ISCP
Islington Safeguarding Children Partnership

Islington Safeguarding Children Partnership

Annual Report 2021-2022

ISCP ANNUAL REPORT 2021-2022

Content:

ISCP ANNUAL REPORT 2021-2022

Introduction by the Independent Chair and Scrutineer

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.

As an independent scrutineer, it is my role to review the annual report for the Islington Safeguarding Children Partnership. This report highlights the commendable work carried out by the partnership, reflecting its unwavering commitment to the safety, well-being, and development of children and young people in the borough.

A key focus of the partnership has been transitional safeguarding, ensuring a smooth and coherent journey for young people as they navigate the complexities of adolescence and transition to adulthood. The collaboration between agencies has been remarkable in this area, creating a strong safety net for these vulnerable young individuals. This continues to be complex and challenging work, particularly for those children who have been experiencing abuse and exploitation. As they reach 18, the services available to them are limited. Abuse and exploitation doesn't end at 18 years of age and yet many services for adults are designed only to support those people with ongoing care and support needs. This important work needs to continue to enable the partnership to develop effective 'Transitional Safeguarding' arrangements.

The partnership has successfully prioritized the voice of children, actively involving them in decision-making processes and leveraging their insights to improve coordinated service delivery. By placing children at the heart of their work, the partnership has demonstrated its dedication to understanding and addressing their unique needs.

The Disproportionality and Inequality Task and Finish Group has carried out excellent work in tackling disparities and promoting equity across the borough. Their efforts have played a crucial role in creating a more inclusive and supportive environment for all children.

The annual report from the Missing Children and Exploitation Subgroup showcases the partnership's unyielding determination to protect children from harm and support those who have been affected by these devastating experiences. Their work is a testament to the importance of a unified approach in tackling these complex issues. Whilst I was pleased to see the routine offer of return home interviews by the Exploitation and Missing Team, it was disappointing to see that only 18% of RHI's offered were successful. RHI's can provide the partnership with a rich picture of intelligence which highlights key themes or trends and assists with activities to prevent further missing episodes. Whilst this is challenging work, I would like to see an increase in the successful completion of RHI's.

The comprehensive Section 11 reports from relevant agencies and schools within the borough demonstrate a strong culture of safeguarding, accountability, and continuous improvement, essential in maintaining a high standard of child protection.

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Introduction by the Independent Chair and Scrutineer

The partnership in Islington has displayed real vigour when it comes to learning from serious cases. The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Such reviews should seek to prevent or reduce the risk of recurrence of similar incidents. It is the responsibility of the Safeguarding Partners to identify serious safeguarding incidents at a local level and then to review them as appropriate so that improvements can be made.

This report includes the details of a number of reviews that were undertaken during this reporting period, along with highlighting how the partnership has learned lessons from high profile national reviews.

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

The partnership's safeguarding and information sharing training has received excellent feedback from delegates, highlighting its effectiveness in fostering a collaborative approach among professionals and empowering them with the knowledge and tools needed to safeguard children.

Lastly, the positive impact of the daily safeguarding meetings cannot be overstated. These meetings have facilitated excellent multi-agency working, enabling swift identification and response to emerging concerns, and fostering a truly united front in the quest to protect the children and young people of the borough.

There are many strengths to the safeguarding children arrangements across Islington. I have found a partnership that is open to scrutiny and challenge and one that strives to continually learn and improve practice.

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.

In conclusion, this annual report showcases the outstanding work carried out by the Islington Safeguarding Children Partnership in the past year. Their dedication, collaborative spirit, and unwavering commitment to child protection have yielded remarkable results, and I am confident that they will continue to make a meaningful difference in the lives of the children and young people they serve.

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.

Alan C Caton OBE
ISCP Independent Chair/Scrutineer

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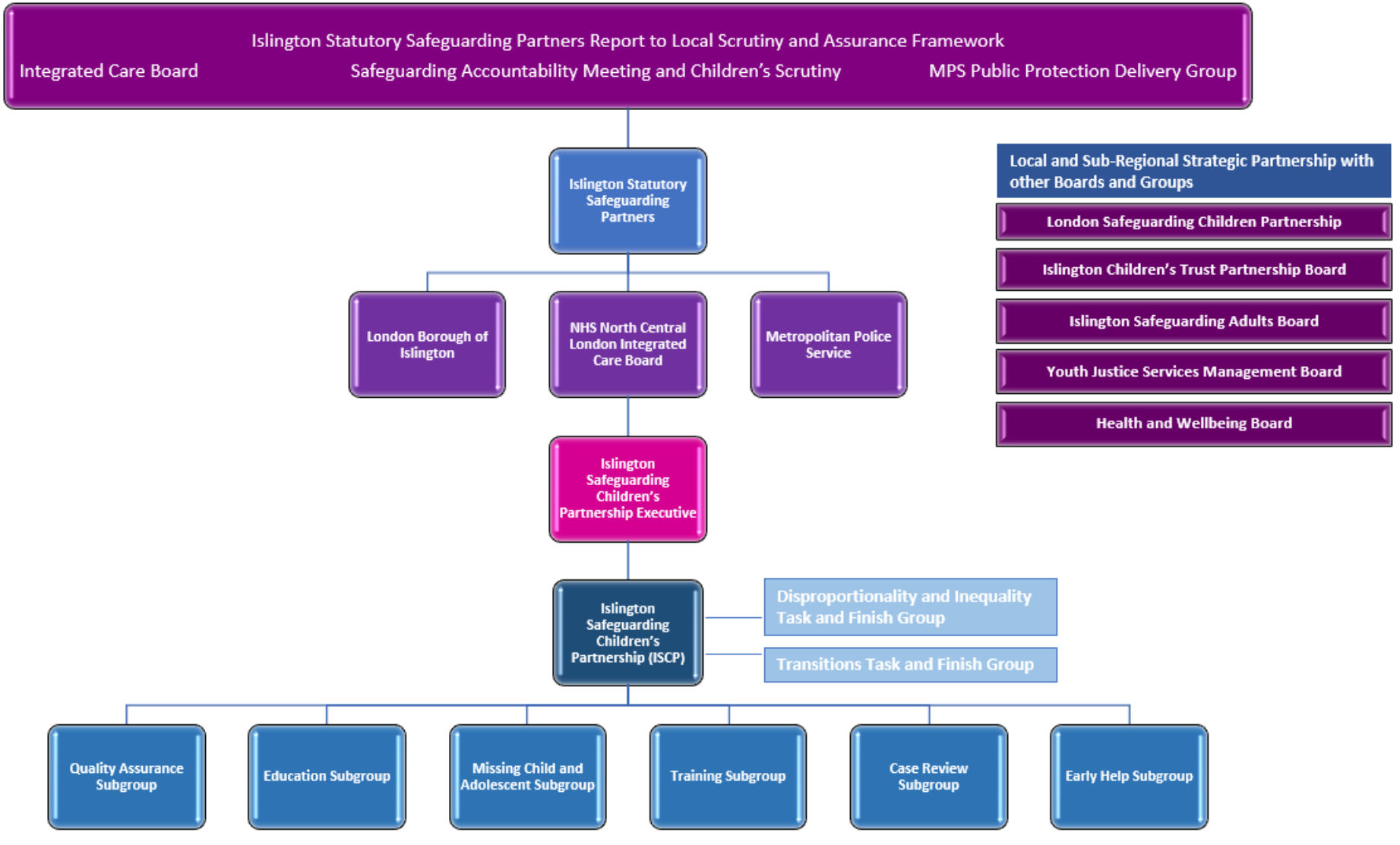
Introduction by Statutory Partners

ISCP Structure Chart



Purpose of ISCP Annual Report

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.
• ICB Governing Body.
• Child Safeguarding Practice Review Panel.
• What Works for Children Social Care.
• Children, Young People & Families.

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

REMIT OF THIS REPORT This report follows the ISCP Annual Report 2021/22 and covers the period from 1st September 2021 to 31st August 2022.

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, Corporate Parenting Board report, Update to the SEMH Review and Survey from the Health and Wellbeing Board.

PUBLICATION

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

ISCP PRIORITIES

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 develop 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.

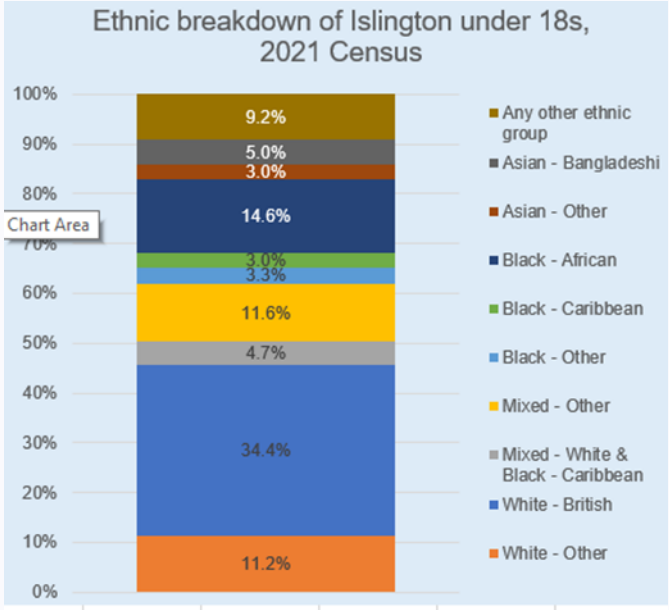
• Identify and help children who are vulnerable to sexual exploitation, criminal exploitation, and gangs.

London Borough of Islington

London Borough of Islington:

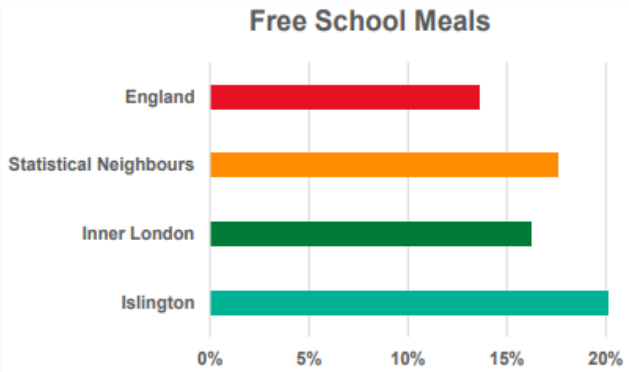
Islington is a small, densely populated inner London borough with a total population of **223,200**, which is estimated to increase by 1.2% by 2040. The borough is the second smallest in London in terms of area (after the City) and has the second highest population density.

The population age profile is on average younger than those for London and England, with 44% being young adults aged between 20 and 39 years. There are approximately **41,200 children** and young people aged 0-19 living in Islington, and around **67,600 0-25 year olds**. The proportion of children from the global majority is relatively high at **65.6%** and a significant proportion of children live in households where English is not the first language.



In terms of relative deprivation, Islington has been identified as one of the most deprived boroughs in London, with higher levels of poverty, unemployment, and inequality compared to other areas of the city. According to the latest Index of Multiple Deprivation (IMD) published by the UK government in 2019, Islington is ranked as the 16th most deprived local authority area in England, out of a total of 317 local authorities. The IMD takes into account a range of factors, including income, employment, health, education, crime, and housing, to provide a comprehensive picture of overall deprivation. While Islington is home to some affluent areas, such as Angel and Canonbury, there are also significant pockets of deprivation and inequality, particularly in parts of Holloway and Finsbury Park.

An example of the deprivation can be illustrated by the percentage of children in Islington on free school meals between **2021 to 2022 in comparison to statistical neighbours and England**:



The London Borough of Islington (LBI) has many positive aspects that contribute to its thriving and vibrant character. Some of the key positives about Islington include:

Culture and Creativity: Islington is home to a diverse range of arts and cultural institutions, including theatres, galleries, museums, and music venues. It is also known for its street art and has a thriving creative scene.

Green Spaces: Despite being a densely populated borough, Islington has many parks and green spaces, including Highbury Fields, Finsbury Park, and Gillespie Park. These spaces provide opportunities for outdoor recreation, community events, and leisure activities.

Community Spirit: Islington has a strong sense of community, with a range of local groups and organizations that bring people together for social, cultural, and civic activities. There is also a strong sense of activism in the borough, with residents actively engaged in campaigns and initiatives related to social justice, environmental sustainability, and other issues.

Diversity: Islington is a diverse borough with a rich mix of cultures, ethnicities, and nationalities. This diversity contributes to a vibrant and dynamic community, with a range of food, music, art, and other cultural offerings.

Transport: Islington has excellent transport links, with a number of tube and bus routes serving the area. This makes it easy to travel within the borough and to other parts of London, making it a convenient and accessible place to live and work.

Overall, these factors contribute to a positive and thriving community in Islington, making it an attractive place to live, work, and visit.

Effectiveness of Children Services Contact / Referral Team

Effectiveness of Islington's Children Services Contact Team

Islington received **12,199 contacts** requesting a service for children in 2021/22, a **9.4% increase** from numbers in 2020/21. The most common source of contacts was from the **police - 30%,** followed by **schools - 15.0%, Hospitals (not A&E) -7%** and **Family members/ Relative and Carer -6%**

Top 7 Contact **Reasons** in 2021/2022

Contact Reason	#	%
Domestic Violence (Physical/Emotional/Financial/Sexual)	1766	14.4%
Parenting Capacity Difficulties	1329	10.8%
Information Requests (Other Agencies)	1027	8.4%
Child Mental Health	1014	8.3%
Specific concerns regarding a sibling	781	6.4%
Physical Abuse	742	6.1%
Parental Mental Health	689	5.6%

• **4,724 (38.5%)** of contacts were progressed to receive an **early help service, 2,325 (19.0%)** received a **statutory social care service, 3997 (32.6%)** received **no further action and 1073 (8.8%)** received **information and advice.** ***NFA Audit.***

• Islington had the **22nd highest rate** of children assessed as Children in Need in the country in 2021/22.

• Compared with statistical neighbours, **Islington had a higher rate of children subject to a child protection plan** (at any point during the year): the rate for 2021-22 was 84 per 10,000 for Islington, versus 79 per 10,000 for the statistical neighbours.

• **Islington also had a higher rate of Section 47s** than the statistical neighbours: the rate per 10,000 children was 196 for Islington, compared with 177 per 10,000 children for the statistical neighbours.

• Islington had **a higher proportion of repeat child protection plans** (24%) compared to statistical neighbours (20%), auditing activity have explored this on page 13

• Overall, the length of child protection plans was slightly longer in 2021-22 than the previous year: in 2021-22 58% of plans ended within a year, compared with 64% in the previous year.

• **Islington** continues to have **more children looked after** per 10,000 than its statistical neighbours – 105 children per 10,000, compared with 69 per 10,000. This is also a noticeable rise for Islington since 2020-21, when the rate was 86 per 10,000. This is likely attributed to a larger cohort of CIN children as well as an influx of Unaccompanied and Separated Children (UASC). The **Corporate Parenting Board** demonstrates their plan to reduce this number (page 17).

• Islington's proportion of looked after children with three of more placements during a year is on a par with the proportion for the statistical neighbours, at **11%**.

Joint Area SEND Inspection in Islington

Joint area SEND inspection in Islington (Ofsted.gov.uk)

Between 8 November 2021 and 12 November 2021, Ofsted and the Care Quality Commission (CQC) conducted a joint inspection of the local area of Islington to judge the effectiveness of the area in implementing the special educational needs and/or disabilities (SEND) reforms as set out in the Children and Families Act 2014.

Inspectors spoke with children and young people with SEND, parents and carers, local authority staff and National Health Service (NHS) officers. They visited a range of providers and spoke to leaders, staff and governors about how they were implementing the SEND reforms. Inspectors looked at a range of information about the performance of the area's self-evaluation. They reviewed performance data and evidence about the local offer and joint commissioning.

Their findings demonstrate a dedicated and ambitious leadership, committed to continuing to improve services that provide the very best for children and young people with SEND.

Evidence and impact of strengths in effectiveness of local area identifying and meeting the needs of children and young people's SEND:

- Strong strategic leadership and well-established teams
- Strong and well-established joint working relationships
- Very effective use of data
- The ability to identify children's' needs in the early years are very well embedded with a strong focus on staff developing staff knowledge and expertise through the Disabled Children's Advice Team offering guidance and consultations to health practitioners. This is also evidenced in babies and young children being able to access nursery provision from 6 months of age as part of the "early opportunities scheme"
- The team of educational psychologists provides timely and effective support to schools in identifying pupils' needs and training staff.
- Robust and integrated approach to supporting children and young people with complex medical and physical needs
- Adhering to the voice of young people in the form of the Young People's Panel producing resources to help children and young people with SEND in acute health settings.
- Parents and school leaders holding specialist services in high regard.
- Education, Health and Care Plans are consistently of high quality and that partnerships with parents and young people are meaningful and effective
- Case officers know young people and their families very well
- Transition planning is strong

Joint Area SEND Inspection in Islington

Areas for development:

- Noted that some schools might not be as inclusive and are slower to identify and meet the needs of pupils who need SEND support.
- Parents noted that at time communication with school can be inconsistent.
- Children and young people wait too long for specialist Autism Spectrum Disorder and mental health interventions
- Due to recruitment issues, some direct speech and language therapy has stopped
- The proportion of fixed-term exclusions for children and young people with SEND is too high in secondary schools.
- The variety of post-16 options for those with the most complex needs is limited and there lacks a systemic and coordinated approach to this.

SEND Strategy 2022 to 2027

Purpose of this strategy is to outline the vision, aspirations, and priorities in Islington for developing support and provision for children and young people with SEND and their families for the next five years. It applies to all partner agencies in Islington who are responsible for commissioning and providing services and view this as a high priority.

