

# ISCP Annual Report

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1<sup>st</sup> September 2020 – 31 August 2021

# ISCP Annual Report 2020-21

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# Update from the Independent Scrutineer

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## 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.

### *Impact of Covid 19*

Safeguarding became even more challenging and complex during this reporting period because of the national pandemic and its associated restrictions and lockdowns. Covid 19 is still very significant, and the partnership has faced unprecedented challenges to support and safeguard vulnerable children and families. The partnership very quickly mobilised during this uncertain time and worked tirelessly to identify and safeguard children who were at an increased risk of harm and exploitation from a range of sources. I recognise the extraordinary efforts made by all frontline practitioners to keep children safe, in particular the work of schools and teachers

who stayed open in order to support our most vulnerable children.

### *Engagement of Relevant Agencies*

The Local Authority, the NHS Clinical Commissioning Group and the Metropolitan Police 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 in 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

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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.

The Education Sub Group has focussed primarily on creating a borough wide protocol to address the issues raised in the most recent Ofsted report on Sexual violence and harassment. The education subgroup facilitated a partner led task and finish group to deliver on two strands – a protocol for schools and a self-evaluation and audit tool for schools to review the current curriculum offer and identify how it could be improved. The Education Sub Group has also monitored the rise in Elective Home Education. In addition to this work the Education Sub Group continues to hold oversight on issues relating to DSL training and supervision meetings, the Section 11 bi-annual safeguarding report. School representation on the subgroup have provided positive feedback, particular on the borough wide protocol.

### *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.

There are excellent processes for managing Rapid Reviews, the report highlights that two were undertaken during this reporting period. The National Panel has agreed with all of the decisions as to whether or not a local child safeguarding practice review was required in each case, highlighting a robust and efficient process.

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 which ensures that the learning is revisited and embedded.

An example of learning from reviews is the formation of an Adolescent Support Intervention Project (ASIP) in Islington. This project has arisen from a number of case

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reviews into the deaths and serious injuries of children across London and nationally, as a result of serious youth violence and knife crime. This is a multi-agency team that works intensively with children who are deemed to be at risk of exclusion. Early indications suggest that this project is diverting children away from harm. This project will be reviewed and I look forward to reporting on its impact in next year's report.

### ***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. This has been evidenced in the *SEND disruption report* where young people have communicated how COVID has affected their wellbeing

and how they would like information to be conveyed to them.

### ***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 data set and is developing a 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. I welcomed a new priority around collecting data of ethnicities in a systematic manner for the Partnership.

### ***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 acknowledging the impact structural racism and inequalities has on the global majority and challenges in understanding this data so improvements can be made.

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## **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 arrangements 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 for the arrangements in Islington 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 and challenge and one which strives to continually learn and improve practice.

There are excellent examples in the annual report which highlight the breadth and depth of partnership activity across Islington to keep children safe. Such examples include the *Daily Safeguarding Meeting* replacing MARAC meetings on page 27, which has increased the multi-agency response to domestic abuse victims.

Another example would be, the *Exploring*

*the Andover Estate and young offenders project* on page 23, which explores complex interdependencies of serious youth violence. These are just a few examples of the innovative approach taken by the Islington partnership to improve outcomes for children, young people and families.

There is strong leadership and a clear sense of joint and equal responsibility from the three safeguarding partners. The partnership is one that is built on high support, high challenge and where difficult conversations are encouraged

Attendance at meetings is good. There is excellent engagement from leaders across the partnership who set a culture, which drives improvement activity.

In my dealings with senior leaders, I have found a strong desire to understand safeguarding, promote change and deliver safeguarding improvements, this was evident with the ongoing work to deliver effective services during the national pandemic.

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

# ISCP Annual Report 2020-21

**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 ISCP'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 *ISCP Annual Report 2020/21* and covers the period from 1st

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\* Children Act 2004

† Working Together to Safeguard Children 2018

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September 2020 to 31<sup>st</sup> August 2021

## ***METHODOLOGY***

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

The report draws heavily on numerous monitoring reports presented to the Partnership 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 Partnership's website.





# Key activities of the ISCP

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### The ISCP had an away-day to consider the partnership priorities.

The event of George Floyd being murdered in 2020 and the subsequent global impact prompted the local authority to take a deep-dive into their own data that identified areas of disproportionality and inequality in service delivery in relation children and families of the Global Majority. For example, an over-representation of Black children in the following areas:

- *Child in need, child protection plans* and also in Early Help services.
- Becoming looked after under police protection and less likely to be in long-term placements.
- Are more likely to have *assessment factors* such as *criminal behaviour, gangs*, but fewer for domestic violence and abuse (DVA) even though 100% of children who commit most offences had DVA in their history.
- *Referrals* and *contacts* to Children Services and also the rate of *re-referrals* in comparison to the overall Islington population of children.

In response to the Local Authority's challenge the ISCP has drafted a new priority::

Address the impact of inequality and structural racism on vulnerable children and to create a better understanding of

data across all of Islington Safeguarding Children Partnership

### ISCP PRIORITIES

Partners and relevant agencies considered the previous priorities and concluded that they should be retained alongside the priority around diversity.

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

- Address the impact of inequality and structural racism on vulnerable children and to create a better understanding of data across all of Islington Safeguarding Children Partnership.
- Address the impact of neglect on children and to help them become more resilient.
- 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

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## ***Children's wishes and feeling in child protection conferences***

The Safeguarding Partnership'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 ISCP has made available a suite of consultation documents for use with parents and children that all professionals can use.

The most recent report to the Partnership shows that physical/virtual participation of children and young people at child protection conferences is still a challenge<sup>3</sup>. Actual attendance of children at child protection conferences remains low. In 2020/21, only seven children aged five and above attended CP conferences (out of 457 conferences, including *unborns* and children under five). However, a child participation audit was conducted and illustrated that 88% of the conferences held show evidence of child participation in either attending, completing the booklet or being consulted about their wishes and feelings regarding involvement of Children Services, the *child and family assessment* and

*child protection conference*. This illustrates a continued improvement of children and young people participating in the conference and in obtaining their wishes and feelings.

## ***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 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 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.

## **KEY ACTIVITIES OF THE MAIN PARTNERSHIP**

The Partnership Board scrutinised work in the following areas:

### ***Private Fostering arrangements***

The Local Authority's annual report to the Partnership is a requirement under *Na-*

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<sup>3</sup> Child Protection Annual Report 2020-2021, presented to Quality Assurance sub-group, October 2021.

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*tional Minimum Standards for Private Fostering*<sup>4</sup> .

## **Current Private Fostering Situation**

There were **eleven** notifications in the year 2020-2021. This is up on the number of notifications in 2019/20 and 2018/19 (four and nine respectively). Only two of these notifications were *private fostering* arrangements. The total number of *private fostering* arrangements is currently two, involving three children, however, during this reporting period two other arrangements have closed.

## **Compliance with *private fostering standards***

The minimum standards (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 in the four arrangements in this reporting period, visits were delayed with only 66% of visits 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.

## **Recommendations from 2019/20 and the update/actions completed**

*Recommendation 1: Team Managers and practice managers across the service to renew and monitor initial and ongoing visits to ensure that social workers are completing these within timescale and each visit meets the statutory requirement.*

**Update:** Supervision notes record that this has been a focus – it needs to be an ongoing recommendation until 100% is reached

*Recommendation 2: Fostering Team to appoint a lead to attend the Private Fostering Consortium meetings and liaise with*

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<sup>4</sup> [National Minimum Standards for Private Fostering](#)

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*the CIN service on any new developments.*

**Update:** A senior social worker was appointed and has been attending the meetings – no new developments arose to share in this reporting period.

Recommendation 3: The *North London Consortium* to add a link for *Islington's Safeguarding Partnership* to their Private Fostering website and continue to review information and documentation and raise awareness.

**Update:** The link is not yet on the website – this is to urgently be communicated to the Chair for action.

*Recommendation 4: The 2020-21 report to report on if and how the Covid pandemic impacted on private fostering arrangements.*

**Update:** This recommendation to be carried over to the 2021-22 report.

*Recommendation 5: Consideration to be given to Islington Children's Services initiating a Private Fostering awareness week every July to promote awareness across the authority.*

**Update:** This recommendation to be carried over to the 2021-22 report.

### LADO Recommendations 2020/21

1. An increase in awareness raising activities to be introduced over the next year.
2. Team Managers and practice managers across the service to renew and monitor initial and ongoing visits to ensure that social workers are completing these within timescale and each visit meets the statutory requirement.
3. The Service Manager for Fostering and Permanency to meet with the Chair of the North London Consortium to ensure the link is added to their Private Fostering website and that a plan of increased awareness-raising can be agreed.
4. The 2021-22 report to report on if and how the Covid pandemic impacted on private fostering arrangements
5. Consideration to be given to Islington Children's Services initiating a Private Fostering awareness week every July to promote 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 Partnership wants to be sure that those who work with children are carefully

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selected and that concerns or allegations against professionals are thoroughly investigated by the Local Authority Designated Officer (LADO) in accordance with the Partnership's procedures.

