will increase capacity.

A lot of work is focussed on promoting strong early attachments.

Covid-19

In some families, stresses about behaviour at school have abated and relationships improved.

Building engagement over video and telephone calls is difficult with families newly referred. It takes longer to build trusting

relationships with families.

Solihull parenting programme

This parenting programme is available online for parents which includes developing an understanding of their child's feelings / needs, parenting responses, parenting styles, emotional regulation, and communication.

The service is considering how to bring more parenting programmes online, e.g. *Domestic Abuse Recovering Together (DART)* / *Caring Dads*.

Although these programmes reduce stress on families, the aim is for face-to-face engagement. The *Early Intervention Foundation* found even one face-to-face meeting with facilitators makes a huge difference in engagement of parents and young people.

Practitioners are being trained in AMBIT, applying mentalization as the guiding framework across four areas of practice:

- Face-to-face work with clients.
- Mentalization between team-members.
- Mentalization across networks.
- Mentalization in fostering a team culture of learning.

Conflict between parents

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Healthy parental relationship training is now being rolled out. The aim is to move away from the notion of female victims failing to support or protect their children and more consistent engagement of men around abuse, including:

- Engaging community and independent DV advocates to wrap around practitioners
- Piloting DV advocates for children and young people.

Education, shielding, and BAME during COVID

Back to School Plan on a Page has been developed that sets out a local framework for how schools might prepare for a gradual, safe, phased return of specific groups of children when a risk assessment confirms it is safe to do so.

There is no blueprint and schools faced many challenges in the process.

Public Health colleagues have developed excellent materials for schools and partners around shielding and what is required at the time to meet government guidelines.

CASE REVIEW SUB-GROUP

¹⁴ The Multi Agency Safeguarding Partnership oversees the completion of serious case reviews commissioned by ISCBs prior to 1.09.2019.

The case review sub-group oversee learning from *serious case review*¹⁴, *rapid reviews*, and *local safeguarding practice reviews*.

Serious Case Reviews

The legacy ISCB commissioned two serious case reviews that were taken over as part of the transitional arrangements between the ISCB and MASA.

Child P

The investigation phase of this review about a teenage child who died because of serious youth violence has been completed. Once pre-publication work between the Board, Partners, and the *Child Safeguarding Practice Review Panel* has been completed, it will be published on the [ISCB Website](#) where it will remain available for one year.

Child Q

The fact-finding phase of this review about a young child who died unexpectedly has been completed. The review panel is finalising the learning and recommendations after which the review will be published in the spring.

Serious Incidents

There is a legal requirement¹⁵ on Local Authorities when it knows or suspects that a child has been abused or neglected, to notify the *Child Safeguarding Practice Review Panel* (of a serious incident) if –

- (a) the child dies or is seriously harmed in the local authority's area, or
- (b) while normally resident in the local authority's area, the child dies or is seriously harmed outside England.

Serious incidents must similarly be reported to the multi-agency safeguarding partnership (ISCB).

Rapid Reviews

On receipt of a *serious incident* notification, the safeguarding partners should promptly undertake a *rapid review* of the case.

The aim of this *rapid review* is to enable safeguarding partners to:

- Gather the facts about the case, as far as they can be readily established at the time.
- Discuss whether there is any immediate action needed to ensure children's

safety and share any learning appropriately.

- Consider the potential for identifying improvements to safeguard and promote the welfare of children.
- Decide what steps they should take next, including whether or not to undertake a *child safeguarding practice review*.

In this reporting year, the safeguarding partnership received two appropriate serious child safeguarding incident notifications from London Borough Islington.

Rapid Reviews were undertaken on both occasions and reports made to the *child safeguarding practice review panel* (the Panel). In one instance, the partnership did not recommend a *local child safeguarding practice review*, and in the other it did. On both occasions, the *Panel* agreed with the Partnership's recommendation.

The case review sub-group is overseeing the implementation of learning and action-plans on all *Rapid Reviews*.

Local Child Safeguarding practice Reviews

Child R

¹⁵ 16C(1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017)

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The Partnership has commissioned a *panel* and an *independent author* to oversee this review. The terms of reference has been agreed, and the review has entered the fact-finding and consultation phase. The review will not complete within the timeframe of this annual report but will be published on the partnership website on completion.

National Child Safeguarding Practice Reviews

During this reporting period, the national panel has published two national reviews:

- Safeguarding Children at risk of criminal exploitation
- Safeguarding children at risk from sudden unexpected infant death

The serious case review sub-group have considered these reviews and local implications for Islington.

Budget and resources

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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 that 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 *multi-agency safeguarding partnerships* are to carry out their statutory duties, they need 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 multi-agency safeguarding partnerships. As yet, we have not seen an increase in funding.

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INCOME	2018/19	2019/20
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

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Total income	£230,800.00	£23,800.00
EXPENDITURE		
Staff		
Salaries, 2.5 staff	£111,248.77	135,955.85
Chair	£24,197.12	£0.00
Sessional worker	£15,760.00	£0.00
Subtotal	£151,205.89	£135,955.85
Board training		
Facilities & refreshments	£4,092.75	£2,092.50
Subtotal	£4,092.75	£2,092.50
Other expenses		
SCRs	£12,490.00	£25,616.14
Training portal license	£276.00	£2,305.53
Legal costs	£0.00	£0.00
Board activities	£2,170.50	£0.00
Stationery, phones, equipment	£319.00	£215.47
Printing	£124.40	£0.00

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Travel	£90.00	£0.00
Other	£0.00	£144.62
Subtotal	£15,469.90	£28,281.76
Total expenditure	£170,768.54	£166,330.11
Income	£230,800.00	£230,800.00
Expenses	£170,768.54	£166,330.11
Balance	£60,031.46	£64,469.89

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 because 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

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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 re-structures 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.