- Ambition One: Fully inclusive education for all: They intend to support all schools and settings in Islington to be inclusive and welcome children and young people with SEND
- Ambition Two: Right support in the right place at the right time for parents and carers: They intend to transform parents' parents experience of the SEND system by delivering the right support in the right place at the right time
- Ambition Three: Equity and excellent education provision: They will deliver new, ambitious and innovative provision that enables children and young people with SEND to receive excellent education in their local community
- Ambition Four: All young people are well prepared for adulthood: They will enable all young people to achieve independence, build good relationships and have a meaningful occupation

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Annual Reports from Partners Agencies: LADO

Assurances of effectiveness from Partner Agencies: Safer Workforce: Local Authority Designated Officer Report

There is a statutory expectation that relevant agencies recruit staff safely, however, there are occasions where allegations are made against staff or volunteers working with children. Relevant agencies should have in place clear procedures to explain what to do when allegations are raised. The LADO should be contacted when there is an allegation that any person who works with children has:

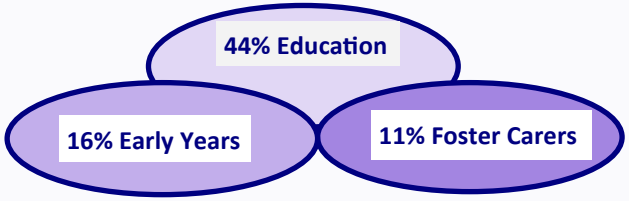
- Behaved in a way that has harmed a child, or may have harmed a child;
- Possibly committed a criminal offence against or related to a child;
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children;
- Behaved or may have behaved in a way that indicates they may not be suitable to work with children.

The ISCP have arrangements in place for monitoring and evaluating the effectiveness of arrangements to manage allegations across the partnership. The ISCP received the 2021/22 LADO Annual Report for scrutiny covering the period from 1st April 2021 to 31st March 2022 and it concerns :

230 Contacts

This is a noticeable increase from last year's 156 contacts and is the highest recorded contacts for Islington for a reporting year.

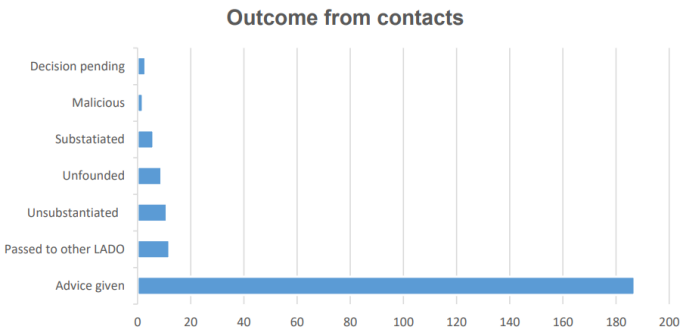
Sources of referrals:



These were the top three work setting where staff were subjected to an allegation being made against them. These figures are consistent with previous years figures and are expected given education is the biggest employer in the children's workforce.

73% of contacts were related to an allegation in the workplace (77% in 2020-21). 16% of contacts were related to an issue in member of staff's private life that raised concern about their suitability to work with children (23% in 2020-21). 11% were unrelated to concerns about harm, such as general complaints (3% in 2020/21).

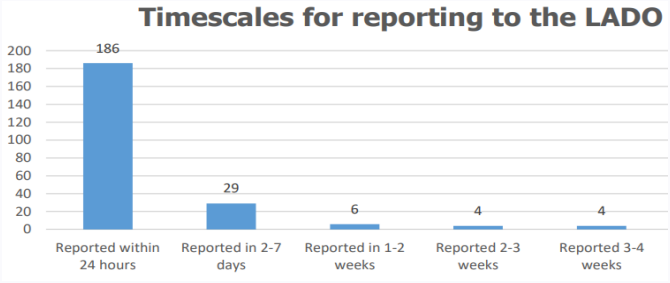
Only 6 cases out of all referrals ended up being substantiated



Nature of concern with referrals:

As in previous years, the majority of contacts related to concerns about physical abuse **123 (53%)** incidents, mainly in relation to use of physical intervention in schools. This is a stark increase from the previous year of 49 contacts, accounting for 31%, which is likely to be attributed to schools re-opening following the Covid 19 lockdowns. The second and third highest number of contacts relate to private life matters 37 (16%) and sexual abuse 34 (15%) respectively.

Partner agencies remain dedicated to managing allegations and attending ASV (Allegations against Staff/ Volunteers) meetings, even on short notice. The shift to virtual meetings during the pandemic has made it easier for agencies to convene meetings promptly, this practice will be maintained going forward.



The LADO has managed to complete actions from previous annual report such as: **1.** Reconvene the ASV steering group once a term with Police, Children's Social Care, Fostering, Early Years and Education. **2.** Transfer of the LADO data to SharePoint to allow greater stability and access to partners. **3.** Continue to host ASV meetings via MS Teams to allow easier participation of partners, with the option of face to face.

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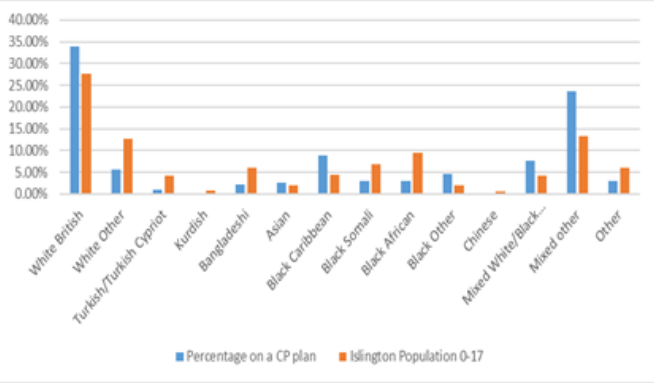
Annual Reports from Partners Agencies: Child Protection Annual Report

LBI Children Services Safeguarding and Quality Assurance Child Protection Annual Report

In 2021/2022, 172 new child protections plans were made, the lowest number of new child protection (CP) plans since 2013/14 and an 18% decrease from the previous year (209). The breakdown of category of abuse is as follows: **Emotional Abuse:** 95 (55%), **Neglect:** 48 (28%), **Physical Abuse:** 15 (9%) **& Sexual Abuse:** 14 (8%) The factors impacting parenting capacity for children subject to child protection plans include: domestic violence and abuse, adult mental health and adult substance misuse.

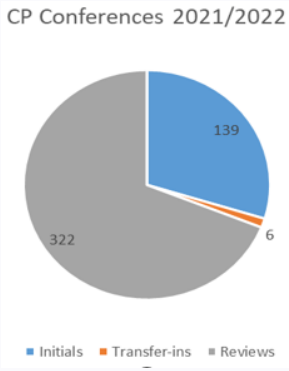
Based on the ethnicity breakdown of child protection plans we can see significant over-representation for Mixed other, Mixed White and Black, Black Caribbean and a under representation for Black African, Black Somali, White Other and Bangladeshi children.

This overrepresentation has been previously been observed by the ISCP and as a result, have set up the Disproportionality and Inequality Task and Finish Group.



In 2021/22, 23.8% of new child protection plans were repeat plans. This means that out of the 172 children made subject of a child protection plan, 41 children from 23 families became subject to a repeat plan. This is an increase from 10.5% in 2020/2021 (although as stated in the annual report for 2020/21, this was an unusually low figure for Islington).

An audit was undertaken of all the **23 repeat CP plans** (for 41 children from 23 families), looking at the time lapse between plans, risk factors and decision making. Most plans were repeated after a time gap of over two years. 13% were repeated within a two-year period – a smaller percentage to last year's 41%. Like previous years, the most common risk factor in repeat plans was domestic violence and abuse. Following the making of a repeat CP plan, 58% (24 children from 10 families) escalated to a parallel legal framework. This demonstrates that LBI CSC are able to identify themes and explore explanations by means of auditing.
To mitigate against repeat plans LBI CSC have made recommendations such as:
- To ensure the right decision is made regarding repeat plans, the CP Coordinator and Service Manager are alerted, and a consultation is sought to confirm the sustainability of positive changes for children's outcomes.
-The Practice and Outcomes Board will conduct more frequent scrutiny due to Islington's vulnerability to repeat plans.
-Ongoing learning for CP Coordinators and Team Managers will focus on the length and quality of CP plan interventions, sustainability of change, and decision-making.
391 child protection conferences were chaired by Islington Child Protection Coordinators in the period between April 2021 and March 2022 (a decrease from 467 the previous year).



Timeliness of CP Conferences:
In 2021/22, 63% of initial conferences were held within this statutory timescale, a slight decrease from 66% the previous year. This means that 39 conferences concerning 82 children were held later than 15 working days from the strategy discussion. Reasons for the delay have been demonstrated, such as: school holiday preventing quoracy or assessments not being completed on time. To mitigate this, their team have recommended that: ICPCs should be scheduled on the same day as the strategy discussion when a team manager anticipates the need for one. Practice/ team managers must receive briefings on timescales and develop strategies to improve ICPC planning for families facing chronic issues.

Recommendations made for this CP annual report:
1.Hybrid model of chairing child protection conferences to move to including all core group members physically in the room by September 2022
2.Promotion of child and family advocacy with FGC manager reviewing up coming conferences to identify opportunities for children to participate more
3.3-month trial of streamlining model of recording review child protection conferences
4.Briefing to teams around strategies to improve strategy discussion to ICPC timescales
5.Briefing to teams to reduce risk of repeat child protection plans such as ensuring there is a consult prior to convening a repeat ICPC.

Annual Reports from Partners Agencies: Whittington and CANDI

Whittington Hospital Adult and Children's Safeguarding six monthly report

March 2022 to September 2022

The report provides assurance around responding to and learning from safeguarding concerns raised from internal incidents and serious incidents; Local Child Safeguarding Practice Reviews.

- Since introducing Elev8, safeguarding training compliance has significantly improved, with Level 1 at 88%, Level 2 at 87%, and Level 3 at 81%. The Elev8 online learning platform is expected to enhance compliance recording.
- Safeguarding cases have become more complex, with increased mental health, substance misuse, and domestic abuse incidents in referrals. Notably, prebirth referrals have risen.
- Adolescent mental health remains a key safeguarding issue. Limited national specialist provision and more complex mental health issues arising at younger ages consistently challenge the safeguarding team.
- Although domestic abuse cases (presenting at health settings as this is contrary to the increase in Islington's DSM) have stabilized across boroughs, they remain the primary reason for social care referrals. More men are reporting themselves as domestic abuse victims.
- In 2021, changes to domestic abuse legislation recognized children living with domestic abuse as victims, significantly impacting safeguarding professionals.
- Under new legislation, Local Safeguarding Practice Reviews (LSPRs), formerly known as Serious Case Reviews (SCRs), currently have nine active reviews (across several boroughs). Whittington Health has a robust action plan addressing SCR learning, with most actions completed before SCR/SPR publication.
- Staff supervision compliance remains high, and ad hoc sessions for discussing complex cases are beneficial for staff.

Acknowledging the needs of the local area is in integral part of collaborative working. As such the Whittington ensures that Trauma Informed Practice (TIP) remains a key focus across practice and TIPS training has been rolled out across the workforce. Supervision models also focus on trauma and the impact this will have on behaviour and emotional wellbeing in both adults and children.

Camden and Islington (Candi) NHS Foundation Trust: Contribution to the ISCP's Priorities

They have been able to demonstrate how they have worked towards to the ISCP's priorities (page 7).

- Candi provide training to their staff discussing the impact parental mental ill health can have on a child's wellbeing. Their 'Think Family' approach towards training aims to promote a holistic risk assessment of cases to ensure that they are able to alert the appropriate professionals should any concerns arise from parental mental ill health.
- They have incorporated the Quality Improvement project that was undertaken by a Domestic Abuse Practitioner which focussed on the challenges practitioners faced pertaining to asking the right questions—allowing them to think about the bigger picture. For example asking questions specific to children being in the family home, the impact of domestic abuse on children and the confidence to conduct multi agency working with seeking advice from relevant agencies. Candi plan to extend the QI project to other teams across the Trust.

Annual Reports from Partners Agencies: Moorfields Eye Hospital

Moorfields Eye Hospital
Safeguarding Children and Young People
Annual Report

Prioritizing the protection of children and young people (CYP)(C&YP) is essential at Moorfields Eye Hospital NHS Foundation Trust, as they continuously promote safeguarding as a core practice component while focusing on the child or young person in decision-making processes and upholding the Trust's legal obligations. This summary offers an overview of C&YP safeguarding activities from April 1, 2021, to March 31, 2022.

During the reporting period, the following learning and improvement outcomes have been achieved:
• The SGC&YP team addressed 549 queries and concerns, an 8% rise from 2020-2021, with 38% open cases in children's social care and 16% from external agencies regarding known Moorfields patients.

• Children's social care referrals increased by 7%, with a potential 27% rise in new referrals had children directly presented to Moorfields. 18% of referrals were related to "Think Family / Child Behind The Adult."

• No child safeguarding serious incidents occurred; 74 incidents were reported, revealing areas for learning in information sharing with external safeguarding services.

• The team helped review 22 complaints (a 17% increase), including four involving vulnerable children, ensuring high-quality responses and adherence to safeguarding obligations.
• Nine Trust documents were reviewed and updated, considering Covid-19 recovery for staff adherence to best practice policies and processes.

• Mandatory child safeguarding training compliance met or exceeded the 80% target for Levels 1, 2, and 4. Level 3 compliance improved in January 2022, while honorary staff compliance is still being addressed.

• Systemic learning is supported through various activities, including training, meetings, briefings, SGC&YP group dissemination, supervision, and the distribution of internal resources, among other methods.

Evidence of their impact to safeguard and promote the wellbeing of children in Islington:

Key achievements during this reporting period we have:
• Continued to respond to safeguarding themes emerging during recovery from the Covid-19 global pandemic.
• Provided a safe and effective service during Team vacancies including provision to covering the Safeguarding Adults agenda during long term sickness.
• Developed a safeguarding children and young people module for the UCL Moorfields MSc Orthoptics.
• Presented three completed audits to the Islington Safeguarding Children's Partnership subgroups.
• Signed Moorfields up to the Islington Safeguarding Children Partnership Children Looked After Pledge.
• Developed a staff myth busting guide to support best practice: "Asking safeguarding questions is it dangerous?"
• Presented an overview of Moorfields approach to addressing the PREVENT Agenda to the Islington Borough PREVENT Board.

Moorfields Hospital evidencing the ISCP's priorities in the following ways:

Neglect:

Released quarterly internal Safeguarding Nuggets Newsletters in 2021-2022. • Created a staff myth-busting guide for safeguarding best practices. • Developed a safeguarding module for UCL/Moorfields MSc Orthoptics with a focus on ophthalmic medical neglect. • Enhanced the "was not brought" procedure flowchart. • Raised awareness of neglect on the safeguarding notice board, including missed appointments and leaving children home alone.

Parental factors:

• Raised awareness of the national Ask for Ani domestic violence codeword across the Trust via intranet and notice boards. • Improved the process for identifying and addressing domestic violence in patients using the Attend Anywhere platform by developing a staff guide based on the 2020 procedure flowchart.

Annual Reports from Partners Agencies: NCL Integrated Care Board

North Central London Integrated Care Board
Contributions to the ISCP Annual Report:

The NCL ICB collaborates with commissioned health providers to ensure service quality and improvements that cater to local needs. Robust safeguarding quality assurance processes are in place, demonstrating effective protection for vulnerable children and young people at risk of or experiencing neglect.

Following the passage of the Health and Care Bill in April 2022, Clinical Commissioning Groups (CCG's) were disbanded with the transfer of statutory safeguarding responsibilities into the newly established North Central London Integrated Care System (NCL ICS) on the 1st July 2022.

The NCL ICB is responsible for ensuring that it, and the services it commissions comply with statutory safeguarding obligations. During the transition from CCG to ICB, due diligence work initiated in April 2022 focuses on maintaining adherence to statutory safeguarding requirements. Over the next year, efforts will continue to develop and strengthen the ICB/ICS Health Safeguarding System Assurance.

The NCL ICB is able to demonstrate how it collaborates with partners to meet the ISCP's priorities, with examples of this highlighted below:

Addressing Neglect

The Children's Joint Commissioning Team leads the Social and Emotional Development work based on the THRIVE Framework, promoting early intervention and prevention for children and young people. They contribute to the commissioning of the IMHARS (Islington Mental Health and Resilience in Schools) program, which adopts a whole-school approach to mental health and resilience, using evidence-based methods. This work is complemented by the well-established Schools Well Being Service (NHSE/I Trailblazer program), across all primary and secondary schools in Islington. The team aims to develop a wave 9 proposal for 2023, further embedding this work and increasing capacity.

Addressing domestic violence, parental mental ill-health and substance abuse

Designated Professionals collaborated with health providers to enhance the health contribution to the ISCP dashboard, incorporating additional data on domestic abuse, substance misuse, and self-harm. This improvement will offer a more comprehensive understanding of the health system response and facilitate a better partnership comprehension of safeguarding challenges and necessary responses.

Identification of children who are vulnerable to sexual exploitation and holding perpetrators to account

In 2021, the Home Office chose 10 pilot sites for devolved decision-making regarding child victims of modern slavery through the National Referral Mechanism (NRM). The Designated Nurse Safeguarding Children ensures health representation with binding decisions, there is a requirement for health representation provided by the Designated Nurse Safeguarding Children. Throughout the pilot, health representation has been consistent, leading to robust and timely decisions for affected children and young people. By the end of March 2022, 39 cases were heard at the NRM pilot, with all but one reaching a decision within the expected 45-day timeframe.