### LADO report

#### Sources and nature of referrals

The ISCP received the *2020/21 LADO Annual Report* for scrutiny covering the period 1st April 2020 to 31st March 2021 and concerns **156 contacts with the LADO**.

This figure is down from the 189 **contacts** in 2019/20. This year's reduction is likely due to the pandemic leading to full or partial closure of services this is further illustrated in only three *Ofsted category 3* complaints compared to 16 last year.

The vast majority of allegations against professional were 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.

#### Nature of referrals

As in previous years, the majority of contacts related to concerns about *physical abuse*, 49 contacts (31%).

The second highest number of contacts related to *private life matters*. Concerns about *private life matters* only progress to an *allegations against staff and volunteers* (ASV) meeting if there is a police investigation, or if a member of staff's own children become subject to child protection procedures.

This year, complaints about *care standards* have doubled. Whilst agencies are aware that such referrals should be dealt with by way of their own complaints or disciplinary procedures, many agencies feel they need to consult the LADO. This increase could potentially be due to the pandemic and agencies wanting to ensure they communicate directly with the LADO about concerns.

The ISCP's *Child Protection Procedures*, require that allegations must be referred within one working day, and this year saw a slight increase over last year, 92% (previously 85%). This demonstrates good knowledge by agencies of their responsibilities to report concerns swiftly. Where

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referrals were not made within one working day, this is taken up by the LADO and safeguarding leads for the relevant agency.

In 78% of referrals, the employer was given advice and 18 cases proceeded to an ASV meeting.

The ISCP procedures expect that:

- 80% of cases should be resolved within one month.
- 90% of cases are resolved within 3 months.
- All, but the most complex investigations, should be completed within 12 months.

Figures demonstrate that the LA completed 100% (previously 82%) of cases within 3 months.

### ADOLESCENT SUPPORT INTERVENTION PROJECT (ASIP)

The ASIP pilot project from the LA Children Services started in May 2021. Their aim is to mitigate the risks of contextual harm (extra familial harm) towards young people by providing an intensive wrap-around service. The service incorporated feedback from 16 and 17 year olds who had been subject to exploitation to inform the design of ASIP.

Throughout the year, the pilot will be reviewed and evaluated to see whether their intensive approach upsills those around the child to be able to respond to risk, provide opportunities to the children by diverting them away from risk and mitigating the need for the young person to become looked after in moments of crisis.

ASIP currently consists of four Specialist Engagement Workers (two of which are qualified Social Workers), a CAMHS practitioner and an Education Specialist worker.

Since the project started, they have supported nine young people. Each intervention is tailored to the identified needs of the young person, but will always look at the systems around the child and work with them, for example family or educational setting. The duration of involvement varies from 6 to 12 months, or more if needed.

This project was created in response to the LA's high CLA rate as well as a more intense response to children and young people at risk of exploitation.

#### ASIP Case Study

JA started to work with ASIP due to concerns of child criminal exploitation (CCE), periods of going missing, substance misuse, low school attendance, and worries of emotional wellbeing due to bereavement.

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## Intervention

Rapport and relationship building with JA, supporting him around his education, sitting in on lessons, timetabling, upskilling teachers, and other staff in being more trauma-informed, bereavement work, respite for one weekend for JA and his brother. Parenting work delivered by a clinical psychologist to create opportunities for parents to *mentalise* JA's experiences.

## Progress

- JA's mother reports he no longer smokes cannabis in his bedroom at night because they have worked on consistent boundaries.
- JA has not gone missing since the start of the ASIP intervention and has become more open about the friends he is with and allowing his mother to have their contact details.
- The ASIP team provided JA with a new school uniform, as a result his attendance and motivation for school increased.
- Mother noted an improvement in JA's behaviour and relationship to her and his brother.

Islington Council launched the new, partnership-focussed five-year *Youth Safety Strategy* in November 2020; it focuses on protecting children and young people from violence, abuse, and exploitation.

## Performance

In the past reporting year, Islington achieved significant reductions in important areas of youth crime:

- 21% reduction in robbery offences with Islington being ranked ninth out of 32 MPS boroughs.
- 9.2% reductions in knife crime (since 2019/20) Islington was ranked 11th out of 32 boroughs.
- 10% reduction in youth violence and 15.8% reduction in serious youth violence in the past year compared to 2019/20.

Regrettably, two young people were murdered in Islington in 2020/21

## Making a difference

Looking at key performance indicators for 2020/21 there is evidence showing the impact of service on the lives of young people:

- **Reduced the number of fixed term and permanent exclusions in Islington schools.** There were two permanent exclusions from Islington secondary

## YOUTH STRATEGY 2020 TO 2025

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schools and zero from primary. Primary fixed-period exclusions also reduced but fixed term exclusions in some secondary schools are still too high.

- **Reduced the number of young people who are Not in Education, Employment or Training (NEET).** Two percent of the 16-17-year-old resident population were NEET. While higher than last year (1.6%), Islington is still below the Central London average (2.2%).
- **Prevented more young people from entering the youth justice system for the first time.** There were 12 First Time Entries (FTE) in 1<sup>st</sup> quarter of 2021/22, while an increase on the previous year when numbers were particularly low during the lockdowns it remains below prior pre-pandemic trend in 2019/20 and 2018/19.
- **Reduced reoffending amongst young people who are being supervised by the Youth Offending Service (YOS)** - In 2021/22 (Q1), provisional data finds 27% reoffended, this is a significant improvement on previous years and is lower than most of London and lower than statistical neighbours.
- **A reduction in the number of custodial sentences.** In the first quarter 2021/22, there were 2 custodial sentences imposed for our young people
- **Reduced disproportionality among young people from the Global Majority.** There continues to be an over representation of children from the Global Majority in Islington Criminal Justice system, while slightly less disproportionate compared to London, the numbers remain stark. The most over-represented group changed from Mixed to Black children.
- **Reduced levels of serious youth violence.** There has been a significant (375) reduction in Serious Youth Violence.
- **Reduced the number of children who go missing from home and care.** The number of children missing from care has remained at lower levels since the pandemic. We did not see an increase over Summer 2020 when restrictions lifted. Children missing from home has, however, risen this year.
- **Reduced the number of knife crime victims under 25.** This year saw 5% reduction in knife crime (non-domestic) where the victim was aged between 1 and 24. The downward trend over the last 3 years is testament of the successful work across our partnership.

### EXPLORING THE ANDOVER ESTATE AND YOUTH OFFENDING

Islington Borough Council and Criminologists at City University of London are now

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in their third partnership project that involves exploring the Andover Estate and youth offending.

The project was designed to enhance existing partnerships with Islington community partners and initiate new partnerships to co-produce detailed biographies for the 25 most prolific offenders in one of the Borough's most deprived areas, the Andover estate.

### **Aim**

To include young offenders and their families/carers as an equal voice in research and innovation activities (interviews, multi-media diaries/outputs) to better understand the complex interdependencies of serious youth violence (SYV) and enhance the local multi-agency approach to addressing and preventing it.

LB of Islington practitioners from *Youth Offending Service, Targeted Youth Service, Integrated Gangs Team, LBI Young Islington Management*, and five young people *Islington Youth Council*.

These practitioners and young people co-designed an engagement approach with support from *Young Islington Service Heads*. The project involved 17 young people, 3 parents / carers and 7 practitioners.

### **Evaluation**

This project demonstrated that children

face the kind of disadvantages that affects their development and threatens their future health and happiness and that early intervention can play an important part in offering these children and their families the support they need to reach their potential.

Effective implementation of early intervention approaches is not straightforward and that it is not always easy to identify the right interventions to support families with multiple and complex needs. The data gathered by the Andover Project confirmed many of the concerns that are known about young people who offend where typical childhoods are characterised by trauma, instability (home and school), absent fathers, parents who offend, early involvement in crime and intervention by the Local Authority from a young age.

The strength of this project is the in-depth, qualitative methodology, which has enabled the voices of young people not only to be heard, but also to directly inform the development of solutions to the multiple, varied and complex challenges shaping many lives on the Andover estate and beyond.

One outcome of capturing these voices has been the identification of several key policy and strategic areas for further development:

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- The new universal youth offer needs to be open to all young people with a particular focus on reaching the most vulnerable and reach into different communities to challenge persistent inequality.
- More bespoke parenting programmes should be developed, some of which should focus on specific communities. This should include more Parent Champions.
- Tackling school exclusions and poor educational attainment for disadvantaged groups must continue to be a strategic priority for the partnership, including addressing inequality and disproportionality issues.
- The availability and accessibility of mentors for young people should be maximised.
- Support in relation to parental and child emotional wellbeing needs to be strengthened.
- Services which provide support to girls and young women should be enhanced.
- More and better training and employment opportunities for the most disadvantaged groups should be developed.
- Develop a multi-faceted approach to community engagement that is more representative and includes the most disadvantaged and vulnerable Andover residents in decision-making about their place
- Explore different approaches to co-design with children, young people and families before commissioning services.
- Develop a 'whole family mindset' across the system to enable a more joined-up approach, while avoiding 'practitioner and service saturation' within the lives of young people and families.
- Take greater account of place-based sensitivities when making decisions about relocation for children, young people and families to optimise access to support networks when accommodated.
- Continue working to reduce school exclusions, which can result in poor outcomes for at risk young people.
- Recognise and harness the talent and experiences of those young people who have exited criminal lifestyles with positive outcomes.
- Increase the number and range of Local Authority Apprenticeships available to the borough's young people.