Addressing the impact of inequality and structural racism on vulnerable children

The ICB and Designated Safeguarding Professionals play a system leadership role in addressing disproportionality and inequality affecting ethnic groups within health and multi-agency partnerships. The Designated Nurse for Safeguarding Children will co-lead the data workstream of the Disproportionality Task and Finish group, helping to better understand the effectiveness and impact of safeguarding and related systems in addressing this priority.

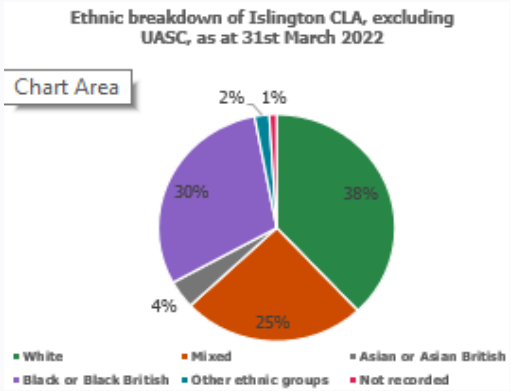
Annual Reports from Partners Agencies: Corporate Parenting Report

Corporate Parenting Board Annual Report

The Corporate Parenting Board (CPD) annual report provides an overview of the achievements, progress and challenges regarding Islington's Children Looked after (CLA), and Care Experienced Young People (CEYP) from 1 April 2020 to 31 March 2022.

As mentioned on page 9, LBI has more children looked after than its statistical neighbours. It is evident that LBI acknowledges so as a result conducted an audit to look at care proceedings to ascertain whether the proportionate decision was taken see page 49. It is likely that the high rates of children looked after, correlates with higher rates of children in CIN and CP.

The CPB annual report also highlights the disproportionality in the global majority being overrepresented which is a theme consistent with previous year.



The report also highlights positives such the CPB's priorities for CYP and the positive impact they are able to evidence. For example , their priority to:

Challenge inequalities by developing life long corporate parenting duties across and beyond the Council

- They offer lifelong corporate parenting, where a task and finish group chaired by Chief Executive to develop and implement this vision.

Plans to prepare CYP for targeted work experience

Impact: Several council departments, including Environment, Public Health, and Community Wealth Building, provide work experience, shadowing opportunities, and employment support advice to young people. One young person was employed full-time after completing work experience with the council's Finance department.

- Islington's protocol for the unnecessary criminalisation of CLA and care-experienced young people formalising Islington's Trauma Informed Practice across ISCP and YJSMB.

Impact: Remand to custody dropped from 28 in 2017/18 to 12 in 2021/22. The reoffending rate for CLA is on par with peers at 33% in 2021/22.

Ensure our children and young people are in safe and stable homes

THE HOUSE PROJECT Islington

Impact: The House Project helps 24 young people annually to transition towards independence. Out of the 67 young people who have participated since August 2018, 36 have moved into their own homes and 9 are in the process of doing so, indicating the program's success. The majority of these individuals are managing their tenancies well, and there have been no reported breakdowns.

Children and young people receive excellent support for their health and wellbeing

- CAMHS service embedded within the CLA, Fostering and IF teams

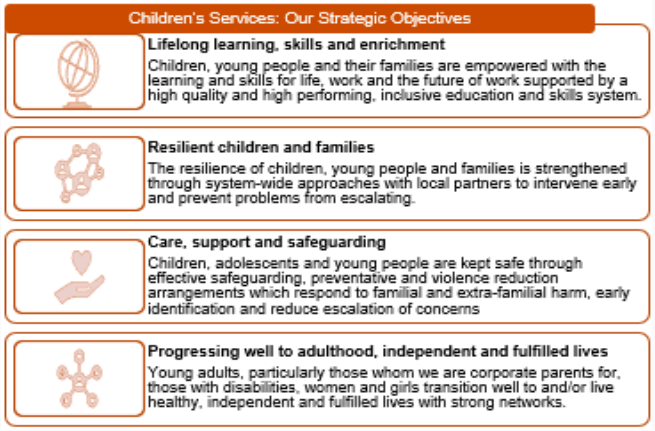
Impact: 115 clients seen by CAMHS with 94% attendance

Ensure children and young people's views and experiences influence how we plan and deliver our services and that our young people receive help in a way that they feel listened to, loved and is accessible to them

- The Children's Active Involvement Service (CAIS) consults with young people, provides activities, and conducts training for foster carers. They also play a key role in staff recruitment. CAIS attends the Corporate Parenting Board and strongly advocates for the views of children and young people.

Impact: Last year, CAIS participated in 46 projects. They developed an app for young people in response to requests from care-experienced individuals.

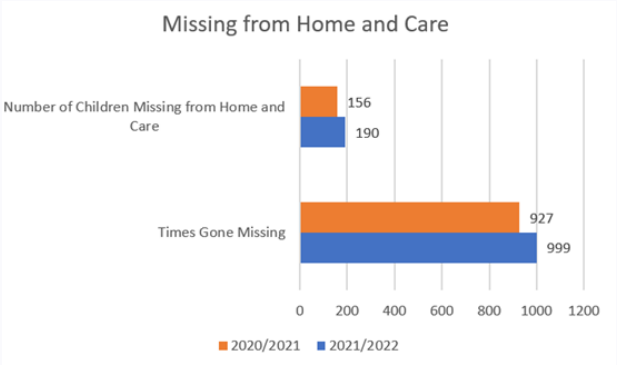
Young commissioners are shaping future plans for regulating providers.



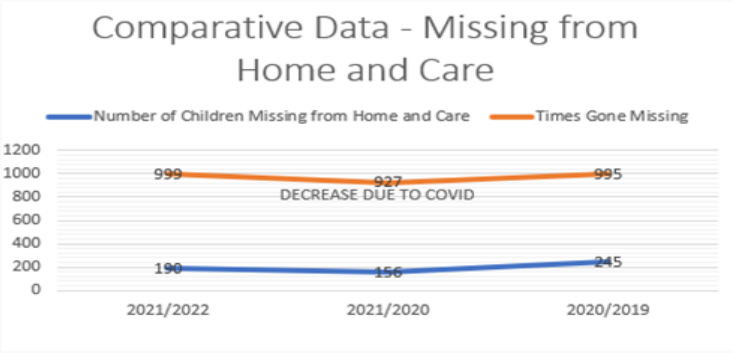
ISCP ANNUAL REPORT 2021-2022

MCAE Annual Report Breakdown - Missing from Care, Home and Education

Missing from home:



103 children went missing from home 257 times. 10% of children accounted for 49% of total missing from home episodes (126). 54% of the episodes the child returned within 24 hrs and 24% returned the following day. Last year: 74 children went missing from home 151 times. In total 54% of the missing episodes from home involved young people returning in less than 24 hours and 24% of episodes related to young people returning the following day.



Of the 10 young people who went missing most frequently, all were considered at risk of exploitation or serious youth violence at some point during the year. The majority (7 out of 10) were boys, while all 3 girls were at risk of sexual exploitation. Notably, 7 out of these 10 most frequently missing children were looked after, indicating that exploitation risks may persist even after a child enters care.

Missing from care:

91 children went missing from care 648 times. 11% of children accounted for 46% of the total of missing from care episodes (304)
53% of the episodes the child returned within 24 hrs and 24% of children returned the following day. Last year: 86 children went missing from care 649 times.
33% of the young people who have gone missing from care are Black. This correlates with an exact match to the ethnicity break down of young people who are looked after by the London Borough of Islington, meaning there is not an over-representation of Black children Looked After going missing. In total 77% of the missing episodes involved young people returning the next day or earlier, an increase of 2% from last year and 5% on 2019-20

There has been a 50% increase in the number of White British young people who have gone missing from care last year and they have gone missing 118% more times. Which means that children with white ethnicity have also increased significantly as a proportion of all children in care who have gone missing.

Return Home Interviews (RHI's)

The Return Home Interview (RHI) process is provided by the Exploitation and missing team, this includes a specialist missing and engagement worker and the four ASIP workers who also carry out RHI's alongside their other duties.

Between April 2021 and March 2022, there were 999 missing episodes and 719 Return Home Interviews were offered. Engaging children and young people in meaningful RHI's remains a challenge, either because the child refuses or it is not possible to contact the young person (phone calls and texts going unanswered after several attempts).

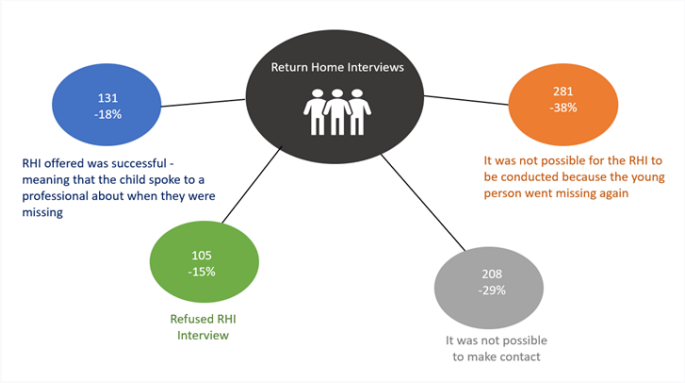
72% RHI were offered for the 999 missing episodes

18% (131) RHI's were successful, meaning the child spoke to a professional about when they were missing and 15% (105) refused the interview.

29% (208), it was not possible to make contact with the child for the interview to go ahead after several attempts

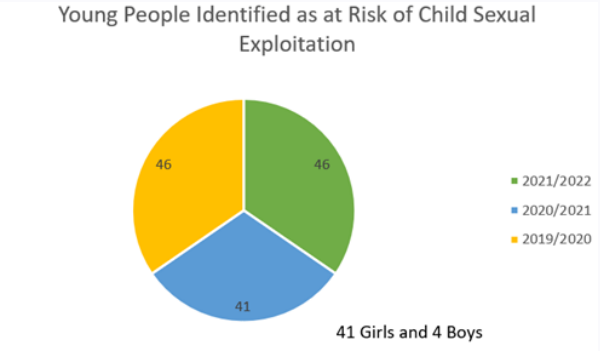
MCAE Annual Report Breakdown - Return Home Interviews RHIs and Child Sexual Exploitation

Impact:



One area that has also emerged as very beneficial is if a child goes missing but isn't open to any service the Engagement worker offers the parent some sessions regarding their potential concerns or possible mild escalation of difficult behaviour at home. This work means the parent either receives the support and some tools to manage the issues themselves or the Engagement worker can recommend appropriate early help support.

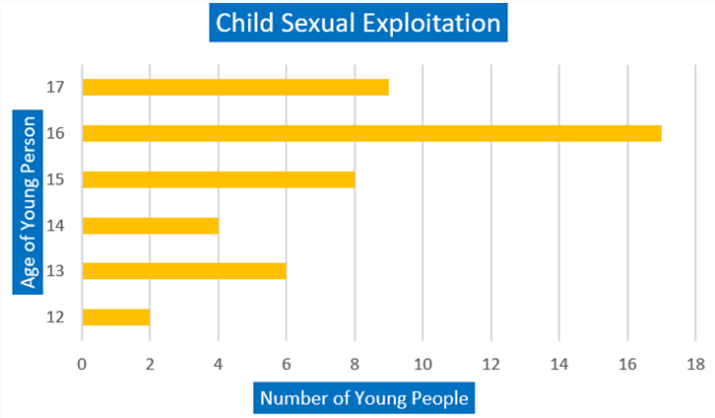
Child Sexual Exploitation



The slight decrease in numbers last year was likely due to the lockdown, and less children being out of the home. Although we are aware that children are often groomed online, but again due to children and parents having less contact with professionals during this time, incidents of online grooming and child sexual exploitation may have been under-reported.

This year, 50% of children identified as being at risk of Child Sexual Exploitation (CSE) were white, while 23% were Black. The number of Asian children identified as being at risk remains consistently low, and it is unclear whether this is because sexual exploitation is not happening within Asian communities or because it is going undetected. It is important to note that while white young females make up the majority of children identified as being at risk, this does not mean that young people of other ethnicities are not also at risk.

There is a noted theme that girls of a younger age are coming to the attention of Police and LBI Children Services for concerns around child sexual exploitation and are going missing more frequently. Young people being groomed and exploited via the internet has remained a significant issue and the way children and young people are exploited online is always evolving. It is an ongoing challenge to safety plan against adolescents need to seek out sexual contact, respond to attention and express their sexuality. This has brought up concerns regarding Online Safety and as a result ISCP have sought more voices of children and families regarding this theme and have also devised a plan to implement more Online Safety sessions for parents and school staff.

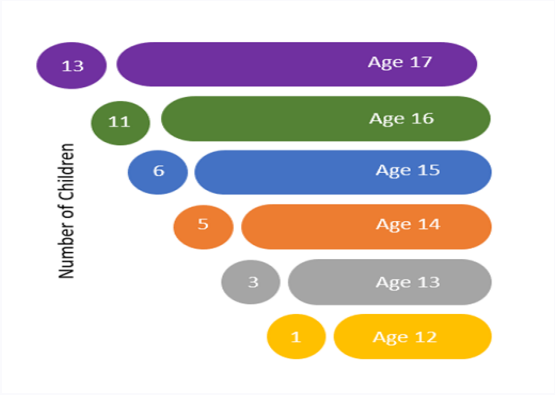


MCAE Annual Report Breakdown - Child Criminal Exploitation, Borough Briefings & MACE

Child Criminal Exploitation:

Between April 2021 and March 2022 51 young people, under the age of 18, were identified as being at risk of Child Criminal Exploitation this is a small decrease on the year before when the number was 55, 11 out of those 51 were female. In 2020/2021 the number was 5 and in 2019/20 there was 1 female identified as at risk of CCE, therefore the significant increase We are seeing more females coming to police attention for criminal activity.

Older children may be stopped and searched by police more and therefore more likely to be found in possession of drugs, indicating they are being exploited to deal or run county lines. The selected month's data shows similar percentages of White and Black young people at risk of CCE, unlike the previous two years which consistently showed overrepresentation of Black males. The data was verified over different time periods and indicates a decline in the numbers of identified Black young people at risk of CCE over the last six months, with a slight increase in mixed heritage young people. The data suggests that the action plans and interventions
put in place by CSC and Young Islington may have contributed to this decline.



Borough Briefings:

An action stemming from the Missing and Child & Adolescent sub-group was to find a way to disseminate pertinent information (informed by Police, CSE team, Gangs Analyst, Integrated Gangs Team, Community Safety Team and YJS) to our partners to raise awareness of activities that occurs throughout the borough that supports the identification of potential and current risks relating to child exploitation. In January 2022 the Exploitation and Missing Team commenced Borough Briefings. The briefings are attended by partners from across the borough who may come into contact with children who are at risk of exploitation, but do not attend MACE or other forums where relevant information can be shared with them, for e.g. General Practitioners, or Youth Workers.

Impact

The briefings have been well attended by partner agencies and the feedback has been positive and therefore they will be continued. Some agencies have reported that it gives them scope on what is happening in the borough so they are able to inform their staff of recent incidents to ensure they are able to keep children safe and promote their welfare. Going forward it would be beneficial to reach out to partners for a more formal evaluation of the briefings to assess any changes needed to the format or content that may be required.

Multi Agency Child Exploitation (MACE):

Established robust process around involving other local authorities in the Pre-MACE/MACE Discussion

Several of the young people who are considered at risk of Exploitation are placed outside of the borough. The Exploitation and Missing team will be in communication with the local exploitation police for the young person and request intel and updates for Pre-MACE. However, over this year it has been discussed that a more formal process around sharing information between different Pre-MACE and MACE panels across the country needs to be established. This is also to make sure that other key agencies such as Health services in different locations are also aware of the exploitation concerns.

Impact:

This piece of work is ongoing, we have strengthened our partnerships with our neighbours such as Camden and Lambeth where and there has been reciprocal information sharing. Over next year The Exploitation and Missing Safeguarding Manager will reach out to their equivalents in other London Boroughs to discuss how more formal information sharing process can be put in place. The London Child Protection Procedures will also be updated shortly to include working with Children Moving Across Boundaries/Boroughs.

MCAE Annual Report Breakdown - ASIP

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.

Between September 2021 to August 2022 ASIP had received a total of 25 referrals, of which 13 received ASIP intervention. Some Interventions have included providing respite trips out of London for families; one to one parenting support; support during times of crisis; home improvements; activities to manage trauma which manifests in aggression; daily support to attend school; reflective spaces for professional networks; formulation workshops with schools; creating bespoke work experience opportunities. ASIP practitioners will also attend strategy meetings to provide input and expertise around contextual risks to the network. ASIP is a trauma informed service, and consists of four Case Managers, a CAMHS Psychologist and a Contextual Safeguarding & Education Lead and the Practice Manager.

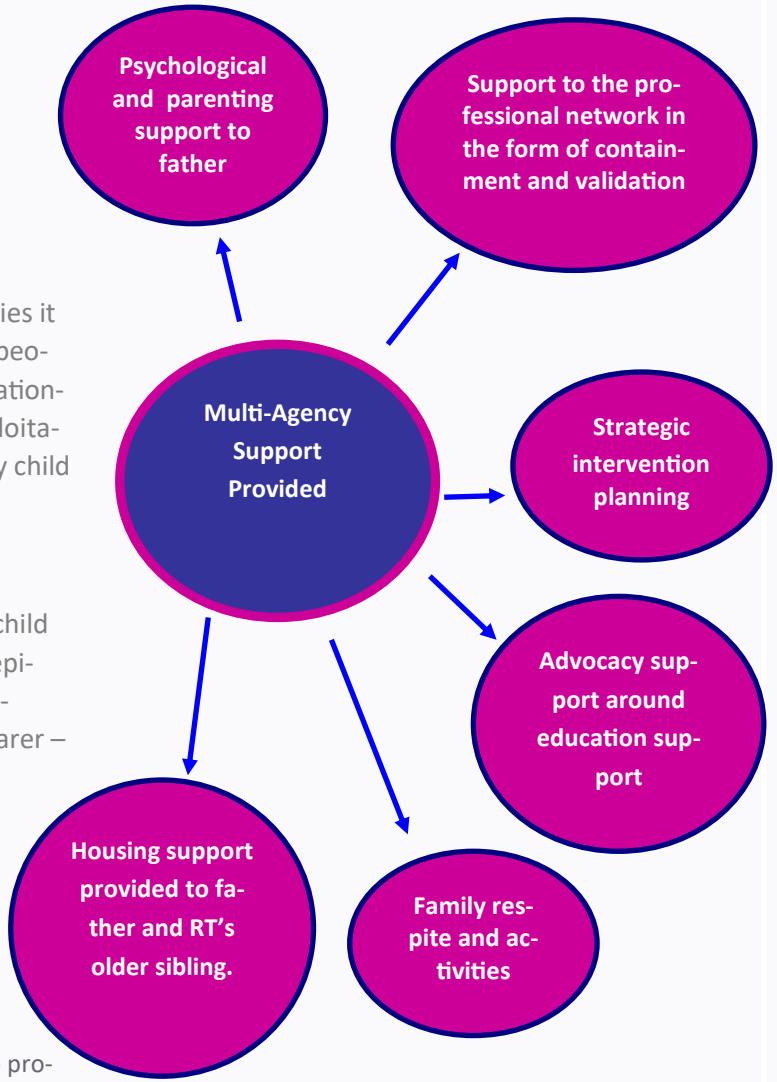
Given the intense service that ASIP provides families it has demonstrated impact on children and young peoples' lives through its intervention. Given its operational role functions and serves children at risk of exploitation it is able to function as an add-on to statutory child in need or child protection intervention.

Evidence of impact on multi-agency working

Child RT was referred to ASIP due to concerns of child sexual and criminal exploitation, regular missing episodes, low school attendance, low emotional well-being and relationship breakdown with primary carer – father.

ASIP Impact continued:

Reduced from Child Protection to Child in Need plan - RT stayed in the family home – Noted improvement in relationship between RT and father – Father had increased ability to mentalise RT's lived experiences. The intervention demonstrated effective partnership working with other relevant agencies and the family to produce a desired outcome.



MCAE Annual Report Breakdown - Serious Youth Violence (SYV) and Harmful Sexual Behaviour

Serious Youth Violence (SYV):

From April 2021– March 2022 39 children have been identified as being at risk of SYV and 47 individuals over the age of 18. It is important to note these are the ages of the young people in March 2022 so when they were identified as at risk of SYV some of those 47 young adults may have been under 18. Out of the 86 young people identified as being at risk of being affected by SYV 1 was female.

Collaborating with IGT and Gangs police, proactive peer mapping remains a challenge due to a younger cohort of mobile children and youth moving between groups and areas. The partnership with Community Safety team has been strengthened, and Community Safety Officers now provide valuable intelligence about gang locations at Pre-MACE and MACE meetings which demonstrates multi-agency working

Evidence of impact is an example of A space underneath a block of flats potentially used by gangs was reported with evidence of drug use and sexual activity. Community Safety collaborated with Parkguard to increase patrols and obtain details of young people stopped for mapping exercises and interventions. The space was closed and is no longer accessible to young people.

Harmful Sexual Behaviour:

Over the last year, 46 HSB consultations were held which is a reduction from the previous year. When the Exploitation and Missing team was created the aim of the HSB branch was to explore child on child sexual abuse and the culture of abuse within gang settings. This remit has expanded and showed a need and gap in the service for support around all types of sexualised behaviour.

Evidence of impact:

The Protocol for Schools for Managing Child-On-Child Sexual Abuse, Violence and Harassment was completed in November 2021. As a result, the Principal Officer Safeguarding in Education along with the ISCP and Health and Well-Being Board organised the delivery of Child on Child Sexual abuse workshops for school to ensure that the protocol is embedded into their policies and practice and they are complying with Ofsted recommendations. This has had positive feedback from schools especially when it relates to real case examples.

MCAE

Analysing and addressing the overrepresentation of Black teenage boys identified as at risk of being involved in serious youth violence.

Further analysis is needed regarding the over representation of black teenage boys at risk of being affected by serious youth violence within Islington. This work will need to be completed in conjunction with the Youth Offending Service and Young Islington Teams with an aim of looking at how young people are identified to services, as well as how and when they are offered intervention and support.

The multi-agency approach to address the over representation needs to be agreed and actioned by the Missing and Child & Adolescent Exploitation Subgroup.

Update:

The Exploitation and Missing Team continue to work with YJS, IGT, TYS and Community Safety Teams to address the over-representation. We continue to ensure that we are sharing information with key agencies via strategy meetings, daily tasking meetings with IGT, and attendance at Islington Group Offending Partnership Panel state in full to ensure we are intervening appropriately. As mentioned earlier in this report there are projects being piloted within the borough which aims to intervene with young black males before they experience or become involved in serous youth violence. The Missing and Child & Adolescent Exploitation Subgroup will also agree what more actions they can take to address this concern.

Contextual Safeguarding:

Contextual Safeguarding will continue to be a priority of The Missing and Child & Adolescent Exploitation Subgroup in 2022/2023, over the last year they have strengthened the partnership work with the Community Safety Team, and they now attend MACE and Pre-MACE and highlight spaces in the borough that require intervention and will provide support and action. For example, several complaints were made about a particular walkway in one of the borough's estates, the Community Safety Service was able to arrange to block one of the entrances so it could no longer be used as a cut through, they stepped up the patrols by Parkguard and sent pictures of the young people to the Exploitation Team and IGT to see if we recognised any of the children to provide support and intervention to them.

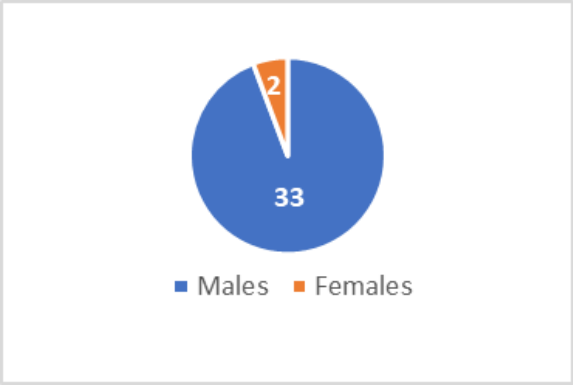
An action plan and proposal for the implementation of a Contextual Safeguarding policy will be presented to the Subgroup in October 2022 with the aim of rolling out the recommended changes in April 2023. It is acknowledged that the existing teams across the borough have good systems of communication in place for responding to incidents, sharing intelligence and exploring contextual risk/harm and not just focussing on individual cases separately. However, the next step forward is implementing how to formalise, record and measure the impact of this work.

National Referral Mechanism

National Referral Mechanism

LBI CSC and London Borough of Camden CSC have undertaken a pilot programme with the Home Office's National Referral Mechanism (NRM). The NRM is a government-led process for identifying and supporting victims of modern slavery and human trafficking in the UK. The NRM provides a framework for the identification of potential victims and ensures they receive appropriate care and support.

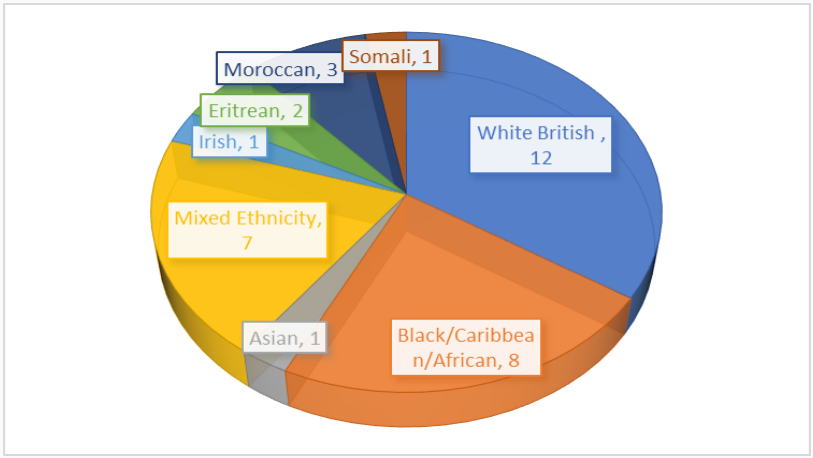
LBI CSC made 23 referrals and LBC CSC made 12 referrals to the pilot panel (35). The demographics of the referrals received thus far are between the ages of 12 and 17.



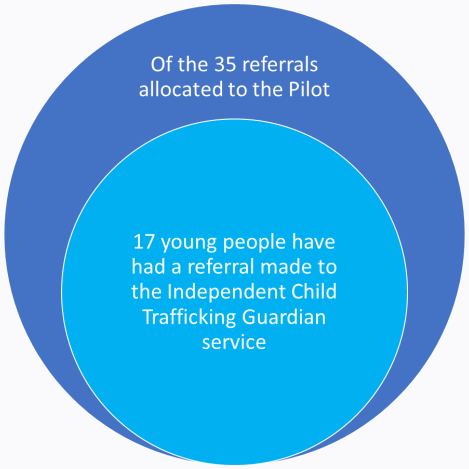
Of the 35 referrals, there have been 20 Positive Reasonable Grounds and Conclusive Grounds decisions made at the first meeting where the cases were heard. 13 referrals were deferred to the following panel meeting where a Positive Reasonable Grounds decision was made at the first meeting and at the second meeting Positive Conclusive Grounds decisions were made.

The remaining cases the first responder/social worker have been asked to make a referral immediately.

The ethnicities of the young people have been recorded as follows:



It has been agreed that, as 5 of the cases raised concerns about exploitation that took place in another country and no concerns around exploitation in the UK were raised, these 5 cases did not require a referral to the Independent Child Trafficking Guarding service.



Impact:

The positive results has enabled the LBI CSC to prevent further harm to vulnerable children by removing them from situations of exploitation, with a plan to provide them with a safer environment. It also supports their recovery and rehabilitation, helping them to overcome the trauma and effects of exploitation and empowering them to move forward with their lives.

Missing from Education : Elective Home Education

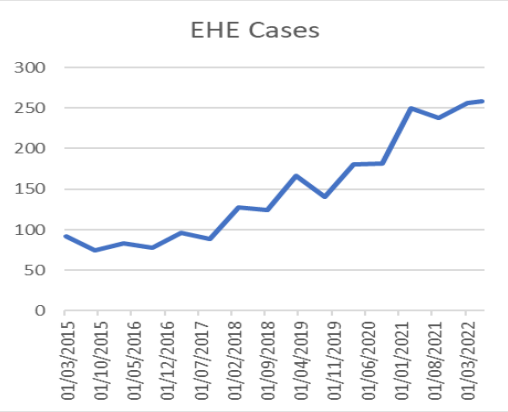
Elective Home Education (EHE)

The access and engagement Team with Pupil Services for the LBI has presented to the ISCP Education subgroup. They reported that there were 250 EHE children since the pandemic (75% increase). As a result of the Covid 19 pandemic their team were not able to visit children in their home, therefore much of the visits relating to 2021 were virtual visits.

EHE Advisor Visits (Including Virtual)	
Calendar Year of Visit	Total
2018	77
2019	116
2020	153
2021	205
2022 (to date)	74

The access and engagement team writes comprehensive reports based on their visit with families who home educate their children. However, there has been a rise in parents wanting their children to return to school as Covid restrictions have lessened.

Sample Date	# of EHE Cases
05/03/2015	92
05/09/2015	75
05/03/2016	83
05/09/2016	78
05/03/2017	96
05/09/2017	89
05/03/2018	128
05/09/2018	124
05/03/2019	167
05/09/2019	141
05/03/2020	180
05/09/2020	182
05/03/2021	250
05/09/2021	238
05/03/2022	256
07/06/2022	258



Although there are currently no specific statutory duties placed on the LBI in relation to this group, the potential safeguarding risks present a moral imperative. Pupil Services' overarching commitment to ensure that every child can be the best they can be, also places a responsibility on them to ensure, as far as the current framework allows, that each child has an at least 'satisfactory' offer. This is an area of work that is always picked up during Ofsted inspection (and mentioned explicitly in the Local Area SEND Inspection framework) and they report regularly to the Islington Safeguarding Children Partnership (ISCP).

In the year 2020, majority of parents reported Covid 19 was there reason for EHE. Furthermore in 2021, this trend continued, however, we believe this may have included parents having a positive experience of home educating during the pandemic and wishing to continue. More recently we have seen a shift back to parents choosing to home educate due to their own cultural or philosophical reason.

Impact

Given the increase in EHE pupils overtime, Pupil Services reported to looking into securing funding to resource staff to visit and advise families who are electively home educating. One of their aims involves targeting new EHE families more quickly to explain the responsibilities they will be taking on and try to resolve any schooling issues, so that the number of EHE reduces over time to numbers closer to pre-epidemic levels.

New Incoming Legislation:

The Schools Bill, published on 12 May 2022, will introduce new legislation establishing an LA administered registration system for children not in school i.e., children not registered at a relevant school (e.g., due to being electively home educated),

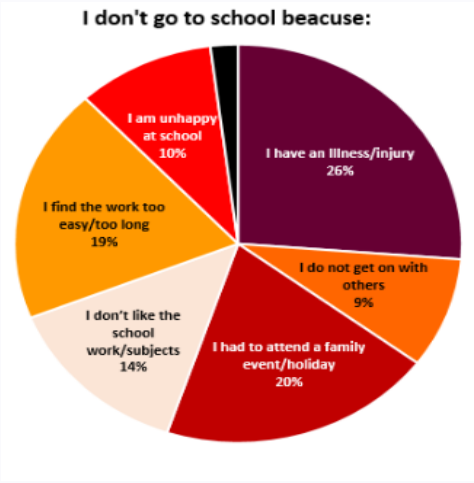
Working Together to Improve School Attendance

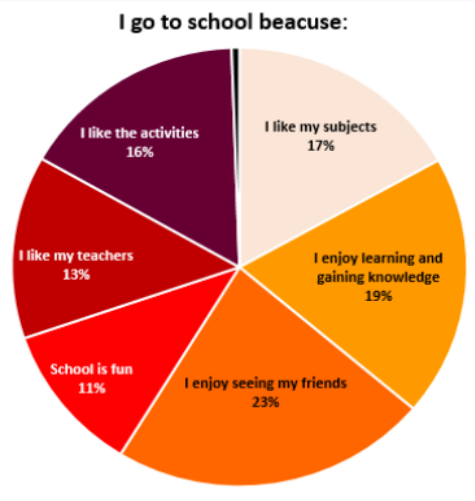
New guidance Working together to improve attendance was published in **April 2022** – will be statutory by **September 2023.** They set out expectations of schools and governors, all local authorities as a minimum are expected to:

-Rigorously track local attendance data to devise a strategic approach to attendance that prioritises the pupils, pupil cohorts and schools on which to provide support and focus its efforts on to unblock area wide barriers to attendance.

-Have a School Attendance Support Team that offers free services to all schools, including regular communication and advice, targeted support meetings using attendance data, multi-disciplinary family support, and legal intervention when necessary. These services aim to enhance attendance and address absenteeism issues by sharing best practices, identifying at-risk pupils, providing whole-family support, and enforcing parental responsibility measures when needed.

Acknowledging the impending changes the London Borough of Islington's Pupil Services conducted a survey on the voice of children in Islington to gain their views regarding attending school. interviewed their response is as follows:

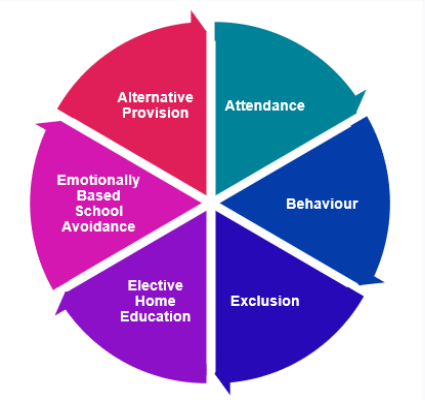




Effective preparation based on New Legislation

The London Borough of Islington's Pupil Services have acknowledged that the Legislation does give local authorities time to make the necessary transitions to meet these expectations and ensure that a School Attendance Support Team is built to meet the expectations. They have acknowledged that whilst there is a lot of room for improvement in this area they may consider that their local specification should stretch beyond these minimum standards, this is also in context of constraints on resources.

The Local Authority is aware of the implications if students do not feel like they belong for the reasons listed below. It is positive to see that the LBI has gained the voice of children to gain a sense of their lived experienced and relationship towards school. Below they have outlined what can happen when children do not feel they belong.