### Recommendations

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- Develop a more sophisticated understanding and use of social media to ensure LBI service engagement methods remain current with and relevant to the young people they support.

### **North Central London Child Death Overview Panel (LADO) Annual Report**

Since September 2019, the CDOP process is no longer overseen by the ISCP, but continues to report into and informs the ISCP work plan.

During the period of April 2019 to March 2020 there were 13 child deaths in LB of Islington, which was the same in the previous two years. The largest number of deaths occur in the first 27 days of life with nearly 50% of deaths occurring during this time.

The breakdown of ethnicities illustrate that of the 82 child deaths across the NCL (Barnet, Camden, Enfield, Haringey and Islington), 10% (13) of the children were marked as unknown, which has implications on the reliability of the statistics.

### **CDOP Priorities for 2020/2021**

- To develop a work plan to fully embed a North Central London approach to the management of all child deaths.
- Support the acute Hospitals to implement their local systems and processes to commence local *Child Death Review Meetings (CDMRs)*.
- Using learning from 2019/20 cases to develop work plan
- To develop a formal system of feedback of learning from Child Death Overview Panel meetings to local, regional, and national agencies, to enable professionals to reflect on practice, and provide scope for improved collaborative learning, better health, and public safety provision.
- To revise and embed the referral pathway for all child deaths across NCL.
- To recommend improvements to the bereavement experience, to ensure all families are offered the assistance, and to measure the effectiveness of support in the local area.
- Ensure each bereaved family has an identified key worker
- To continue the implementation of the eCDOP system and ensure all cases are reviewed, uploaded and completed on the electronic system.
- To improve completion of templates on the eCDOP system for all cases.
- Develop a business case for continuation of the transformation work of the panel

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- Support Trusts to establish Child Death Review meetings

### **Violence Against Women and Girls (VAWG)**

Islington's *Violence Against Women and Girls* (VAWG) service is supporting a large numbers of women and girls who need support and protection.

There has been an increase to the Islington VAWG service between 2020 and 2021 having 13 Independent Domestic Violence Advisors (IDVA), 5 Specialist VAWG posts which has led to a 56% increase in number of survivors supported in 2020/21 compared to 2019/20.

### **Daily Safeguarding Meetings (DSMs)**

Islington's VAWG service also established one of London's first successful *Daily Safeguarding Meetings* (DSMs) and a range of excellent commissioned services for women and girls which provides a much faster, whole-system response to high risk cases of domestic abuse.

The DSM replaced the MARAC on 4<sup>th</sup> January 2021. It is a multi-agency led, fully integrated approach to needs management for victims of domestic abuse across Islington Council, embedding the domestic abuse MARAC-process into the LBI Multi Agency Safeguarding Hub (MASH).

DSMs aims to address the needs at the time the intervention will have the greatest impact and to maximise victim engagement using service user led feedback to monitor the DSM outcomes.

Introducing DSMs led to:

- 10% decrease in repeat referrals in the six months since they commenced
- 88% of survivors engaged with the DSM process to express their wishes and feelings, compared to 18% with the MARAC.
- Responses to high and medium risk referrals were fifteen times quicker when referred to the DSM
- Non-core agencies (including A&E, Sexual and Mental Health Clinics, GPs, and education) were three times more likely to refer to the DSM than they had been to the MARAC.
- 305% increase in requests for civil and legal protection orders
- 188% increase in number of referrals heard through the DSM and pre-DSM improving risk management

### **ISCP Risks and Issues register**

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

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

The partnership's away day in July 2021 supported further development of our risk strategy.

### **Risks during 2021/21**

This year saw significant staff changes to senior roles in the MPS. The risk was mitigated by officers covering senior partnership roles during vacancies. Roles have since been filled and the risk was removed.

### **Lay Members**

The Partnership benefits from having a lay member who actively contributes to the work of the Partnership. 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 Partnership where appropriate, and continues to bringing a fresh perspective from Islington's residents.

### **EDUCATION SUB-GROUP**

The sub-group is coordinated with the *Islington Head Teachers' Forum* to ensure

collaboration between the Partnership 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.

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

The ISCP is pleased 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:

- Staff well-being due to the stressors associated with COVID; for e.g. managing to keep school open whilst working in COVID bubbles and the extra pressures when staff are off sick.
- Impact of COVID managing and containing children's, parents and staffs heightened anxieties.
- Communication with CSC around threshold decisions and not always being informed that cases have closed in a timely manner.
- Managing the complexities of their role relating to safeguarding e.g. school bordering several boroughs

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- DSL's are feeling overwhelmed about the vast expectation from government and other agencies regarding safeguarding because more tasks are being added to their roles, this has been compounded by COVID
- Parental relationships and conflict

### *Everyone's invited*

*Everyone's Invited* is a public website whose "mission is to expose and eradicate rape culture with empathy, compassion, and understanding." Thousands of public testimonies have been recording about children's experience of rape culture in schools and universities.

### **Department for Education's response**

The *Department for Education* requested that *Ofsted* carry out a review of safeguarding, the curriculum, multi-agency safeguarding arrangements, the victim's voice and reporting policies in schools and colleges.

The review also included information about allegations and incidents, the extent of schools' and colleges' knowledge of the incidents, the safeguarding responses, the use of sanctions, their safeguarding knowledge, culture and effectiveness, the adequacy of the curriculum and teaching and the extent to which inspections explored relevant cases.

This was because of the number of disclosures of sexual abuse and harassment made on the *Everyone's Invited* website.

*Ofsted's* thematic review revealed how prevalent sexual harassment and online sexual abuse are for children and young people. For this reason, the report recommended that schools, colleges, and multi-agency partners act as though sexual harassment and online sexual abuse are happening, even when there are no specific reports.

### **Everyone's Invited task and finish group**

ISCP's response was to set up a task and finish group in May 2021 under the governance of the Education Sub-Group. Its focus was to create a protocol and procedure for schools, settings, and colleges on managing peer-on-peer sexual violence, abuse and harassment and also to focus on communication, curriculum and training.

The protocols establish and reinforce a culture where sexual violence, abuse and harassment are not tolerated, where there is clear guidance for managing cases, supported by an effective curriculum, communications and training.

The sub-group will continue to oversee the implementation of the protocol and measuring the outcomes through the

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deep-dives and the S175 (S11) Audits in schools and education settings.

### *Missing Pupil Procedures*

When a pupil has been alerted as 'Missing Pupil Alert' 'Off-Rolling Notification' or 'No Show' a referral is sent to the Access and Engagement Team who allocates (or rejects) the case for further investigation.

Database checks are conducted to identify alternative contacts, previous school or siblings for the pupil. If the pupil is not located then this is escalated to Children Services Contact Team to conduct further checks. A Pupil Tracking Officer refers to relevant local authority if the family have moved out of borough. This is escalated to home visits if the pupil still cannot be located, where a letter is left to make contact. If no response, this is escalated to Children Social Care or Police where a decision is made to make a 'Missing Persons' report to the Police or register the child to the DfE's 'Lost Pupil' database on School to School.

This procedure is there to assist all schools and other professionals who work with children and families with Islington to ensure that they meet statutory duties relating to the provision of education and safeguarding the welfare of missing children. It also ensures robust agency systems are in place to identify, refer and track children missing children from education or at risk of doing so.

- As part of our Missing Pupil Procedures, schools are asked to consider a range of potential risk factors including neglect when referring cases to the LA for further investigation.
- Feedback is provided to schools and where appropriate, schools are requested to carry out further casework.
- This process supports schools with familiarising themselves with the risk factors, procedures and tools available for locating children missing from education.
- For cases under investigation by the LA, review meetings are held every two weeks to review progress. The meetings are chaired and attended by senior officers in Pupil Services and ensure that issues leading to children missing education due to parental neglect (and a range of other factors) are addressed.

### **Impact**

Robust procedures ensure that 94% of children referred as 'Missing Pupils' are found and returned to school.

### *Elective Home Education (EHE)*

While Elective Home Education (EHE) in itself does not necessarily indicate that children are more vulnerable, reduced opportunities for ad-hoc and planned contact

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with professionals outside the home is a risk factor.

As part of our EHE procedures, a risk assessment is carried out by the LA to identify children who may be vulnerable, including to sexual exploitation.

Because of a recommendation from *Child B Brighton & Hove Serious case review*, the POSIE has developed a child's page linked to the LA EHE and ISCP webpage for parents.

We have reached out to children who are Electively Home Educated by providing a means for them to contact us for support online.

### Impact

- Because of the pandemic, home visits have not taken place in person (our pre-COVID practice), with families being offered online appointments instead.
- This is a concern as the opportunity to identify children at risk of sexual exploitation is considerably reduced.