Extending the role of the Virtual School Head

The non-statutory guidance from the Department for Education aims to assist local authorities and Virtual School Heads (VSHs) in:

- Enhancing their strategic leadership role in promoting the educational outcomes of children aged 0-18 with a social worker or those who previously had a social worker.
- Make visible the disadvantages that children with a social worker can experience, enhancing partnerships between education settings and local authorities to help all agencies hold high aspirations for these children.
- Promote practice that supports children's engagement in education, recognising that attending an education setting can be an important factor in helping to keep children safe from harm.
- Level up children's outcomes and narrow the attainment gap so every child can reach their potential. This will include helping to make sure that children with a social worker benefit from support to recover from the impact of COVID-19.

Transitional Safeguarding

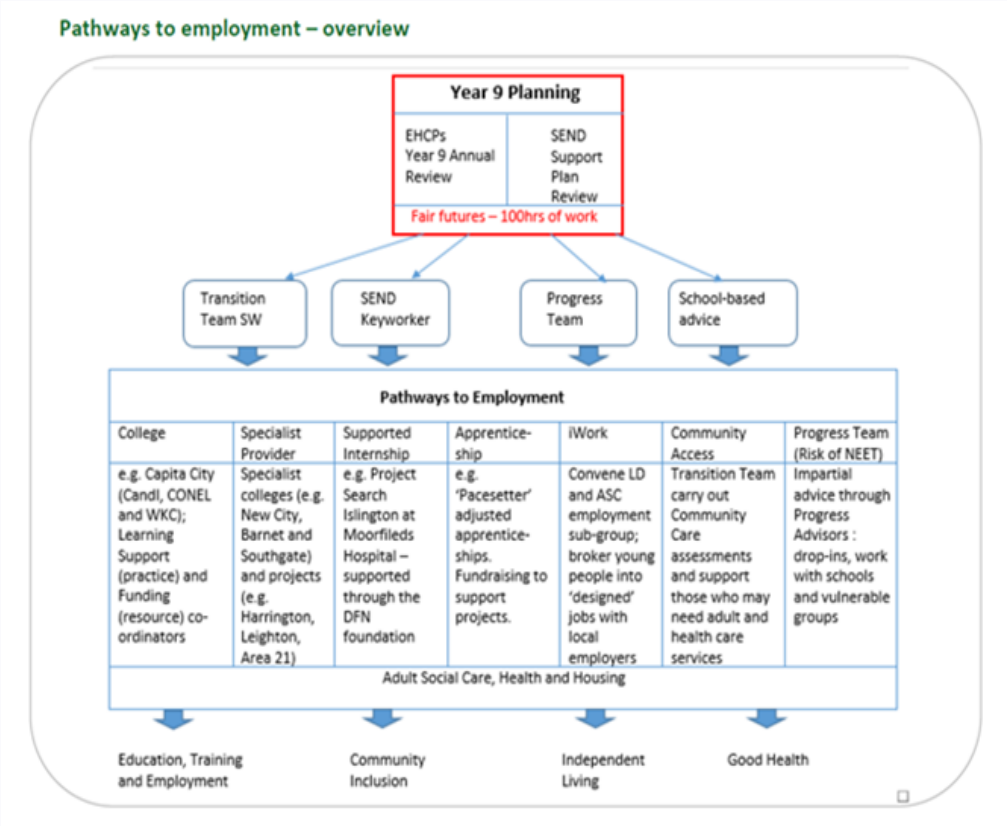
Transitional Safeguarding

The Bridging the gap report co-produced with the Chief Social Worker for Adults, Research in Practice et al (June 2021) defines the concept of Transitional Safeguarding as an approach to safeguarding adolescents and young adults that is adaptable across various developmental stages. It is informed by the most up-to-date evidence and draws from both children's and adult safeguarding practices. Its goal is to equip young people with the necessary skills and knowledge to navigate their transition into adulthood successfully. Transitional Safeguarding recognizes that the transition is an ongoing process rather than a one-time event, and that every young person experiences this journey differently.

The ISCP in conjunction with the Islington Safeguarding Adults Board (ISAB) sought to explore the multi-agency transitional safeguarding arrangements within Islington. A task and finish group was created to bring relevant agencies to ascertain whether there were any gaps within service provisions. It was also born out of a Serious Adult Review conducted by ISAB involving DD, a young woman had a complicated medical and vulnerable background who according to the Coroner passed away due to mismanagement of her diabetes medication (Islington SAB - Safeguarding Adults Review: DD).

Transition can be a difficult period for young adults. DD was known to children's services, but after becoming an adult, some services stopped while others passed her case on to adult services. DD was accustomed to and trusted certain children's services and found it challenging to adjust without the same level of support after transitioning to adult services.

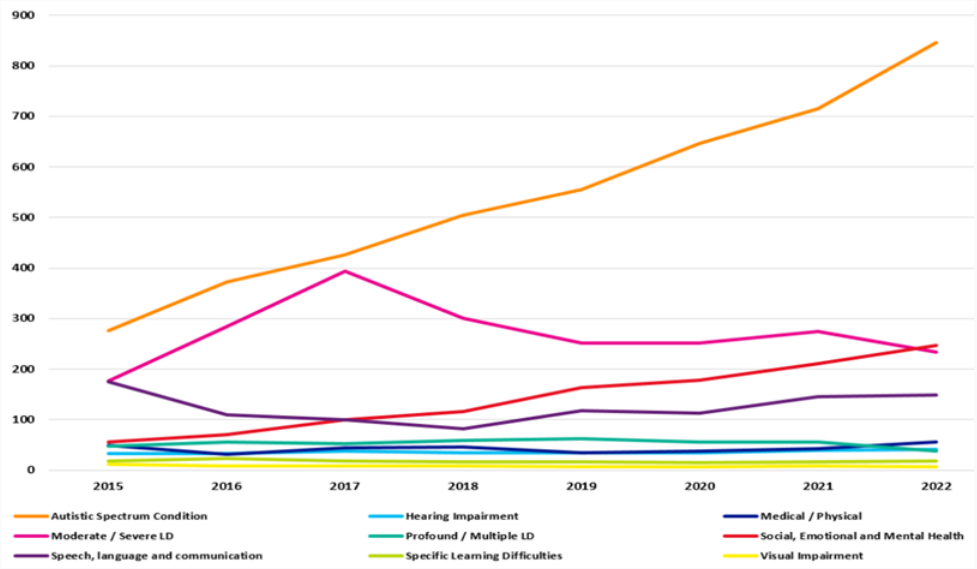
The SEND inspection by Ofsted, as mentioned earlier, highlighted the transitions planning is very strong. And the task and finish group demonstrated that there were several pathways available for vulnerable young persons to transition as evidenced by Islington's Multi Agency Progression to Adulthood Protocol (2019).



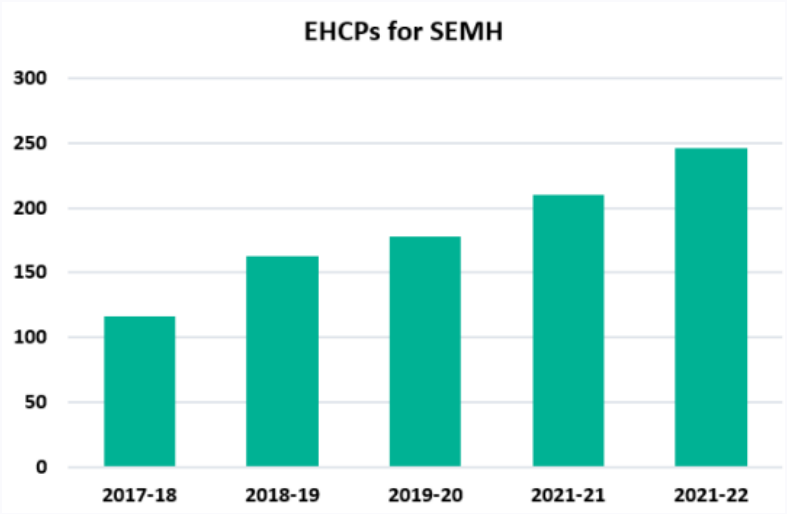
Transitional Safeguarding

Projections by SEND

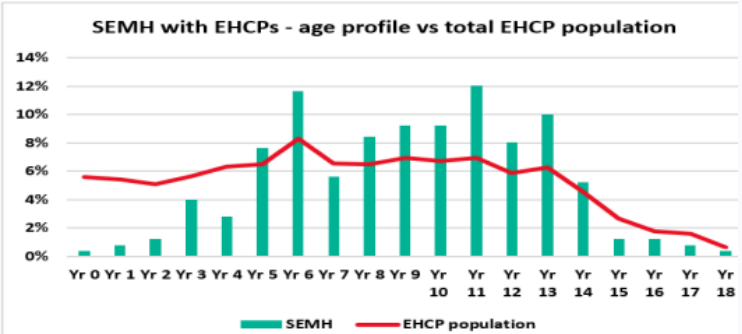
Whilst there is strong planning towards vulnerable children/young person's transitioning into adulthood, the SEND Projections report devised by Pupil Services envisions that the scope for vulnerabilities are likely to increase given the stark increase of EHCPs due to SEMH as well as diagnoses of Autism Spectrum Disorder.



These projections (specifically ASD and SEMH) highlight that there is likely to be a significant impact on how these vulnerable children transition into adulthood and may correlate with safeguarding concerns in adolescence, that may create unmet needs in Adult Services due to less services being available when an adult. ISCP will continue progress the Transitional Safeguarding task and finish group to gain assurances that the impact on vulnerable adolescents are mitigated.



The number of Islington children with EHCPs with SEMH as their main area of need has increased by 112% over the last five years and the age profile of those with SEMH as their main area of need does not follow the same local or national pattern as for all EHCPs, this is demonstrated in ages 6 and 8 to 14 years old where there is a disproportionate higher number of EHCP compared to national figures. As mentioned in the previous paragraph this may give partner agencies an opportunity to plan for services due to possible capacity concerns in SEMH services. This may also create reflections or explorations for the process of how EHCPs are assessed or carried out for SEMH concerns.



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North Central London Children and Young People's Mental Health and Wellbeing Transformation Plan

The purpose of their transformation plan is to improve the support for children and young people with emotional wellbeing and/or mental health concerns is a key priority for North Central London's NHS and Local Authorities (Barnet, Camden, Enfield, Haringey & Islington).

Their approach for facilitating the plan:

PHASE 1: Bring together an overview of achievements, challenges and priorities both at NCL population level and borough level. Agree direction of travel with key ICS stakeholders. 1st November 2021: Publish initial NCL CYP MH and Wellbeing transformation plan

PHASE 2: 'Keeping 'Live' In line with ICS development, work on joint plans with key ICS stakeholders, undertake prioritisation, further coproduction and engagement with service users, maintaining a 'live' document which we will update as plans develop.

Voice of the children informing Service delivery

NCL have the relevant data regarding Islington's demographics and deprived areas. This along with the impact that the pandemic has had on Islington, (young people are concerned about education, finances, and their future, while young children worry about their families) has contributed to informing the service delivery.

The Transformation plan has used engagement and coproduction with children and parents (service users) to inform their strategic health needs analysis. The local community have been involved in workshops, sharing their views in consultation exercises and helped shaped services. An example:

Islington
Participation project led by an organisation called Peer Power, engaged with over 100 young people some of whom on edge of criminal justice pathways or already known to YOS, to understand how they want to access health services.

The Transformational Plan incorporates a Thrive model:

Islington is progressing in the thriving domain in the following areas:

• Developed framework called iMHARS has been developed to support a whole-school approach to mental health and resilience in Islington schools.

•Trauma-informed training is being implemented in primary and secondary schools to embed principles and practices for addressing trauma and its intergenerational effects.

•In 2019, a central access point for children and young people was launched to access social, emotional, and mental health services (SEMH), integrating CAMHS into Islington's Children's Service Contact Team (CSCT) front door. This "no wrong referral" model improves access to various health, social, and digital community-based services for local children and young people.

The NCL have acknowledged the increased waiting times for CAMHS services in Islington and as a result have implemented a 'Getting Help' domain that aims to reduce waiting time for Autism spectrum assessments for children 5 to 18 and has already begun to address pathways into adulthood by developing a Joint Strategy across Council and ICB to support and set out our ambitions and activity to support 'Progression to Adulthood'

In line with transitions, they have set ambitions to extend current service models to create a comprehensive 0 to 25 offer to support transitions from CAMHS to AMHS where locality based wellbeing hubs for young adults with emerging mental health needs can be met

With the transformation plan the NCL have acknowledged that they need to improve how they monitor and make use of population and service data on ethnicity, gender, age sexual orientation, disability and other characteristics which is in line with the ISCP priority. .

Social Emotional Mental Health (SEMH) Review 2022:

SEMH Review:

Age Group: The SEMH review has also taken note of the ages of children and young person referred to their service. It is noteworthy, the numbers of <5 year olds being referred to local CAMHS has risen by almost 50% in the past three years.

Across NCL this age grouping has risen by 500 % between 2021-2022. This suggests CYP are accessing services earlier, benefiting from early intervention

Age Bands	Year 1: Oct19-Sep20	Year 2: Oct20-Sep21	Year 3: Oct21-Sep22
0-4 Early Years	69	118	157
5-10 Primary	473	553	694
11-15 Secondary	**560**	**848**	**1040**
Post 16	262	346	365
	1364	1865	2256

Waiting times for CAMHS

Contacts: SEMH referrals have increased significantly during the past 3 years and this has resulted in longer wait times and challenges meeting the 8-week KPI for first contact. The average wait time across SEMH is 8-12 weeks, with some waiting over 16 weeks. For CAMHS therapies, the average wait time for first contact is 11.6 weeks, and the average wait time for second contact is 11.3 weeks, an increase from 8.3 weeks in Q1 2022.

SEMH providers report CYP presenting with complex psychosocial difficulties. Providers record complexities for therapeutic intervention and redirection for further support. The Brandon Centre found an average of 7 presenting issues in 11.2% of cases in 2021-2022, including anxiety, low mood, self-esteem, and thoughts of self harm.

In order to respond to increased need: the SEMH team aims to reach more CYP faster with enhanced funding focusing on addressing equity of access in terms of Equality, Diversion & Inclusion. They plan to monitor and evaluate all CYP groups accessing the service through enhanced reporting structures and maintaining the SEMH Provider Dashboard. SEMH services will be promoted to all groups across all settings to increase the breadth of reach and empower CYP to seek advice and support through self-referral. A priority system is in development to ensure no CYP waits longer than necessary.

Progress of the implementation of the SEMH review will be monitored at the SEMH Partnership Board

Voice of Islington Children

Islington children and young people's Health and Wellbeing survey 2021-22.

The survey was commissioned by the Islington Public Health Team to collect robust information about young people's lifestyles. They surveyed **2799 pupils, in 25 primary and 9 secondary school settings in Islington.**

They covered areas such as: *Healthy weight, healthy lives, Physical activity, alcohol, smoking and drugs, relationships and sexual health, safety including bullying and online safety, & mental health and wellbeing*

Children's view about Internet Safety:

11% (5% in 2017) of primary pupils said that, in the last year, they have sent personal information or images to someone which they then wished they hadn't; 19% (11% in 2017) of secondary pupils said the same. 34% of primary and 33% of secondary pupils said they have viewed a message or picture in the last year that scared them or made them upset. When they received something nasty, 19% of primary pupils and 21% of secondary pupils deleted it without showing anyone. 12% of secondary pupils have been sent a violent photo, video or livestream; 6% have been sent links to extremist views or organisations

Overall Life Satisfaction

Overall life satisfaction has decreased compared to 2017. 64% (75% in 2017) of primary pupils and 50% (63% in 2017) of secondary pupils responded that they are 'quite' or 'very' happy with their life at the moment, while 18% (12% in 2017) of primary pupils (18% boys and 14% girls) and 21% (16% in 2017) of secondary pupils reported that they are 'fairly' or 'very' unhappy with their life at the moment.

High self-esteem and resilience levels help pupils persevere and cope with daily challenges. There has been an overall drop in self-esteem and resilience scores compared to 2017. 32% (23% in 2017) of primary pupils and 31% (17% in 2017) of secondary pupils had a medium-low self-esteem score (9 or less). 15% (12% in 2017) of primary pupils and 29% (26% in 2017) of secondary pupils had a low measure of resilience.

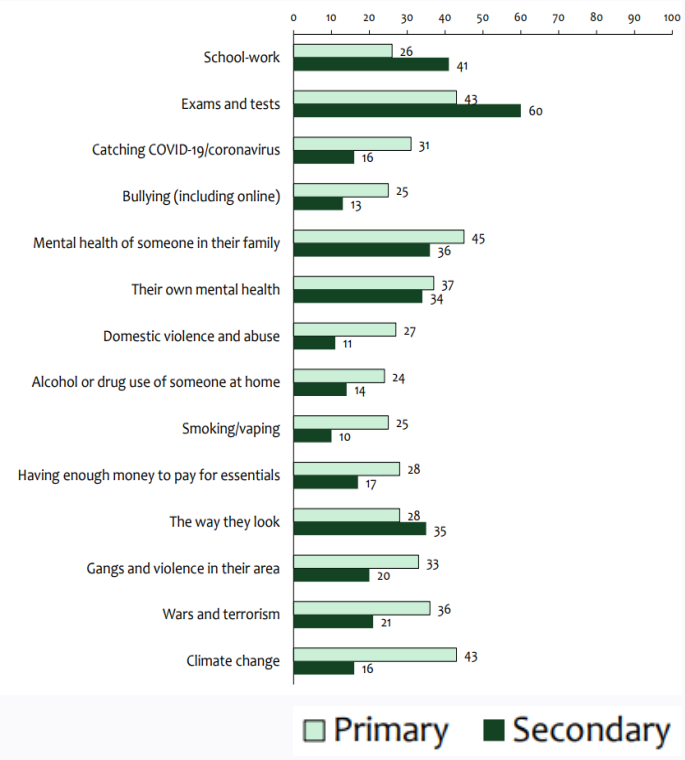
These statistics are quite helpful in understanding the lived experiences of children and young people across the borough and support the partnership to identify themes and patterns to support informing service delivery.

Mental Health and Well-being

90% of primary and 85% of secondary pupils responded that they worry about at least one of the issues listed 'quite a lot' or 'a lot'; 33% said they worry about more than 5 of them.

In most cases, primary pupils report more worrying than secondary pupils do.

Girls report more worrying than do boys. Worries 'quite a lot' or 'a lot' included:



Everyone's Invited & Operation Encompass

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. 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 multiagency partners act as though sexual harassment and online sexual abuse are happening, even when there are no specific reports.

Evidence & Impact

As a result of this the ISCP created a task and finish group and created the protocol for managing child on child sexual violence, abuse and harassment in schools, settings and colleges. This was disseminated to all education provisions in November 2021. To support schools with the protocol the ISCP, Principle of Safeguarding in Education and the Health and Wellbeing Board developed and facilitated three well attended workshops (between 2021-22) to spread awareness and understanding about child-on-child abuse.

Operation Encompass

Designated Safeguarding Leads in Education need to be informed of domestic abuse incidents to monitor the child's welfare at school and, if necessary, implement additional support measures. To facilitate this information sharing, the MPS has introduced Operation Encompass.

Currently, the majority of state schools in Islington have joined the Encompass information sharing agreement. This allows police to share details of any domestic abuse incidents they know of with schools, ensuring schools are aware of the child's situation when they attend the following day. Although Operation Encompass is currently only available to state schools, it is hoped to expand the program to private schools in the near future.

Disproportionality and Inequality

Disproportionality and Inequality

Task and Finish Group:

The ISCP created a task and finish group to create systems and processes to understand and mitigate against the disproportionality and inequality impacting particular ethnic groups. The task and finish group created two work streams to focus on respective identified themes.

Workstream One:

Data Analysis- Gathering and understanding data regarding several ethnic groups across relevant agencies in the partnership and determining whether they are accessing services disproportionately.

Progress and impact: Relevant agencies have been able to demonstrate an understanding of the data available to them and identify areas of development such as recording ethnicities correctly and setting up a more robust recording system.

Voice of the children and families:
Incorporating a continuous exercise to obtain feedback from all service users who use their services. Consideration for the voice of the child and families encompassing their experience with services in the context of their ethnicity.

Working with partners to see to what extent their agencies are representative of the Islington population: Determining our partner agencies operational and senior management staff are representative of the services users' using services and the population of the local area.

Workstream Two:

Training: Gain an understanding of partner agency's training about cultural competence and then set an agreed benchmark on the expectations for partner agencies to promote awareness and understanding of cultural competence within their respective workforce.

Embed in Practice: Partner agencies to incorporate learning of cultural competence into practice. Consideration on how they will measure the impact this has on their service users' experience and to also be informed by the changes in data and feedback from young people and families.

Coordinated Service delivery: Identify gaps and create action plans to reflect needs to address these gaps across the Partnership.

Disproportionality and Inequality

Islington Youth Justice Service Disproportionality Action Plan

Islington Youth Justice Service (YJS) is committed to tackling disproportionality and working closely with partners to address these areas. They follow the council's anti-racist strategic vision and have developed an operational plan focused on disproportionality.

Plan: The operational plan aims to address education, courts, police, staff training, interventions, reports, and assessments.

Projects/ Partnerships: Islington Youth Justice Service holds monthly disproportionality meetings with relevant partners to increase joint working and invite services within Young Islington for e.g. YOS Police.

They liaise with the Independent Stop and Search Commissioner, this partnership working allows them to follow up on stop and search complaints and the regularly sit on the stop and search community monitoring group.

They partner with the Metropolitan Police Service to deliver a bi-monthly programme exploring young person and parent/carer experiences of policing.

They work with the Wipers Youth Service, which delivers a personal development and leadership programme addressing issues around race and identity.

Islington has a dedicated Interventions Lead developing interventions aimed at exploring identity with young people, a Group of Peer Advocates for increased feedback and input, and monthly reflective supervision for staff.

A staff survey is in development to obtain feedback and evaluate responses to issues around discrimination.

Action Plan

The YJS has set out an action plan for its operational staff to aid in mitigating against the disproportionality observed towards the global majority. A few examples are listed below

They aim to develop staff skills and confidence in understanding and addressing disproportionality and racism, and continue to promote anti-racist practice.

They have done this by exploring the use of language concerning race, racism, gangs, groups and youth violence through workshops, case discussions, supervision and QA processes. Implementing the use of genograms and ecomaps, create a resource pool for exploring identity, and develop the use of social graces in assessments.

Impact:

The workshop improved reflections of identity and intersectionality in assessments, and specific interventions addressing identity have been positively received by both young people and staff. Social GRACES are used in every YJS assessment, enhancing the understanding of young people and families.

Action

The YJS have also explored how they can support young people who are disproportionality stopped and searched by Police.

They have implemented this action by promoting stop and search information events for young people through the Islington Stop and Search commissioner. Invite YJS Police to local disproportionality meetings, review data on repeat stop and searches, collaborate with CHOICE on training new recruits.

Impact:

Police have allowed for specific cases of body worn footage to be reviewed to give young people a voice and hold police to account. A high number of student police officers have been trained by the YJS, young people and parent champions. Strong relations have been built between police colleagues and YJS and opened up communication for raising concerns regarding disproportionate stop and searches and ensuring there is oversight in addressing strip searches that take place to young people.

Next Steps

Islington YJS will continue to plan and develop and improve outcomes for Black, Asian, Mixed, and other Ethnic minority young people in the criminal justice system. They will continue to self-audit their assessments, reports, risk assessments, and use of breach to understand the impact of unconscious bias. They will continue to review their operational and strategic action plans, assess outcomes, and incorporate feedback from surveys. The management team will make individual pledges to tackle disproportionality within the youth justice system.

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Disproportionality and Inequality (SEMH) Review 2022:

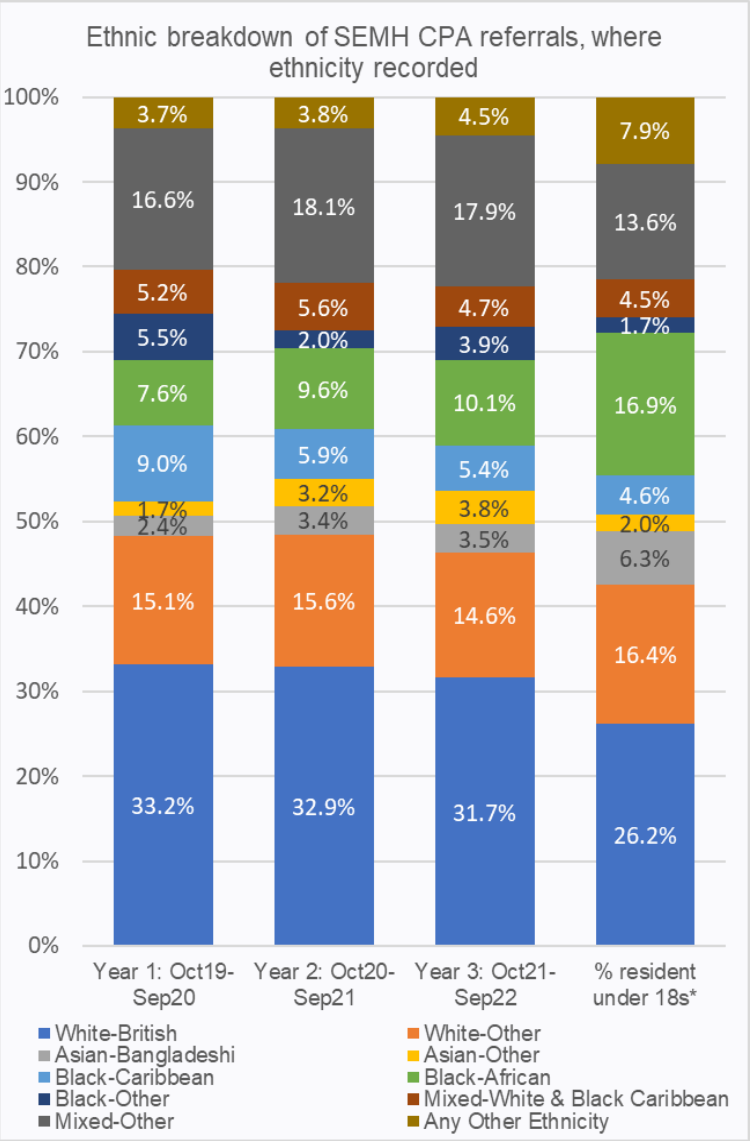
SEMH Review:

Islington Social Emotional Mental Health Service have undertaken a review of its services and referral activity and were able to share some of its findings particularly relating to disproportionality and inequality from 2019 to 2022. The review identified that their mental health services were not meeting the needs of some of the ethnic groups within the local area of Islington.

Referrals:

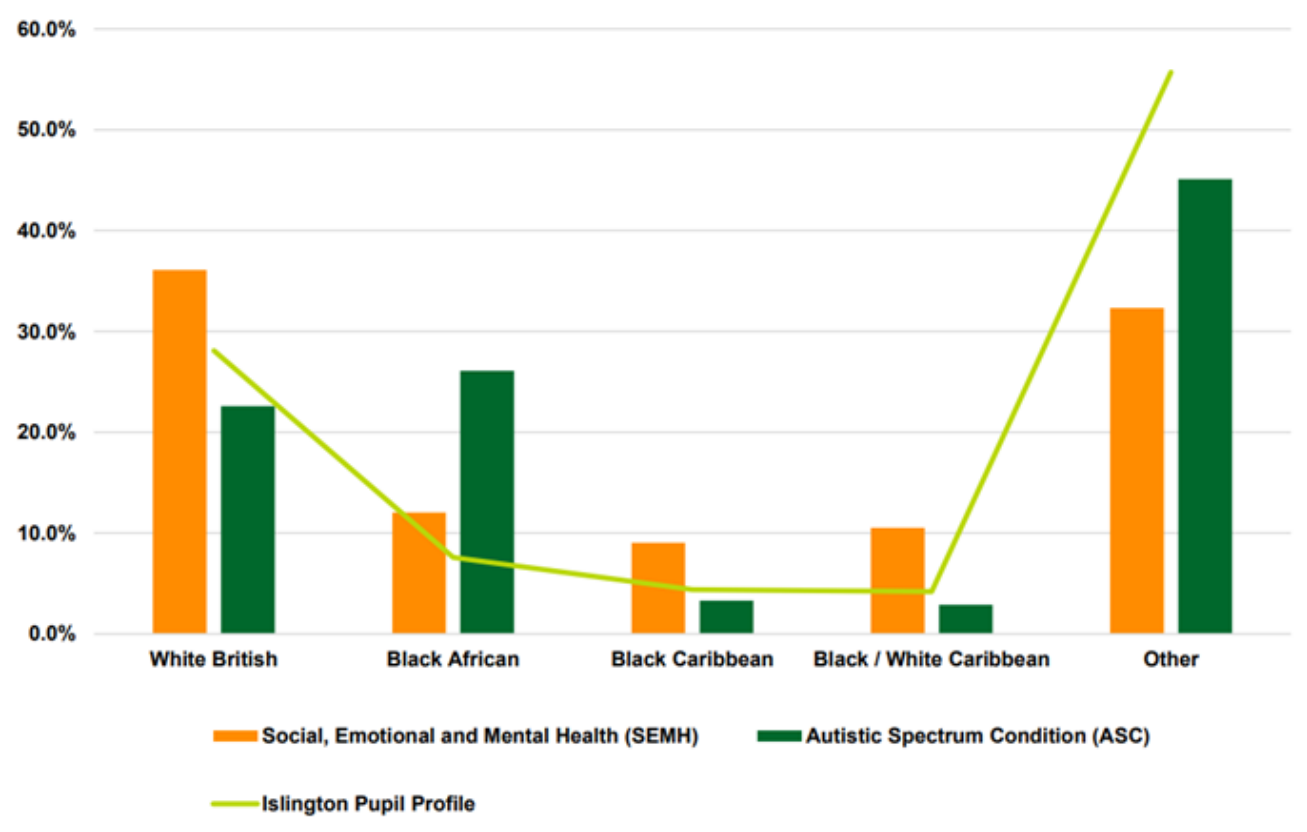
Referrals sent into SEMH services demonstrate that there is a disparity among the referred ethnic groups against the Islington population.

- **Across the three years the number/percentage of White British/Other has been consistent.**
- There is an increase in the number of Black-African CYP being referred to the service however this group has remained underrepresented throughout this period.
- **There is a significant proportion of ethnicity unknown and not recorded which has impact on true understanding of ethnicity accessing the service.**
- There was an over-representation of people from White British backgrounds in inpatient CAMHS in North Central and East London (NCEL), and an under-representation of people from Asian and Asian British backgrounds in the study period (April 2018 to December 2020). These differences are statistically significant, suggesting there were significantly more White inpatients than expected, and significantly fewer Asian inpatients than expected, based on the demographics of the local population.
- **41% of the local NCEL population aged 11–17 years old are from White ethnic groups, but 54% of those admitted to CAMHS inpatient services in their dataset were from White ethnic groups.**
- There appears to be an under-representation of children and young people from Black ethnic groups but this is not statistically significant.
- **There appears to be a particular under-representation of some ethnic groups such as Pakistani (1.8% of inpatients in their dataset were Pakistani compared with 5.5% of the local population), Indian (1.4% of inpatients compared with 4.7% of the local population), and Black African (7.8% of inpatients compared with 11.7% of the local population). Statistical tests were not carried out on these differences.**
- There has been a disproportionate number of referrals made for Black African cohort between 2019-2022. Black African CYP make up 16.9% of the local population whilst referrals remained much lower for this group - 7.6% (19/20), 9.6% (20/21) & 10.1% (2022).
- Whilst there are indications that the numbers of referrals to CYP from the global majority population are increasing there is further investment taking place to increase access for underrepresented groups.



Disproportionality and Inequality (SEMH) Review 2022:

SEMH & Autism Spectrum Condition Disproportionality



What this tells us:

The light green line shows the profile for all Islington children.

For ASC (dark green) :

- Black African children are significantly over-represented in this area of need (26.1% of the ASC population vs 7.6% of the general population)
- White British, Black Caribbean & Black / White Caribbean are under-represented in this area of need compared to the general population (White British: 22% vs 28.1%; Black Caribbean: 3.3% vs 4.4%; Black / White Caribbean: 2.9% vs 4.2%)

For SEMH (orange):

- White British, Black African, Black Caribbean and Black / White Caribbean children are all over-represented in this area of need (White British by 8%, Black African by 5%, Black Caribbean by 5% and Black / White Caribbean by 6%)

Young Black Men and Mental Health

Young Black and Mental Health

LB Islington were able to identify the themes and patterns relating to work on engaging young black men with mental health services. The new Elevate Young Black Men and Mental Health initiative is a innovate community based, multifaceted and youth led mental health /well-being programme designed to support young black men aged 11-25 through a suite of culturally competent therapeutic and mentoring interventions to support young black men to thrive and access the best life opportunities.

Their proposed service delivery has been informed by their extensive engagement with 46 young black boys and men over the course of 4 months to help shape, design and construct the mental health programme.

The emerging themes from their research interviews demonstrated views such as:

- Negative images about Black Masculinity
- Lack of positive role model/ absent role models
- Lack of support in school
- Access to safe trusted spaces
- Everyday experiences of racism, discrimination and daily micro-aggressions

Voice of the Child on their experiences of Mental Health Services

How is mental health perceived in the Black Community?
It is not always seen as a big deal. Sometimes young black men don't want to show themselves to be vulnerable especially around white people as it is another excuse for them to be discriminated against. You have to be very careful. You don't want to show your distress. In my culture I don't want to let my parents down. White people will always get more help.
Young person aged 16

Definitely having role models that look like you who can share your pain and struggles will help a lot. There is a youth club I go to where there are a lot of black male youth workers – all my friends go there for that reason – because they are people who look like us and we can connect to.
Young person, aged 16

There are no spaces where we can access support and that's how young black men often end up in bad situations. We tend to hold it all in and deal with it in other ways sometimes illegal routes. I always struggled when I was growing up and I never saw counselling as worthwhile. It was not helpful. Counsellors never reflected who I was. *Young person, aged 16*

Their findings help shape and design their programme offer which starts with the Becoming a Man Programme (BAM) in four schools which plan to deliver 24 month group counselling and 1-1 support. BAM is an evidence-based, group counselling/mentoring programme that is focused on building social, emotional and behavioural skills among young male students.

Islington schools will deliver up to 5 BAM circles per school. Each circle comprises up to 8-16 young people, so 24-36 young people per school. Target Year 8, 9 & Year 10. Each school will be allocated a full time trained BAM counsellor who will deliver up to 5 BAM circles per week and offer 1.1 mentoring support to young people engaged in the programme. BAM counsellors will also facilitate training and awareness sessions across the school community .

To help facilitate the integration of BAM into each school we will work with schools in March to June 2023 through a series of theory of change events. At the end of Year 1, we will assess the learning, impact of programme through holistic assessments throughout its delivery; A BAM cross Islington schools delivery group will be set up to oversee its delivery and implementation across two schools .