### *Operation Encompass:*

It is important that Designated Safeguarding Leads in Education are aware of domestic abuse incidents so they are able to monitor the welfare of the child whilst they are at school and if necessary, put ad-

ditional support measures in place. In order to provide that information, the MPS has introduced *Operation Encompass*. So far 66% (45/68) of state schools in Islington have signed up to the Encompass information sharing agreement.

This enables police to provide schools with details of any domestic abuse incident they may be aware of so that the school is aware of the circumstances for when the child attends school the following day. At present *Operation Encompass* is only offered to state schools but it is hoped that this can be expanded to private schools in the near future.

### *Trauma Informed Practice in Schools (iTIPS)*

Trauma Informed Practice for schools began 4 years ago and is in its 4<sup>th</sup> wave with 20 primary and 4 secondary schools having now received training. With further funding from *Public Health England Better Mental Health* fund it will continued to be rolled out with additional 1-2 secondary schools and three additional primary schools next year.

To embed iTIPS, training is followed by support for the setting by means of developing an action plan led by an organisational working group supported by a CAMHS clinician (or Education Psychologists or CAMHS clinician in schools).

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Since the programme started, 1507 staff have received or are in the process of receiving ITIPS training, across 83 different training events.

## Feedback from surveying iTIPS sites

- Staff felt that the training helped in their understanding of how to help children identify and manage their emotions (rating 4.12 out of 5)
- Staff felt that the training would have a positive impact on their work (rating 4.21 out of 5)
- Staff felt that the training helped provide ideas on how to develop their own work,(rating 4.12 out of 5)

## Impact on system

One of the aims of TIPS is to embed trauma informed practice across education settings in order to promote the welfare of children and young people.

The programme has resulted in schools reframing how behaviour is viewed across the school, as a result staff have reported that they are able to be more preventative instead of reactive, hence able to meet their pupils' needs.

Schools have feedback that they have created an individualised approach to children's needs and understand as a school

that if child's SEMH needs are not addressed then learning won't happen. The ITIPS approach for schools has supported a reduction in exclusions for primary schools and an improved attendance.

## Impact on staff

Training on staff-regulation and self-care with staff requesting more for the future and feeling better able to manage their own emotions when a pupil displays challenging behaviour.

Understanding the trauma and how it can impact pupil's behaviour and their role in supporting them with increased strategies to manage their emotions.

## Impact on pupils

- Four children who found following instructions, getting on with their peers, seeing beyond their point of view and dealing with any last minute changes in routine challenging, have all made huge leaps forward
- Some children's behaviours have moved from being dangerous to being brilliant
- Noticing from walking around the school, that more pupils are taking a minute outside of the class to self-regulate, and then returning to learning

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- Promising results re exclusions and developing self-awareness

### **Learning and development for the ITIPS team**

- Continue with network meetings to share ideas and generate new ones
- Consider developing a mentoring programme
- Consider ways to share practical ideas, resources, current research and events across the borough related to trauma informed practices with schools, such as a newsletter to maintain momentum and keep iTIPS present in staff's minds

### **COVID-19 Disruption and response to SEND children and young people**

The SEND service conducted a self-evaluation report between April 2020 to May 2021 to determine the effectiveness in identifying and meeting the needs of children and young people who have SEND and affected by Covid-19 restrictions.

A strong message from the youth council was for the participation of children and young people in the renewal process and in future planning for emergencies. They have feedback that Children and Young People (CYP) would have benefited from more targeted around COVID-19, and this remains the case as lockdown eases and

guidance becoming more nuanced.

Key concerns from families (apart from fear of contracting the virus) have been that their child will not get the emotional, behavioural, and educational support that they need. They felt there were also barriers in accessing services during lockdowns. A survey carried out by our *Parent Carer Forum* and *Centre 404* (Voluntary Sector) (March 2021).

### **Views of children and young people**

The things that children and young people have said helped them during lockdowns were: routine and structure, contact with friends and the wider school community, physical activity and learning new skills.

Whilst some evidence collated from surveys and interviews indicate some improved mental wellbeing in young people, observation highlight that this has been less so for LGBTQ+ students and those with a health problem or SEND.

A common theme was that CYP wanted a sense of control over their lives, things to do, and meaningful connections with others. Many young people reported concerns and uncertainty about their future, this was particularly the case for children with vulnerabilities such as care leavers, young carers and low-income families for whom the "new normal" brought on new issues that exacerbated inequalities and

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exclusion – these are important considerations for the future development of SEND services.

### Gaps

- On the lived experience of children living in shielding households
- On the impact of COVID-related illness and bereavement on children and young people
- On the potential impacts on the development and lifelong wellbeing of this generation of children and young people

### What SEND did

SEND have also developed a *Transition Support Matrix*, which coordinates information and planning of all of the mentoring, and support projects that can help young people from different backgrounds and with varying needs to make a successful transition from primary to secondary school. This includes time-frames in which support will take place and will support schools to map the appropriate programme to the right individuals and/or groups.

A Partnership Project comprising representatives across the *People Directorate* including *Pupil Services, School Improvement, Data and Performance, Digital Services, Children's Social Care* and *Bright*

*Start / Early Help* was set up to agree a multi-disciplinary support offer.

By the end of November 2020, Islington's overall attendance figure was 95.2%, on par with pre-COVID figures and over 7 percentage points above national figures at that time of 88%.

### **MISSING CHILD AND ADOLESCENT EXPLOITATION SUB-GROUP**

The Partnership, through the work of its MCAE 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 in 2019, which continues to form the basis of the subgroup's action plan for 2020/21:

- Boys and Young Men
- County Lines
- Harmful Sexual Behaviour
- Intelligence Gathering and Information Sharing

The sub-group are currently in the process of reviewing their action plan and this will be updated for next year's annual report.

Data analysis undertaken in relation to

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vulnerable adolescents, alongside lessons learned from serious case reviews and offending profile reviews identify common themes. The most significant of which is the impact of early childhood experiences of trauma on outcomes for children and young people as they develop. In addition, the link between children who are not in education or who have experienced school exclusions, and the risk of exploitation and contextual harm in the community.

The LA's Children's Services Scrutiny Committee (2019) highlighted the impact of school exclusions on young people, as Islington's exclusion rate is higher than neighbouring boroughs and have implemented 14 recommendations that aims to improve this.

### **Multi Agency Child Exploitation (MACE)**

MACE now explores links between *gangs* and *serious youth violence*, *child sexual exploitation*, and *child criminal exploitation* in terms of *Prevention, Protection, Prosecution* and *Partnership*.

This approach has supported the partnership to consider *contextual safeguarding* including specific locations in the borough that require intervention in order to reduce risks and safeguard children. *Community Safety* is now part of the MACE and we have seen very positive examples

of partnership-working, which in turn has reduced risk to children in Islington.

The MCAE sub-group have ratified plans for *Borough Briefings* where the themes and trends identified in MACE will be disseminated to safeguarding leads in partners and relevant agencies from January 2022. This will support partner agencies to be aware of location hot spots, patterns of behaviour and diversion tactics conducted.

The aim is to develop a multi-agency, partnership approach to Contextual Safeguarding across the borough so that professionals are better able to identify and report concerns they observe in the community and to be aware of contextual risk areas to further promote the welfare and safeguarding of children.

### **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*.

Unfortunately, due to the Covid-19 pandemic the training offer reduced throughout this reporting year, as a result virtual meetings and consultations increased. It was also a challenge to adapt the training to suit the online format.

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However, they have already planned to implement training across the partnership from January 2022.

### **School-based preventative education**

COVID-19 pandemic had a significant impact on the amount of children and young people not receiving any group work and awareness raising sessions across the Exploitation and Missing focus areas. This is something that will begin to take place as practitioners are allowed to administer sessions in schools.

### **Children who go missing from home and care**

In 2020/21, 156 children were reported *missing from home* and *missing from care*. This is a significant reduction over 2019-2020 (245). We believe this reduction was due to the impact of lockdown

These 156 children went missing a total of 927 times, a slight reduction over the previous year (995).

### **Children who going missing from home**

In total, 52% of the *missing episodes* involved young people going missing for less than 24 hours, with 21% of children returning the following day.

Four percent of the missing episodes were for longer than 2 weeks and 1% (one child)

went *missing* for more than one month.

### **Children missing from care**

In total 75% of the missing episodes involved young people returning the next day or earlier; an increase of 5% from last year. This figure reflects the developments being put in place through the *Philomena Protocol* as many young people are being recorded as missing but are actually returning to placement late, rather than not at all.

Four percent of the missing episodes were for young people who went missing longer than a week, this is a reduction from seven percent last year. This equates to 30 separate incidents where young people went missing from care for longer than one week.

Three young people went missing from care for longer than one month. Two of these young people were Looked After due to being Unaccompanied Asylum Seeking children.

### **Children missing from care and the Philomena protocol**

The Philomena protocol requires that every young person aged between 13 and 17 have a pre-agreed grab pack on file outlining the actions that should be taken if that young person does not return to their home on time e.g. phoning the young person, checking their room and/or

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phoning their family members they often stay with.

The actions taken are then shared on an online portal to the Met Police who will review whether to open the young person as a missing person. This protocol was implemented after the Met Police found in one year that 95% of people categorised as absent were children aged 13 to 17 years old and in the majority of these cases children returned home after a few hours. This statistic was very similar to Islington Police.

### Return Home Interviews (RHI's)

The *Return Home Interview* (RHI) process is provided by the Exploitation and missing team's two RHI workers. RHI's were impacted by the COVID Pandemic that led to RHIs being completed by telephone, this may have impacted how feedback was given to the RHI staff from young people.

During 2020/21, 776 Return Home Interviews were offered to children missing from care and those that were missing without authorisation. Seventy two percent have been completed:

- In 93 episodes (18%), the child refused the interview;
- Forty five episodes (9%), it was not possible to make contact with the child for the interview to go ahead after several attempts;

- Four episodes (1%) were not required due to it being an unauthorised absence and
- For 264 episodes (34%) were not possible as the child was still missing.

### Positive changes

During 2020/21 we expanded the role further and the RHI workers offered some of the young people 3 – 6 intervention sessions, particularly to young people who had frequently gone missing and also to those who have only gone missing once or a few times.

This work has proved very successful and is built on the theory around contacting a family and/or young person at the "reachable moment".

Another area of success was working with parents open to intervention was focusing on indicators, response to escalation of concerns and helping them to engage with services such as TYS or Social Care.

### Impact

One mother feedback that she and the RHI worker were able to establish a positive relationship because help was offered when she was most anxious about her daughter. The RHI worker was then able to mediate and assist the Social Worker and parents to establish a more positive working relationship than before.

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## Child Sexual Exploitation

During 2020/21, 41 young people were identified as at risk of Child Sexual Exploitation (CSE) compared to 46 in 2019/2020.

Even though the overall number of young people identified as at risk of CSE has not been dramatically effected by Covid-19, there is a question about its impact when looking at the age of young people being identified.

In 2019/20 the most common ages for young people at risk of CSE was 14 and 17(N=14). In 2020/21 only 6, fourteen year olds were considered at risk of CSE, the most common age was 15.

There were no changes in terms of ethnicity and diversity:

- 36% of the young people were white;
- 39% black;
- 1% Turkish,
- 21% were of unknown or mixed parentage.

It is noteworthy that in 2020/21 there have been no Asian young people identified as at risk of CSE compared to 2019/20 only 1% was of Asian/Bangladeshi heritage. This leads to a question around identification and referral routes, as it seems

unlikely that young people from this ethnic group are not experiencing exploitation. At 39% Black young people were over-represented.

## Harmful Sexual Behaviour (HSB)

When concerns about HSB is referred, a consultation with the Specialist Social Worker for CSE and HSB is held. Over the last year, 58 such consultations were held between social workers and specialist colleagues.

Over the past year, the number of HSB referrals fluctuated month to month and it was not possible to identify a specific pattern.

## Child Criminal Exploitation

Between April 2020/21, 55 young people, under the age of 18, were identified as being at risk of Child Criminal Exploitation, the same number that were identified in 2018/19. Five were female which is an increase over 2019/20 when only one female was identified as at risk of CCE.

The ethnicity analysis of a cross-section of young people shows that 53% of the young people were recorded as Black, 21% as white, 19% having mixed parentage and 6% as Asian. There is a clear over representation of black, young males identified as at risk of Criminal Exploitation.

## Serious Youth Violence (SYV)

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In 2020/21, 32 children have been identified as being at risk of SYV and 42 person who were over the age of 18. (Note: some of those 42 young adults may have been under 18 when they were identified). Out of the 74 young people identified as at risk of SYV only three were female.

### **Covid-19 impact**

During the epidemic, the nature of gang-linked violence has changed. Although there have been incidents of serious youth violence but during large parts of the year, usual patterns were not observed: because of lockdown, young people were more likely to be identified when congregating in groups; they stayed at home more and away from locations where they could be groomed in to gang linked violence.

Unfortunately, grooming and rivalry between groups has moved online during this year and it is difficult to assess and understand its full impact.

### ***MPS Predatory Offender Unit***

This unit is successful tracking down and arresting some of our *High Harm Offenders* responsible for rapes, and domestic violence and abuse offences e.g. a case where two children were protected from an address where they were being exploited by a male in the supply and packaging class A.

The Predatory Offender Unit also uses innovative methods to ensure the safeguarding of children, even when there is little evidence to achieve a successful prosecution against the offender, e.g. making use of Modern Day Slavery legislation. The unit secured the first ever Slavery and Trafficking Risk Order linked to a County Lines investigation in London.

### **QUALITY ASSURANCE SUB-GROUP**

Attendance at the sub-group is good, and commitment is strong. The meeting is 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***

### **ISCP Core Business Report**

The sub-group scrutinises the performance report prior to it being presented to the Partnership. The members assist in the analysis that is written as an accompanying commentary report for each Partnership.

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

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## Areas discussed / audited included

- A report highlighting children subjected to Police Protection and disproportionality.
- The need to improve data analysis across the London Metropolitan Police and sharing with the ISCP.
- Auditing activity of children on child protection plans for 18 months or longer. The audit found no delays in practice and that concerning cases were escalated to PLO or care proceedings. Care proceedings complete in a timely manner and delays to children minimised.
- Audit of health contribution to strategy meetings.
- Moorfields hospital's evaluation of structured safeguarding children supervision.
- Moorfields audit of child protection flag audit on case system.

The data from the Metropolitan Police, particularly Borough level data remain insufficient although work is being carried out Pan-London to remedy this. The ISCP Business Unit has been working with data-

analysts' to develop a scorecard to 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 Partnership approval).

## Data Highlights<sup>5</sup>

- Islington received 11,147 contacts requesting a service for children in 2020/21, a 1.8% increase from 2019/20. The most common source of contacts were from the Police (34.4%), followed by schools (10.2%). The latter is a decrease from 13% attributable to lock down during the pandemic.
- The most common reasons for contacts were domestic violence and abuse (15.6%), information requests (10.9%), concerns around parenting capacity (10%), child mental health (7%), specific concerns regarding a sibling (6.9%), parental mental ill health (5.3%)
- 3,843 (36.2%) of contacts were progressed to receive an early help service and 1,918 (18.1%) received a statutory social care service.
- Islington had the 23rd highest rate of children assessed as Children in Need

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<sup>5</sup> LBI Child Protection Annual Report, 17 September 2020

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in the country in 2019/20.

- Islington had a higher rate of children with child protection plans and a higher rate of child protection enquiries compared to their statistical neighbours.
- We had a lower proportion of repeat child protection plans compared to statistical neighbours; the result of reviewing and auditing practice in this area.
- 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 - over 50% of child protection plans ended within nine months in 2020/21
- Islington applies to court for orders to protect children more than most other boroughs, they had the 25th highest rate nationally
- 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 three times during a year is slightly lower than our statistical neighbours.

### **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.

### **Islington CCG Safeguarding Children and Adults Annual Report**

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

- Support development of NCL ICS Safeguarding partnership; working together to identify shared agendas and seek opportunities for joint working.
- Harmonisation of NCL Safeguarding Policies/procedures/processes.
- Continue to improve arrangements for gaining safeguarding assurance from all providers.
- Develop NCL Primary Care Matrix.
- NCL Designated Staff to take one statutory area of priority to develop across the NCL footprint as system leaders.
- Adapt Safeguarding Strategy in line with changing guidance issued by

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NHSE/I.

- Plan and implement the key deliverables laid out in the new LeDeR policy which should be implemented in 2021/22. Learning from Audits

### **Child Protection Plans (CPP) for longer than 18 months**

In March 2021, there were 17 children from 10 families who were subject to a CPP for longer than 18 months: six families were on plans for emotional and four for child neglect. Six of the 10 sibling groups (12 children in total) were also in Family Court Proceedings, which add to the length of plans, exacerbated by Covid-19 related delays.

The remaining four sibling groups (5 children) have remained on CP plans.

The Safeguarding and Quality Assurance Team carried out an audit and made the following Recommendations:

- Child Protection coordinators to monitor CP plans between child protection meetings
- Child Protection Coordinators to receive monthly reports of child protection plans over 14 months

### **School Nurse Quality Improvement**

### **Project**

This project looked at enhancing the response to safeguarding invitations received in the school nursing service. Specifically, to balance the need to provide reports for child safeguarding meetings for children not known to the school health service. In many instances, other specialised health care professionals e.g. CAMHS practitioner or the Speech and Language Therapist were already involved.

### **Findings**

Audits were conducted on 30 records of school-aged children where the service received an invite from social care to attend an initial or review child protection case conference.

Eighty percent of the records did not have an identified health need or any information to indicate for a school nurse to attend.

- Eighty three percent of records were not reviewed by a safeguarding advisor or a senior clinician prior to the decision that they would not attend the conference.
- 63% of the records had another identified health care practitioner (HCP) actively working with them (e.g. CAMHS, speech and language, Looked After Team, a nurse specialist and the health living nutritionist)

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A focus group with HCPs and school nurses agreed that reducing attendance at conferences would support early identification and prevention in schools.