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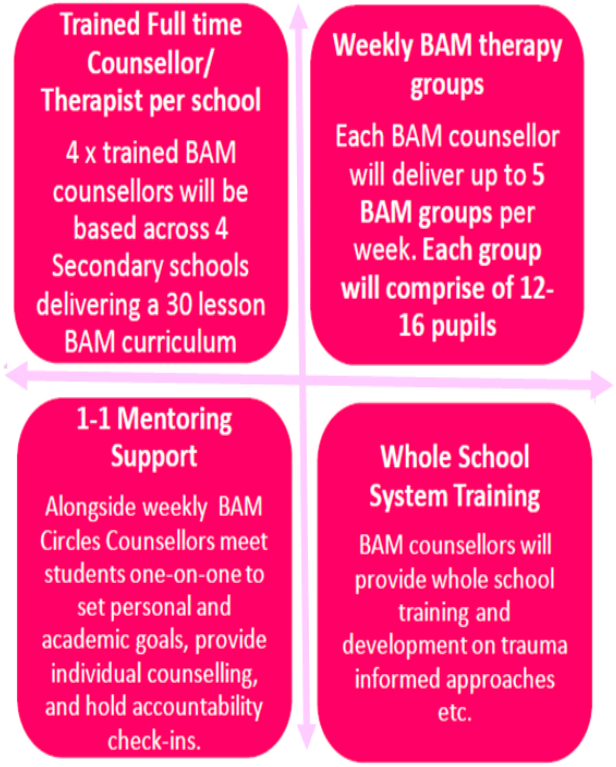
Young Black Men and Mental Health

Becoming a Man Programme Offer



Impact and Outcomes

Individual level Outcomes

- Improve the educational attainment, aspirations and life chances
- Improvement in physical, emotional mental and well-being outcomes
- To reduce school exclusions and improve attendance to school
- Improvement in access to mental health interventions

Whole school level Outcomes

- Improve educational attainment, aspirations and outcomes for all pupils
- Reduction in school based exclusions (fixed term & permanent)
- Reduction in persistent school absenteeism
- Improvement in physical, emotional mental and well-being outcomes

The BAM programmes will commence in **September 2022** so the measured impact will be reported on, in the next annual report.

The Young Black Men and Mental Health programme also runs the new Elevate Hub which is a dynamic and innovative multidisciplinary team designed to provide a suite of holistic psychological therapies and youth work interventions for young people aged between 11-25 who are at risk of poor health outcomes, serious youth violence and exclusions from schools .

Private Fostering

PRIVATE FOSTERING

The Children Act 1989 defines private fostering as when a child under the age of 16 (or under 18 if the child has a disability) is cared for, and provided with accommodation by someone other than a close relative, guardian or someone with parental responsibility, for 28 days or longer.

LBI CSC specific responsibilities in relation to identifying, assessing and monitoring private fostering arrangements were outlined within their annual report, highlighting how they have met the *National Minimum Standards for Private Fostering*[*].

Evidence/ Impact:

LBI CSC evidence how they have met the National Minimum Standard, also outlining their recommendations for improvements.

Notification: LBI CSC reports a clear notification pathway where notifications coming through the Children Services Contact Team (CSCT) are immediately transferred to the Child in Need (CIN) Service for an assessment, well within 7 days.

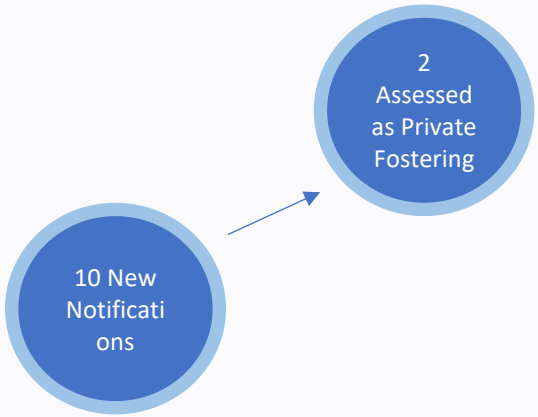
Safeguarding and promoting welfare: The report places a large emphasis on the social worker's due diligence in conducting a thorough a private fostering assessment to establish the suitability of the proposed or current private foster carer. This full assessment is then scrutinised by and signed off by the Assistant Director or Director of Safeguarding through the Access to Care and Resources Panel (ACRP) to ensure rigorous testing is applied.

Advice and Support: The report provides assurances that private foster carers, their privately fostered children and parents of privately fostered children are made aware of the processes this involves, including everyone's roles and responsibilities, information regarding financial support available and support services available for them to access.

Monitoring compliance with duties and functions in relation to private fostering: LBI CSC arranges that a Social Worker visits a privately fostered child in their area – in line with the statutory requirements. The LBI CSC data team is able to outline the effectiveness of this by using a tracker tool.

Evidence:

Between April 2021 and March 2022



Current private fostering arrangements:

LBI CSC acknowledges in their report that private foster care arrangements remain low in Islington therefore they continue to raise awareness through their foundation and refresher safeguarding training.

Impact:

Timeliness of visits has improved this reporting period.

In this reporting year, awareness-raising has focused mainly on ensuring that all safeguarding training offered to staff across the council includes a focus on private fostering.

Managers for across LBI CSC were recommended to renew and monitor initial and on-going visits to ensure social workers were visiting in timescales. 4 out of 5 children were visited on timescales, only 1 missed 2 timescales.

Added Recommendations for next reporting period:

The 2022-23 report will report on the impact of the Ukraine War and subsequent Homes for Ukraine scheme on private fostering arrangements.

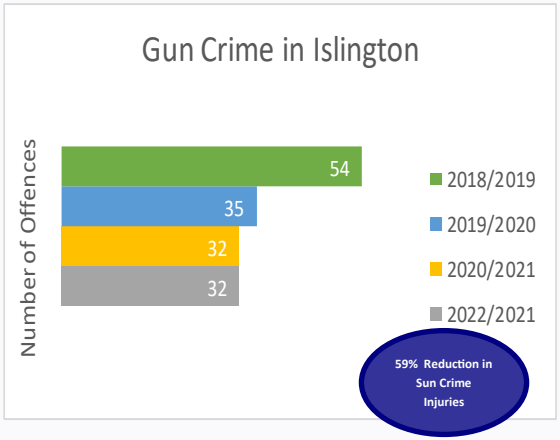
ISCP ANNUAL REPORT 2021-2022

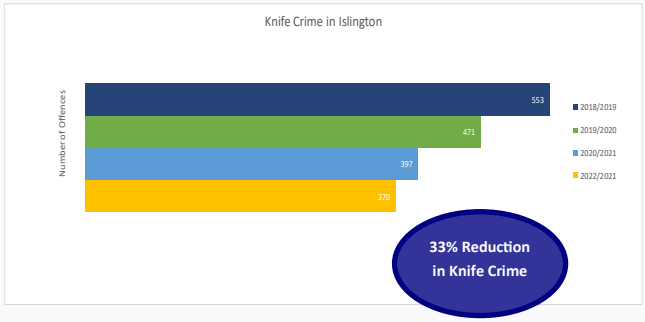
Update on Youth Safety Strategy 2020-2025

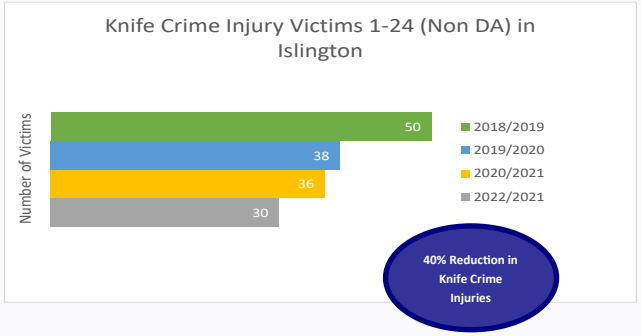
Islington Council launched the new, partnership-focussed five-year Youth Safety Strategy in November 2020; it focuses on protecting children and young people from violence, abuse, and exploitation.

Impact:

Whilst 2020 to 2021 were devasting years for teenage homicides in London, especially in knife crime, the youth safety strategy have shown evidence and impact of their services to reduce several areas, such as: knife crime, knife crime injury victims, gun crime, serious youth violence and youth violence in Islington.







Impact evidenced through the Youth Safety Strategic Objectives:

Prevention

The new young Islington universal offer is complete and includes continued high quality opportunities for young people aged 8+ across several youth hubs such as the Rose Bowl, Lift and Platform. Plus their vibrant summer offer – Summerversity and Launch Pad had over 900 young people engaged this year.

Identification

500 parents / carers have been offered online training and workshops from the Violence Reduction Unit (VRU) Parental Support Team.

96% agreed that training equipped them with practical knowledge that they will put into practice.

67% training helped them understand how to better support or access support for their children

Engagement:

Islington has large Somali population so 67 Somali parents / carers have completed the parent champions training since July 2021. 170 Somali parents/carers have been reached – empowering and enabling them to have more opportunities

ISCP ANNUAL REPORT 2021-2022

Update on Youth Safety Strategy 2020-2025

Diversion (from Youth Justice System):

Targeted Youth Support (TYS) led triage process exceeded the intended target of 80-85% with 91% diverted in 2021 to 2022.

Support:

74 young people engaged with VRU and TYS transitions project over the last 2 years. They noted a profound positive impact on young peoples' behaviour (80%) with an attendance and engagement of 85%. The parents reported an improvement in engagement with school (93%) and better equipped to communicate with school staff (80%).

Protection:

408 young people engaged and supported through their commissioned services with over **1,888** one to one contacts and **1,346** hours of mentoring. **168** Safe Havens have been developed with 197 viewed over the last 6 months (reporting period).

Disruption:

2,288 knives and other bladed items removed from the 6 knife surrender bins in Islington since October 2020

Enforcement & Prosecution:

The MPS predatory offender unit have secured the first slavery and trafficking risk order in the whole of the MPS in relation to county lines

The Youth Safety Strategy have listed out their priorities for 2022-23

Voice of the Child:

St Giles involved with young person due to concerns around gang involvement and SYV:

'Working with Maddie is positive, she calms me down and gives me a good mindset, I'm more able to think positively and clearly.'

Abianda Young woman -Reflection on the STAR project

'I let go of negativity and focused on me. I've learnt all you need is consistency and that consistency is progress'

Wipers Young person - reflection on the mentoring project

'I would recommend Wipers mentoring to any of my friends, especially the ones who don't have such support, my favourite part of each session was our discussion on the way to our activity. I felt heard and listened to by my mentor'

Impact:

- Decreasing school exclusion rates
- Reducing disproportionality in the youth justice system
- Increasing peer led support to parents/carers
- Supporting Parent champions to deliver a knife harm prevention programme in schools and youth clubs
- Improving awareness of services and opportunities for Young People and families including local youth provision and access to mental health and wellbeing services
- Strengthening Young People's relationship with the police through community led engagement events
- Sharing good practice around Co-production and engagement/empowerment of young

Update on VAWG Strategy 2021-2026

Violence Against Women & Girls (VAWG) Strategy 2021 to 2026:

The VAWG strategy was published in November 2021 and are currently 9 months into their journey. The strategy sets out the ambition that Islington continues

to be one of the leading and most forward thinking areas in the country when it comes to tackling all forms of VAWG. VAWG in Islington have outlined four aims as part of their strategy as follows:

Evidencing the Impact of VAWG from January 2022:

Police Performance:

- 2.076 — Domestic Abuse related crimes reported to Islington Police
- 3.349 — Domestic Abuse related incidents reported to Islington Police
- 8.7% — Sanction detection rate for the Domestic Abuse offences
- 28% — Islington Police Daily Safeguarding Meeting referral rate
- 1.105 — Survivors supported by the VAWG services
- 126 — 126 Survivors supported by the VAWG counselling service
- 79% — Of survivors supported stated that they feel safer after engaging with services
- 133 — Staff attended VAWG Workforce Developme nt training

Update on VAWG Strategy 2021-2026

I left the house with empty hands. I have no cash with me and I am 6 months pregnant. You are providing me with knowledge I did not have and I feel hopeful. Thank you very much for your support from my heart'

Service User Samira Project

'There are no words to express how I'm feeling. I've been through so many professionals and tried to explain what has been happening to me; consultants, psychiatrists, doctors, and yet nothing. There was still no support for me. You've actually listened and never judged. I've always felt judged in my life. You've done an excellent job.'

Survivor supported by Solace

'I really feel heard and hope that this time professionals support me in keeping safe. I want to keep safe for my daughter – she is my world and I want to model a good relationship for her, away from my ex-partner'

Survivor supported by MASH IDVA

Daily Safeguarding Meeting (DSM)

Islington Domestic Abuse Daily Safeguarding Meeting (DSM)

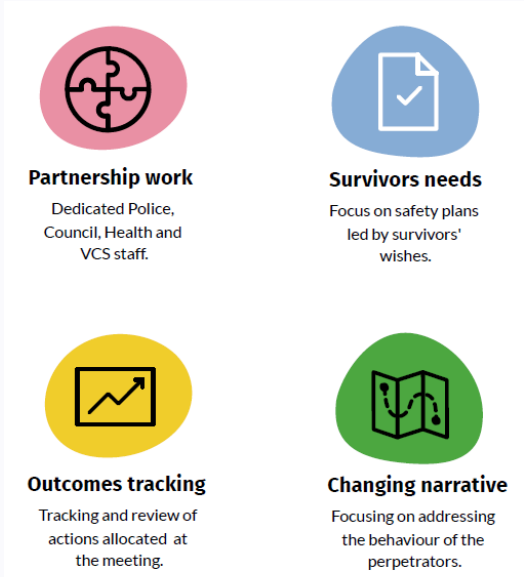
DSM (previously the DA MARAC) is a multi-agency led, fully integrated approach to needs management for survivors of high risk domestic abuse aiming to reduce the risk of serious harm or domestic homicide.

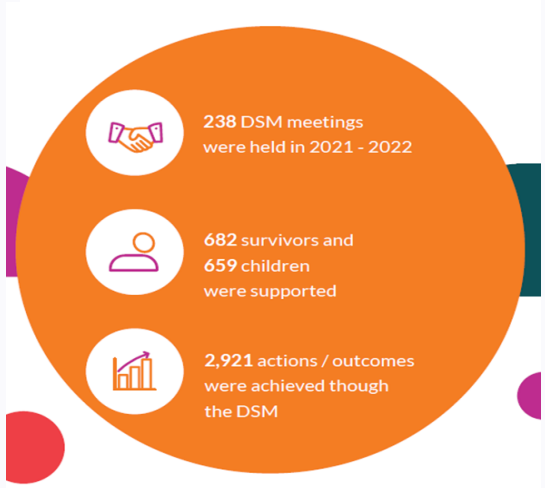
DSM fully replaced the DA MARAC which previously met monthly until January 2021. It was changed from monthly due to the struggle to cope with demand of hearing 35 to 55 cases with timescales causing high risk survivors a delay in intervention. The DSM currently meets each day during the working week in order to address the needs at the time the intervention will have the greatest impact and to maximise victim engagement.

DSM provides a dynamic information sharing and needs management approach, staffed by key agency decision makers who are able to contribute and work cohesively as a multi-agency team.

The DSM occurs daily from Monday to Friday and hears up to three being identified as high and medium risk of harm and domestic abuse.

Evidence of Impact:





Daily Safeguarding Meeting (DSM)

DSM performance highlights (January - September 2022)

Increased reporting of domestic abuse incidents across all services

39% higher non-police (early identification) referral rate to DSM than national average across MARACs

Decreased repeat referral rate

6% lower repeat referral rate comparing to London average

Increased engagement with survivors

65% higher engagement with survivors comparing to same period engagement with MARAC in 2019

Increased accuracy of police referrals

61% increase since DSM launched with Islington being the highest across London (second highest borough accuracy rate is 34%).

Other KPI Performance highlights (2021 comparison)

Profile of survivors to be demographically representative of Islington's population

7%

increase in survivors supported by the VAWG services who are from **Black, Asian and minoritised communities (61% total)**

Increased engagement with under-represented groups

12%

increase in survivors supported by the VAWG services who disclosed **disability or mental health support needs (57% total)**

Increased engagement with under-represented groups

3%

increase in survivors supported by the VAWG services who are **LGBTQ+ (7% total)**

Increased the number of survivors accessing VAWG services and support

9%

increase in total number of survivors supported by the VAWG services (1,105 supported to date by commissioned services)

ISCP ANNUAL REPORT 2021-2022

Update on VAWG Strategy 2021-2026

DSM data Q1 2022

National and London 12 months comparison (based on National 292 MARACs and London 32 MARACs data average including Islington's DSM: July 2021 - June 2022)

REFERRALS IDENTIFICATION

Islington DSM saw nearly double the number of national average and SafeLives recommended volume of referrals for Islington.

REDUCING THE RISK

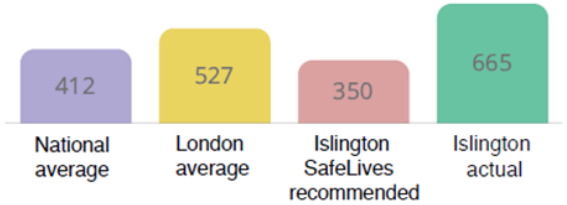
Islington DSM repeat referral rates are 7% lower than the national average and in line with London average.
*Islington MARAC data comparison from 2019/2020

EQUALITY

Islington DSM referrals for survivors from Black, Asian and minoritised ethnic communities and LGBTQ+ communities and for survivors with a disability are significantly higher than the London average.