A safeguarding protocol was drafted outlining potential new ways of working that will be embedded through training and supervision.

This audit outlined 13 recommendations that will be taken forward to improve the several parts of their system.

### Late Initial Child Protection Conferences (ICPC)

London Child Protection Procedures (4.1.7) state that ICPCs should take place no later than 15 working days of the first strategy meeting/discussion where child protection enquiries were initiated.

Within that time, the social worker must investigate suspicions of significant harm, complete a child and family assessment, explain the outcome to the child and family, and find a suitable time for an ICPC.

This audit covered from April 2020 to March 2021 and examined ICPCs that were convened outside the 15 day requirement and involved 219 children.

### Findings

- It found that 64% of investigations happened within the timescale, below national average (75%). Conferences for 36% (79 children, 44 families) were

held late.

- The ICPCs were conducted throughout the COVID pandemic so some conferences were impacted by practical, emotional and physical health challenges, resulted in 45% of late conferences.
- The most common factor (40% of all late ICPCs) were late bookings by social work teams.
- The audit concluded that the majority of families presented with chronic problems, having received an ongoing social care service, and it should therefore be possible to have more conferences on time.
- 58% of the late conferences were late within 1 to 7 days and no children were left at risk because of delays.

### Recommendations

- For families already receiving a child in need service, more care needs to be taken in the timing of strategy discussions to allow sufficient time for reassessment and preparation for an ICPC
- Conferences must be booked on the same day as the strategy discussion when it seems likely an ICPC may be needed.

### Audit: How Health professionals'

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### **views and perceptions of safeguarding children and young people responsibilities informs Level 3 training**

This audit covers a longitudinal study from January 2017 to January 2020, of how health practitioners perceive their professional and personal views on their safeguarding responsibilities. It also looked at what resources they were accessing for safeguarding advice and support, and to identify common themes.

#### **Findings**

- 201 staff undertook Level 3 face to face safeguarding training over the audit period, having all completed pre-training questionnaires.
- Overall, staff confidence, knowledge and discussing concerns with children and families increased over the period of the audit.
- Staff who attended the training identified as having a clearer understanding of their role in safeguarding.

### **Disproportionality in use of Powers and Police Protection (PPP)**

The Children Social Care Practice and Outcomes Board found that:

- Over a 4-month period powers of police protection (PPP) were used on 14 children
- 64% of children were female.
- 43% of children were Black African and Caribbean were of the largest ethnic group
- The reasons for using PPP ranged included physical abuse and parental substance abuse.
- 71% (10 children) became looked after and 64% (9)

Whilst it could be argued that all children were correctly protected by using PPP, the audit raised further questions about whether other services were involved and the large number of Black Caribbean children in the cohort.

It was agreed that an MPS audit should be carried out to look at patterns, and whether there is scope for learning especially in the context for cultural differences.

### **Health involvement in Strategy Discussions**

Where there is reasonable cause to suspect a child is suffering or likely to suffer significant harm a strategy meeting/ should take place with the Police, LA children's social care, health professionals and other agencies as appropriate.

A sample of 95 children were drawn from all strategy discussion between January to

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March 2021, 194 children from 116 families.)

## Findings

- CIN teams included health in 87% of their strategy discussions. The issue of 8 children not having health in their strategy has been dealt with.
- The Children Looked After service and Independent Futures, the audit found that in 76% of cases health had not been invited to the strategy discussion. (However, there was evidence of a recommendation to follow up with health. This area of practice requires improvement to ensure that all children receive the same service regardless of service area.
- Across the whole of Children Social Care, in 67% of meetings practice managers contacted health and they actively took part in the strategy discussion. The information provided by health was clear and concise and health provided a recommendation on whether they agreed threshold to progress to a section 47 child protection enquiry.

Several recommendations were made to improve practice.

## Accident and Emergency Attendances of children

Following the Laming Inquiry into the death of Victoria Climbié (DH 2003), Laming (DH 2009) recommended that information relating to a child's attendance at Accident and Emergency Departments, their discharge from hospital and follow up appointments should be shared with primary care and community services. The objectives of this audit were to:

- Ensure that notifications of significant ED attendances are acknowledged, reviewed and actioned by health visiting and school nursing teams.
- Identify any gaps in follow up.
- Ensure the notification system is operating as expected.

## Findings

- 132 paediatric cases attended the Whittington Hospital during the period of 14<sup>th</sup> December to January 2021.
- In 75% of the cases a health visitor or school nurse had made an entry on their RIO database. Of those, 50% were followed up with a phone call and 24% were followed up with a face to face contact.

The results illustrated that pathways worked well, but was not auditable unless the event was diarised.

A recommendation was made for clearer

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guidance.

## **Audit of Islington Child Protection Medical Examinations (CPME)**

The Royal College of Paediatrics and Child Health (RCPCH) and the Child Protection Special Interest Group (CPSIG) published standards about the service delivery aspects of CPME.

The Audits examined all aspects of CPME such as the referral process, examination, accurate and timely reports and supporting the child, the family, and clinicians.

The audit considered, 39 cases from September to October 2020: 26 underwent CP medical, ten were seen the same day, another ten the day after and 2 were seen two days after with the remaining deemed no urgent and seen 8 to 22 days later.

The majority cases audited were of physical abuse and fewer requests were made for neglect.

## **Findings**

Improvements to be made on accessing paediatric dentists when further dental assessments are needed.

High numbers of signed consent from parents to allow CPME.

Noticeably lower number for signed consent for photography to be taken.

## ***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 report highlighted key safeguarding data e.g. CP investigations, referral and children subject to CP plans and summarised key quality assurance activity during the year, which is reflected elsewhere in this section.

The report was presented by the Director for Children Services to the Council's Scrutiny Committee in March 2021 showing good governance over safeguarding in the Council.

It showed that *Islington Safeguarding and Family Support Service (SFSS)* was working with 979 children in need, 349 children who are looked after, of which 25 are disabled children and 55 are *Unaccompanied Asylum Seeking Children (UASC)*, 586 care leavers and 194 children with child protection plans. The majority of child protection

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plans are due to *emotional abuse or neglect*.

Characteristics of parents whose children have *child protection plans* include *domestic violence and abuse* (47%), *adult mental health* (36%) and *adult substance misuse* (26%).

Islington's *Youth and Community Service* was working with 57 Youth Offending interventions. There were no custodial interventions at the time, but five remand interventions and 52 community interventions.

The report covered services, interventions, outcomes, and governance arrangements in the People Directorate very well, and showed that the welfare of Islington's children were promoted, and when needed they were protected from harm.

As there have been changes in governance arrangements around early help services, in future a separate report should be requested from the relevant service director.

### **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 LCSPRs
- LADO allegations.
- Serious incidents.
- Inspections.

The Safeguarding report was comprehensive, informative and outlined salient priorities with the aim to have positive impact on promoting welfare of children. Such as: supporting the introduction of Trauma Informed Practice approach to practice across the trust, supporting health strategies in relating to gangs, adolescent

### **Moorfields Eye Hospital Safeguarding Children and Young People Annual report 2020/21**

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.

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The S11<sup>6</sup> duty of organisations are specifically, and helpfully, addressed in the report, as are the *ISCP 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:

- Developed a Home Alone Procedure Flowchart and Leaflet to underpin when a safeguarding response may be required.
  - There were no *Serious Incidents* relating to safeguarding children during this reporting period, although 38 safeguarding incidents were reported by staff from a wide range of roles and responsibilities.
  - Twelve 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.
  - Mandatory safeguarding children training compliance at Levels 1, 2 and 4 remained above the 80% target throughout the year. Level 3 compliance dropped slightly however staff required to complete this level have completed Level 1 and 2 separately ensuring no member of staff is without any safeguarding training.
- Systemic learning is supported through a variety of activities including training, via team meetings and briefings, supervision, distribution of the internal Safeguarding Nuggets Newsletters, attendance at meetings, staff question and answer sessions, Safeguarding Notice Partnerships and via comprehensive feedback through incident reporting.
  - Despite a reduction in clinical activity due to the covid-19 global pandemic, queries to the safeguarding children and young people team rose by 15% compared to 2019/20. Queries raised by external statutory agencies in relation to children who are known patients of Moorfields rose by 40%.

### TRAINING AND WORKFORCE DEVELOPMENT SUB-GROUP

The ISCP sub-group is chaired by the *Named Nurse for Safeguarding* in Whit-

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<sup>6</sup> Section 11, Children Act 2004

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tington NHS and attended by a wide variety of agencies, including representatives from the private and voluntary sector.

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

### **ISCP Training Strategy**

The training strategy<sup>7</sup> will be reviewed during the next reporting cycle and will further develop so the following are incorporated in the strategy:

- Harmful Sexual Behaviour
- Disproportionality
- Cultural Competence

### **Amendments to Core Training**

The ISCP 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 2020* and *Keeping Children Safe in Education 2021*.

- 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)

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<sup>7</sup> [Competence Still Matters](#)

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## **Key Training data**

Due to the impact of COVID -19, ISCP's face to face training offer is still paused and we continue to offer training virtually.

The ISCP trained 793 members of staff throughout the reporting period. This is slightly higher than our previous year (645) but can be explained due to restart of our training program (impacted by COVID). Since the introduction of the virtual offer, uptake has remained high if not higher than in previous years due to the more accessible nature.

## **Training cancellations**

It is expected that some learners will need to withdraw from courses because of sickness, operational pressures, or staff changes. One 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%. Non-attendance rates are very low and not a reason for concern.

## **Places withdrawn by the ISCP**

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 ISCP 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 ISCP Business Unit will in future not require line manager approval but allocate a place when requested. Courses will remain free to audiences who qualify for

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courses as specified in the ISCP training strategy, otherwise a course booking may attract a fee. This will be phased in during the next financial year.

### Training audience

There is an excellent variety of staff from all sectors attending ISCP 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. ISCP training is very well regarded by attendees and 97% reported that the course met their training needs very well, 99% thought ISCP courses fulfilled their published objectives and 100% of participants stated that ISCP 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 re-

sult 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 ISCP course to their colleagues.

### Training from other partners

#### Metropolitan Police BCU Islington and Camden

The MPS have restructured their three-week *Advanced Safeguarding Training Course* for Detectives consisting of Domestic abuse (DA), Serious Sexual Offences (SSO) and Child Abuse Investigations. The course is not delivered in three bespoke training sessions covering the same training objectives. There is a one-week course for DA and SSO and a two-week course for *Child Abuse investigations*.

Officers now only need to take training in the unit that they belong to. Training is delivered in accordance to Working Together statutory guidance that states that all police forces should have police officers trained in child abuse investigations.

Since the pandemic the use of virtual training has been instrumental in the MPS, as a result there has been an increase in the number of Detectives trained and are on task to deliver this training to every Detective within the Public Protection strand.

The MPS in partnership with the College of

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Policing also deliver the bespoke DA training for every front-line uniform officer from Constable to Inspector rank.

Education:

Early Help:

### Local Authority

The Workforce Development Service provided training to staff, including:

- Core training organised and facilitated by WDT
- Management training programmes
- Events for Organisation
- Bespoke training/development and additional support

### SFS, TYS & YOS Core Training

The programme originally planned for the summer-term was put on hold at the beginning of April due to the COVID.

After a period of adjustment to virtual working the decision was taken to deliver all core training online, which continues except for very few courses (e.g first aid).

All training was available and accessed by SFS, TYS, YOS, EH/Bright Start and take up was high across the organisation.

Nineteen courses were delivered between

June 2020 and March 2021, some on multiple occasions. This included all core training, which was well attended, and some newly developed courses aimed to meet specific needs identified during this time:

- Social Care Induction for new staff
- County lines webinar
- Child protection and domestic violence and abuse
- Child protection and section 47 enquires
- Gangs & serious youth violence
- Motivational practice
- *PACEful practice*: UASC young people in the context of recent placement breakdowns
- Trafficking and county lines
- Parents who misuse substances and impact on children
- Motivational practice for RAA
- Writing court statements
- Child sexual exploitation
- Recognising and responding to sexually harmful behaviour
- Introduction to DDP for CLA/IF and

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DCT services

- RiP Analysis and critical thinking in assessment
- Purposeful Planning
- Working with men who use violence
- Gender and sexuality awareness
- Direct work with C&YP & Adults, (for working online)
- Direct work with children and families including adaptations for working online

### **Foster carer's training**

A specialist online training programme for foster carers also commenced from June 2020. Prior to this, at the start of the first lock down narrated power points were developed and shared with foster carers to support and maintain a connection with foster carers. Regular emails to carers with links to videos and support and webinars by Public Health were arranged and on offer.

The training programme went online in June and covered:

- Bereavement and loss
  - Relationships with adolescents in challenging times
  - Managing virtual contact
- With support, foster carers adapted and made the transition to online training and attendance was good.
- The following courses were presented:
- Bereavement and Loss
  - Relationship with Adolescents during challenging times
  - Working with Parents who use substances and the impact on their children
  - Working with UASC
  - PACE Parenting (over 10's)
  - PACE Parenting (under 10's)
  - Supporting Secondary School Children Returning to School
  - Attachment-Based Parenting Course
  - Online Safety for Foster Carer's
  - Safe Caring
  - Grooming, Exploitation and County Lines
  - Child Protection
  - Writing and Recording Skills
  - Valuing Identity and Life Story Work

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- Disability Awareness
- Gender and Sexuality Awareness
- Introduction to Talking to Young People about Sexual Health

### Management training programme

The Council's management training programme commenced in January 2021, and has been redesigned to meet the key priorities for SFS, TYS & YOS over the next 12 months. The programme includes a combination of internal and external facilitators and separate groups for Team Managers and Practice managers:

- Mentalization for managers
- Developments in practice in domestic violence & abuse

### Staff and manager forums

There were four forums co-ordinated and facilitated between October 2020 and March 2021:

- Two managers forums which focused on challenging inequalities (parts 1 & 2)
- Two practitioners forums also focusing on challenging inequalities and promoting health and well being

### Health

Compliance with safeguarding training has been summarised in Health Safeguarding Annual Reports and won't be repeated.

### VAWG Training

VAWG trained 348 professionals including Police Officers, NHS, Housing and Social Care staff completed VAWG Development Training focused on supporting survivors and working with men using violence and abuse in their relationships.

The service supported more than 150 consultations with children's services staff working with fathers who are perpetrators of domestic abuse during 2020/21

### EARLY HELP (EH) SUB-GROUP

The Early Help sub-group meetings are well attended by a variety of partners.

### Early Help Strategy

The Early Help sub-group was set up in September 2019. The existing early help strategy, Early Intervention and Help 2015-25, was agreed by the group as in need of some review, in particular in relation to the role that partners play in early help.

A workshop with partners held in January 2020 identified key themes in line with Start Well and Fairer Together. A work plan to consult key partners was underway but was put on hold at the start of the

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pandemic. Work to refine the terms of reference and membership in line with the revised strategy was also put on hold.

The strategy, terms of reference and membership returned to be considered by the sub-group in April 2021. Discussion, and a presentation updating the group on the Fairer Together structure, raised questions about where the strategy redesign should rest and what the appropriate line of governance should be. Reviewing the strategy and terms of reference has not progressed yet due to a combination of factors, including continued management of the ongoing impact of Covid-19 on services, issues linked to structures, governance and accountability and capacity to lead the work. As the changes bed in together with the establishment of governance structures, refreshing the strategy and clarifying the terms of reference for the sub group are key priorities to progress during 2022.

### **Liquidlogic EHM Portal**

The rollout of the EHM portal was delayed by the COVID 19 pandemic. It has been in development for the past 18 months with the aim to develop an operational multi-agency portal system for children that is more effective for partners to access.

The work is currently in its final stages and due to be completed by May 2022. Key stakeholders including Children Services Contact Team, Early Help, the Disabled

Children's Team and the SEMH team have been engaged in testing processes. Once implemented, further work to engage with and give access to external partners, such as the NHS, schools, play and youth providers etc will take place. The portal creates a more collaborative approach to identifying and supporting children and young people early which is likely to lead to better outcomes and to avoid concerns escalating.

The role of the Early Help sub-group has been to review and give feedback on the proposed system. The project was brought back to the sub-group in July 2021 resulting in a recognition that key partners had not been sufficiently involved. This was subsequently addressed and since then the sub-group has received regular updates on progress.

### **Outcomes**

The subgroup partners are aware of the importance of understanding the impact of early help services on children and families and the importance of measuring outcomes. The activity of partners and outcomes achieved are monitored in a range of ways: through the *Supporting Families (formerly Troubled Families) outcomes framework*, self-evaluation activity and for the LB of Islington's Early Help teams through analysis of progress mapped against the *Family Star*. To improve ways of evaluating impact, the LB of Islington

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commissioned a study: Children's Data, Co-production and Use. A proposal from Oxford and Sussex Universities: Rees Centre

The Rees Centre proposed working with Early Help, Early Years and Play and Youth services to identify the key data which demonstrates the value of early intervention and prevention and its impact on children and families. Services already have a range of quantitative outcomes measures and indicators for monitoring performance but it is often not easy to demonstrate the value of early intervention.

This project seeks to engage practitioners and communities about the importance and usefulness of data to measure the effectiveness of early intervention and early help and to improve the quality of dialogue about and learning from the data used.

This approach also demonstrates the importance of capturing the voice of the community, families, children, and young people, which in turn enables LB of Islington to understand needs better and to ensure policy and services are designed to better meet those needs and have impact.

Work by the Rees Centre has been reported to the sub-group over the course of the year. Some parts of the project

have been delayed due to COVID but they are due to be completed within the next reporting cycle of the Partnership's annual report.

### *Presentations to the sub-group relating to services*

In the previous reporting year, it had become clear that the pandemic was a continuing factor and the sub-group agreed that it should focus on four priority areas while the pandemic continued and into the recovery period. These areas were:

- emotional and mental health;
- family stress and relationships;
- poverty and finances.

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

### **COVID-19 response to food insecurity in Islington**

The Islington Food Poverty Alliance (FPA) presented the outline of their work in defining food poverty, how it affects vulnerable children, and the impact COVID-19 had on experiences of food poverty for vulnerable families. Their aim was to outline the

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support available and place a strategic focus for Islington FPA with an action plan spanning from 2019 to 2022.

Their action plan was based on four key themes:

- Accurate identification of food poverty.
- Measurement of food poverty and actions to mitigate it while tackling the root causes of food poverty.
- Ensure there is adequate crisis support so that no one goes hungry
- Improving cross-service communication across Islington.

The FPA outlined the support they were able to offer ranging from emergency support, community food initiatives (hot meals, community lunches and food pantries), applying for free school meals and income maximisation support to support with benefits.

### **Social Emotional Mental Health (SEMH)**

The Social Emotional Mental Health (SEMH) service had been designed in true collaboration with a range of local stakeholders in 2019. Currently, the SEMH integration of CSCT, CAMHS and Barnados acting as a central point of access for refer-

als is making progress and a positive impact in meeting the emotional and mental health needs of young people.

As a result, it has decreased the pressure on CAMHS referrals by designing this new pathway.

There is daily triaging and allocation of referrals, and weekly SEMH intake meetings with SEMH therapeutic and emotional wellbeing providers.

Since the launch of the SEMH last year the partnership have seen lower waiting times, quicker responses regarding child mental health in light of COVID and referral data to measure impact.

Whilst the pandemic did have an impact on how SEMH was able to deliver its services, they were able to get feedback from service users to inform the required changes to meet young people's needs.

There were also monthly SEMH meetings with partners, included school, early help services to address gaps and identify solutions by sharing best practice. This resulted in an overall increase in children and young people being seen by mental health services.

SEMH were able to adapt to the impact of the lockdown and work collaboratively with other partners such as Public Health, School Improvement Service, Health and Wellbeing Team and Early Help to support

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return to school including resources for young people and families' e.g. new SEMH leaflet.

### **Perinatal Mental Health (PNMH) work within Bright Start**

This presentation showed that health visitors / early help practitioners receive consultation, advice and supervision from Psychologists from the Parent and Baby Psychology Service. This in turn would create PNMH champions.

A Needs assessment for parents with mild to moderate PNMH issues was completed in 2019 and made recommendations that formed the basis of further development of the PNMH services within Bright Start over the last two years.

The PNMH update included several responses to improved services such as:

- The Maternal Mood Assessment (MMA): The MMA template reflects a conversation with health visitors, rather than a checklist. This aims to collate qualitative information about a mother's experience of motherhood to form a better assessment. In April 84% of mothers had a MMA completed by the child was 8 weeks in comparison to previous year of 75% data
- *Emotional Well-being visits:* This recommends 6 visits that are

structured around – Listening, Wellbeing activity/ Active problem solving and Happiness Task. The expectation is that health visitors will completed the visits and MMA and they will be trained in January 2022 to do so.

The above aims to support expecting mother but also to provide early help and early identification of any vulnerabilities for impending motherhood.

### **PICT and CAMHS in Early Help Service:**

Provides support for staff in understanding mental health difficulties and best approaches. It allows practitioners to support change in parents' relationship to help and enable them to take up specific mental health support.

### **Fairer Together**

*Fairer Together* continues to deliver on their programme and have started two projects:

*Start Well* which aims to track the life of children and families across the LA using analytical tools to visualise the results (child poverty, pupil premium) within localities in the LA.

It also aims to ensure that all children start school ready to learn, that all young people grow up in households with good levels of income and all young people leaving school life have good social emotional,

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mental health in education, employment or training.

The *Youth Project* index aims to measure social and environmental progress in Islington and focuses on outcome measures for the borough's youth. The aim of these data sets are to create digital dashboards of visualising areas that highlight inter-linked trends in vulnerabilities and give a deeper knowledge of inequalities in accessing services.

## **Reducing Parental Conflict**

Healthy parental relationship training did not meet all its objectives in the last reporting period, however, will be implemented again during 2021/22. It aims to:

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

## **Education, shielding, and BAME during COVID**

A *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**

The case review sub-group oversee learning from *serious case review*<sup>8</sup>, *rapid reviews*, and *local child safeguarding practice reviews*.

### **Action Plans for legacy reviews**

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

### **Child P**

This Serious Case Review relates to a teenager who died because of serious youth violence. The review was published and outlined several, multi-agency, recommendations that has since been implemented or

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<sup>8</sup> The Multi Agency Safeguarding Partnership oversees the completion of serious case reviews commissioned by ISCBs prior to 1.09.2019.

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that are in the process of being implemented, including:

### **Joint supervision Protocol between Islington Safeguarding and Family Support and Young Islington**

This recommendation was implemented in August 2021 with the aim to enhance joint working by providing a forum for case discussion that facilitates risk assessment, information sharing, co-ordinated planning leading to better service delivery and therefore better outcomes for the young person.

In the next reporting cycle the partnership will be able to ascertain the impact of the protocol on children and young people.

### **Child Q**

This Serious Case Review relates to a child who died unexpectedly; the review has been finalised and awaits completion of parallel statutory processes before publication.

ISCP sought assurances from partner agencies that their training strategy includes awareness raising about the importance of including fathers and other male family members in assessments and ongoing work.

Early Help services have implemented more robust oversight of including fathers' views in assessments. Children Social Care

workforce development service is reviewing training content to ensure fathers are included in the assessment process.

### **Child K**

Brent Safeguarding Children Partnership (the LSCB) carried out a review of the services provided to a 16-year-old boy, Child K.

### **High Risk Moves for Children and Families: Joint Housing and Children Services protocol**

The Serious Case Reviews of Child K and Child P identified key learning for safeguarding partners when working with children involved in and at risk of serious youth violence and exploitation.

The Housing Directorate reviewed their procedures of managing requests for re-housing LBI tenants who cannot remain in their tenancies due to risks related to Serious Youth Violence and Child Criminal Exploitation.

The approach ensures that information is shared as early as possible so that housing is able to work in partnership with other professionals, to support the family, to develop a realistic joint plan that manages the risks as effectively as possible.

This approach ensure safeguarding and promoting the welfare of children by

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working collaboratively to relocate families away from high risk while also being mindful of the learning from the national review, *It was Hard to Escape*, that cautions about the value of moving families.

## Fixed Period Exclusions Flowchart

Both Child K and Child P's reviews, along with the *It was Hard to Escape* was review led to further learning and protocols being developed in relation to exclusions.

The *Fixed Period Exclusion Flowchart* is a multi-agency joined-up approach to supporting children and young people at risk of exclusion.

## Serious Incidents

There is a legal requirement<sup>9</sup> 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 (ISCP).

## Rapid Reviews

On receipt of a *serious incident* notification, the safeguarding partners should promptly undertake a *rapid review* of the case 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 serious child safeguarding incident notifications from London Borough Islington.

*Rapid Reviews* were undertaken on both occasions and Rapid Review Reports were provided to the *National child safeguarding practice review panel* (the Panel). In

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<sup>9</sup> 16C(1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017)

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one instances, 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**

The review is nearing completion and the Partnership is considering publication alongside ongoing, parallel statutory investigations.

### ***Learning events***

The ISCP has developed learning events for partners and practitioners to disseminate learning for local and national reviews.

# Conclusions and key messages

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**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 we work to address inequalities and structural racism towards the Global Majority and improve data collection of ethnic groups to improve their outcomes.
- Address the impact of inequality and structural racism on vulnerable children and to create a better understanding of data across all of Islington Safeguarding Children Partnership.
- Ensure that the priority given to all forms of exploitation by the Safeguarding Partnership is reflected in organisational plans, and that partners play their part in the work of The Partnership's sub-groups.
- Ensure that recovery planning allows for children to have the opportunity to disclose what may have happened whilst in lockdown.
- 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.

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- 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 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 Partnership 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 con-

sidered in developing and implementing key plans and strategies.

- Ensure the workforce is aware of their individual safeguarding responsibilities and that they can access LSCP 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 Partnership informed of any organisational restructures so that partners can understand the impacts on their capacity to safeguard children and young people in Islington.
- Ask questions about ethnicity, disability, gender to ensure strategic planning and that commissioning arrangements are sensitive to these issues.

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

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

- Use safeguarding courses and learning events to keep themselves up to date with lessons learnt from research and

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serious case reviews to improve their practice.

- Should familiarise themselves with the role of the ISCP and *London's Child Protection Procedures*.
- Should subscribe to the Islington Safeguarding Partnership website and visit it regularly to keep up to date at [www.islingtonscb.org.uk](http://www.islingtonscb.org.uk)
- Ensure that they are familiar with and routinely refer to The Partnership'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 Partnership and use them to make sure the voices of children and young people and front-line practitioners are heard at The Partnership.