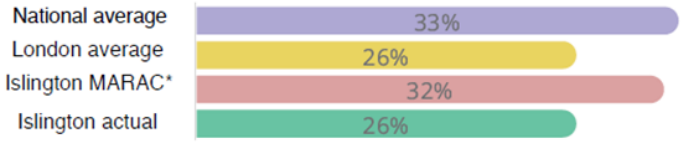
REFERRALS IDENTIFICATION

National and London comparison



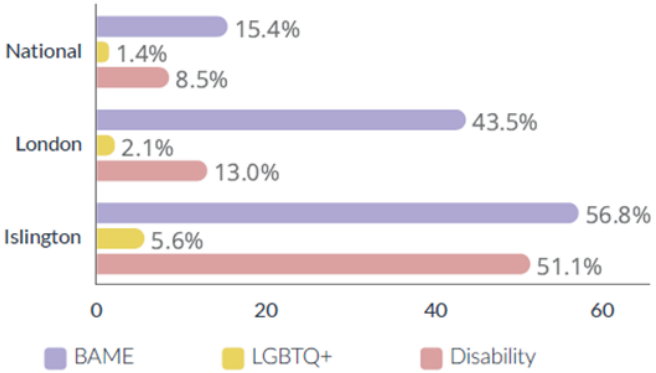
REDUCING THE RISK

National and London comparison



Equality

National and London comparison



Why is DSM making a difference?

Better engagement with survivors

76% of survivors engaged with the DSM process to express their wishes and feelings, compared to 18% with MARAC

Quicker response

responses to high and medium referrals were **15 times quicker** when referred to the DSM

Managing risks from the perpetrator

over **7 times higher** number of requests for civil and legal protection orders

Increased risk management

non-core agencies (including A&E, Sexual and Mental Health Clinics, GPs and Education) were **4 times more likely** to refer to the DSM than they had been to MARAC.

Assurances on Quality

ISCP Dashboard:

The ISCP quality assurance 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*. The LBI Data and Performance team previously provided the Quality Assurance sub-group with performance data in the form of PDFs highlighting the themes and patterns of contacts and referrals, CP and CIN plans, amount of strategy discussions and S47 within a given period. This would demonstrate how partner agencies worked together, looking at the amount and types of referrals they sent to the Children Services Contact Team.

This data is now being presented on a digitally interactive Power BI software. This will allow partners to interact and analyse the data presented once access is given to external agencies from the LBI.

Section 11 Education:

The Principle of Safeguarding in Education compiled the section 11 responses from 59 Islington Schools, Nurseries and Colleges (59) and 72 Islington Early Years provisions and produced a report that outlined their strengths and areas for development.

Summary of S11 feedback:

The audits have shown a widespread commitment to safeguarding children in Islington, with only a few schools failing to complete the audit despite reminders, and one school providing an independent review to demonstrate compliance with Section 11; while most settings provided comprehensive responses to the compliance checklist, those with limited responses will be contacted and offered support to ensure their safeguarding practice meets the necessary standards, and those who have not covered all key elements will be supported to create action plans, with cross-checking of Annual Safeguarding Reports to Governors to further assess compliance.

Key findings:

Trauma informed approach:

The report evidenced that several primary schools adopted a trauma informed approach that has led to reduced negative impacts of childhood adversity, improved child mental health, and more inclusive schools where students feel valued and supported.

Robust Safeguarding culture:

The section 11 self-assessment emphasizes developing a culture of safeguarding within a whole-school approach, requiring commitment from all stakeholders. Under Standard 1, the audit showed that most settings have strong pastoral approaches and encourage collaborative efforts between safeguarding governors, designated safeguarding leads, and other leaders. It also features safeguarding being a regular feature of staff and governing body meetings, and School Improvement Plans including online safety and clear responsibility for identified actions.

The Expanding Role of the Designated Safeguarding Lead:

The role of the Designated Safeguarding Lead (DSL) has expanded into a senior leadership role with wider responsibilities, and despite a requirement for both the DSL and their deputies to complete the same level of training and development, the enormity of their responsibilities, particularly since the pandemic and lockdowns, has not been recognised with additional funding or support. This may have resulted in experienced DSLs leaving the role; the achievement gaps between vulnerable children and their peers should be addressed as part of an organizational approach rather than being solely the responsibility of the DSL, and DSLs should be acknowledged and applauded for their hard work and the valuable role they play in safeguarding children to help them feel respected and highly regarded.

Child on Child abuse:

There were noted actions from schools to embed the ISCP child on child sexual violence and harassment protocol and to further progress their resources in this area as well as online safety. In addition to ensuring that child on child abuse is always on the agenda for staff safeguarding updates

Recommendations and actions created from the Section 11 audit:

The recommendations involve improving attendance at the DSL Forum, providing protected time for Designated Safeguarding Leads, delivering various training courses and workshops on safeguarding topics- including sexual and criminal exploitation, strengthening school practices related to KCSIE, safer recruitment, and record-keeping, as well as reflecting on allegations and lessons learned. These actions are to be taken by various teams including POSIE, LADO, CSC Exploitation and Missing Team, Prevent Education Officer, ISCP, and Bright Futures.

Assurances on Quality: Section 11

Section 11 of the Statutory Partners and Relevant Agencies: Seeking assurance on Safeguarding standards

Section 11 of the 2004 Children Act sets out the provision for Local Children Safeguarding Partnerships to undertake a self-assessment audit of how organisations and services are meeting standards to safeguard children and young people. It was recognised that all relevant agencies and VCS are at differing stages as it pertains to their responses against all 8 standards.

The ISCP received 9 comprehensive responses in the Section 11 Audit and they all demonstrated great compliance against the 8 standards provided. As part of one of ISCP action plans (LCSPR) there has been on going work to seek assurances on safer recruitment which has appeared to be quite thorough within the responses gathered from relevant agencies. We have chosen some the areas where they have evidenced strengths and areas for development:

Arsenal Football Club: Able to demonstrate an effective system of using the voice of the child to inform some of their service delivery and ensuring they have robust safer recruitment systems in place. However, they also acknowledge an area for development within their learning and development training and have proposed that they will be improving their recording system within 6 months of submitting their S11 response.

Chance UK VCS: Reporting strengths in their interagency working both at an Early help and a statutory intervention level. Given their youth workers often have close relationships with young person this aides the assessment and Information sharing aspect at all levels. They have also demonstrated areas for development in learning from reviews with trying to incorporate more reflective space and translation of themes throughout their teams.

Camden and Islington NHS Foundation Trust (CANDI) Whilst CANDI is an adult mental health Trust and are not commissioned to provide services to children they are aware that there is a need to strengthen its performance in ensuring their core staff are competent and capable and confident in incorporating a "Think Family" approach to recognise safeguarding concerns. They compound on this by ensuring their staff (in contact with parents) are trained in Safeguarding Level 3 a those not in contact with services users demonstrated competence in Level 1.

They have identified a need in ensuring that more bespoke safeguarding children training and have devised a plan to ensure this is completed to a satisfactory level.

North Central London Clinical Commissioning Group (now Integrated Care Board): The NCL CCG has demonstrated its ability to take the views of children and families to improve service delivery and this is evidenced in their involvement with the SEMH Review which looked at its impact on the LBI CSC contact team for referrals. Their collaboration with the Local Authority to commission services demonstrates the partnership working to ensure the welfare of children are promoted and safeguarded. Examples of this include the overall co-designing of workshops to engage young people collaboratively in architecting the design and development of the Young Black Men and Mental Health programme and service offer. of the new Young Black Men and Mental Health Elevate Service Provision. They demonstrated an area for development to improve effectiveness in confirming their auditing process regarding the use of safer recruitment and managing allegations procedure in the NCL CCG.

National Probation Service: They clearly outline their clear statement regarding their responsibility towards children and this being available to their staff, they evidence this through their pre-sentence report to ensure that the voice of the child is paramount in assessing and managing risk. This has been compounded by their involvement with the MASH Team in CSCT or being accessible for information where it involves checks pertaining to parents' involvement or being known to Probation. In service delivery they demonstrate how they work with partners in order to ensure children are safeguarded and their welfare promoted through attending CIN, CP, MAPPA meetings whilst also ensuring their staff are trained effectively to acknowledge risk and knowing where to report.

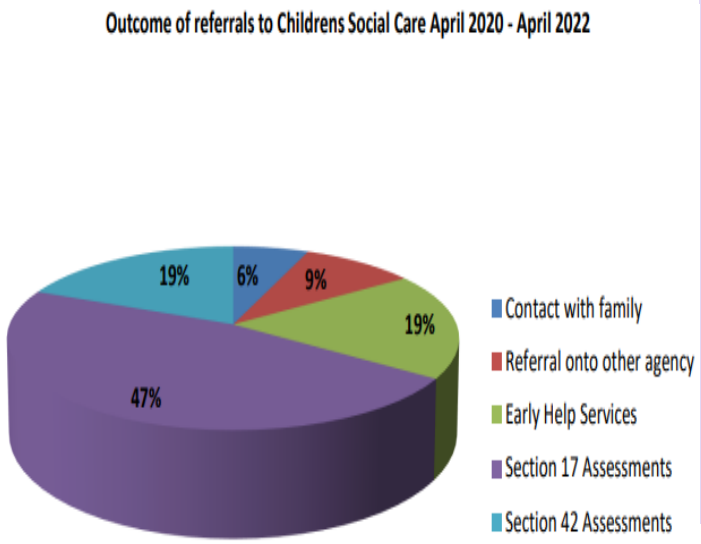
Whittington Hospital: They have evidenced in their report clear complaints procedures from using Patient Advisory report clear complaints procedures from using Patient Advisory Liaison Service (PALS) and Children's and Young Persons Integrated Care Service Unit (CYP ICSU) an active Young Person forum where they are able to gain the voice of children and families to improve services as it pertains to safeguarding children and promoting their welfare. They evidence areas for development for improved effectiveness which was raised in a recent rapid review report that highlighted a need for a more stringent discharge planning guidance policy that incorporated an agreed flowchart to improve processes.

Assurances on Quality: Section 11

Moorfield Eye Hospital: Moorfields Hospital have been able to evidence statutory duty towards children in ensuring they are able to measure the impact of the referrals made to Children Services and their outcomes are. Whilst they take on the voice of children and families and incorporate into service delivery by having age-appropriate focus groups read and critique ophthalmic information leaflets, suggestions are incorporated reflecting their views and are then available in hospital. They have also acknowledged where areas of development can improve effectiveness such as strengthen their transitions process for vulnerable young people into adulthood.

They highlight an area for development in ensuring they are more effective in strengthen links with MASH by updating their information sharing agreement.

Police: They report clear lines of accountability when it comes to safeguarding children and they acknowledge the need for this given the frequent changes in roles across their Basic Command Unit in Central North. They report their significant contribution to partner/inter-agency working in the context of being the number one referrer to Children Services whilst having an integral part of the MASH process in obtaining the necessary information to ensure children are safeguarded and their welfare promoted. The Police also committed to attending training organised by CSC and promotes this process across various corporate safeguarding courses. They have identified areas for development to improve effectiveness in the context of learning from review and the importance of this being fed into the BCU organisational learning hub to support staff development and practice.



CAFCASS: They evidence their service development has taken into account the need to safeguard children by incorporating their strategic plan setting out their vision which has been informed by their partners and staff. Their aim is to improve experiences and outcome for children and is being monitored by their CMT and bi-annual reporting to Cafcass Board. They are also able to incorporate the voice of the children from their family forum development work which features restorative 'listen and learn' and 'how was it for you' conversations with children. This adds to their collaborative audit process in order to continue to improve services and outcomes for children.

Local Authority: Following the outstanding rating from Ofsted's full inspection of LBI Children Services' in March 2020, this set tone for their Section 11 submission where they were able to highlight a vast amount of strengths through their inter- agency working, as well as evidencing outstanding leadership, management, and governance. OFSTED findings demonstrates that the LBI CSC effective in timely communication with the police and other professionals within the multiagency safeguarding hub (MASH) and external partners results in prompt help and protection for children. LBI CSC also spearheaded the data analysis of ethnic groups within the local area and how this demonstrated disproportionality and inequality in how the global majority accessed services.

Assurances on Quality: FGM and No Further Action Audit

Female Genital Mutilation (FGM) and abuse linked to faith and belief

ISCP has continued to highlight the dangers and risks associated with FGM by working with the voluntary sector, relevant partners and communities to protect girls and young women from FGM.

Evidence of responding to local learning:

Manor Gardens is a Welfare Trust and a relevant agency within the ISCP. They are a part of Islington's FGM steering group and have conducted an audit alongside LBI Children Services to look at FGM referrals over the last 3 years (2019 to 2022) to ascertain a clearer understanding of the number of referrals made, the services initiating the referrals and the outcomes for children and families involved. In addition to the in-depth scrutiny of the referrals covered in the above timeframe

The examination of referrals over the mentioned period was thorough, and a comparison was drawn with the three years prior to it (2016-2018). The results showed that the referral rates were indeed higher in the earlier period, with 32 referrals. This can be partly attributed to the changes made in 2015 to the Female Genital Mutilation Act 2003, which made it mandatory for professionals to report cases of FGM as a form of child abuse. This increased awareness may have led to a rise in referrals during this time.

The Children Services Contact Team (CSCT) received 15 referrals who were all from African descent: 5 Somali, 1 Somaliland; 3 Ethiopian, 1 Eritrean; 2 Nigerian; 2 Ugandan and 1 Ugandan/Nigerian.

11 of these cases were no further action (2 referrals received for one family in time period)

2 cases referred to Targeted Services (Early Help)

4 cases were transferred to Children Social Care

They concluded that the low number of referrals could indicate the following:

A greater understanding within the affected communities about the harm and legal implications of FGM making the practice less prevalent. Contrastingly, the low referrals could mean that affected communities are still practicing FGM on girls, but this form of abuse still remains a 'hidden harm' that professionals have yet to adequately address.

It was noted that the referrals do not reflect the affected communities residing in Islington, as no referrals made for families of Middle Eastern background.

The audit concluded that the ISCP should continue to deliver training around FGM to create further awareness and increase professional curiosity. FGM is featured in all of ISCP core training such as foundation safeguarding training, refresher safeguarding and DSL training.

Audit on Child and Family Assessments with outcome of No Further Action:

The LBI CSC wanted to better understand the circumstances and decisions making that lead to an outcome of no further action. Their audit set to understand Child and Family Assessments of 275 children from 131 sibling groups within 9 month period.

They investigated the reasons for the children being referred to CSC, why the outcome of the Child & Family assessment resulted in "no further action":

-if there has been a subsequent repeat referral,

-If the children were seen during these assessments,

-if the professional network was consulted about the outcome, and

-the level of management supervision oversight involved.

These factors are important to understand the history of the case and to assess the appropriateness and effectiveness of any interventions or decision-making related to safeguarding these children.

They found that only 11% of the sibling groups were re-referred which demonstrates that safe decisions are made when closing a child's case but where there is reoccurring need, referrers are confident to refer back to Islington Safeguarding and Family Support Service.

Assurances on Quality: Children with Persistent Absence and Children in Care Proceedings

Children with Persistent Absence

LBI CSC carried out an audit of 41 children and has presented their findings on interventions for children with Child Protection or Child in Need Plans and persistent school absence, examining multi-agency collaboration to improve attendance.

68% of the cases the primary area of need was identified by the social worker
80% of cases evidenced joint working among the professional network
85% of cases plans were reviewed regularly with appropriate professionals involved
54% of plans included strategies to improve school attendance
54% of the cases a formulation of reasons for poor attendance was not included in the plan.
66% of the cases parental factors (mental health, DVA) were seen as a barrier to improving
66% of parents were motivated to improve school attendance.
44% of children were motivated to make improvements
63% of cases included fathers or non-resident parent
17% of cases auditors found concerns around racism and discrimination had been considered

DSL and Parental Feedback: (9 parents & 11 DSLs)
67% of parents felt the relationship with the social worker was respectful, 11% partially
78% of parents felt school attendance had improved as a result of intervention
100% of DSLs felt joint working with social workers and the school helped improved attendance
Overall, 77% of this audit was rated good with 20% being outstanding. This audit was able to demonstrate good partnership working with a multi agency approach in mitigating against persistence absence. The children lack of motivation further illustrates the point of why early intervention is vital to lessen the likelihood of wanting to attend school. It also showed that they understood what the child's lived experience was and understood the social, parental and financial factors an incorporated them to improve school attendance. It was also noticed that management supervision was purposeful 78% of cases drove best practice providing clear rationale for decision making and making steps to include fathers or non resident parents.

LBI CSC have already begun to work towards the recommendations made:

- ◊ Having explicit discussions in supervision with manager for children with persistent absence issues to implement improvements.
- ◊ Include explicit questions on culture identity and discrimination in the child and family assessment for all children and ensure quality assurance in supervision.
- ◊ Run a Headteacher's Forum dedicated to improving school attendance by the Director of Learning and Culture and the Headteacher of the Virtual School.

Children in Care Proceedings

Auditors reviewed records of 20 children who entered care proceedings and an interim care order was granted over the last 6 months in a London borough with a high number of children in care. The purpose of the audit was to scrutinize the records and explore whether entering care proceedings was the best option, whether other options were explored, and whether it was necessary to enter care proceedings. The auditors found that 60% of the records were good, 10% were outstanding, and 30% required improvement.

Demographics
30% mixed parentage | 30% white British
10% Black Caribbean | 10% white Irish
10% Asian | 5% Bangladeshi | 5% Any other white

Findings
80% of the cases found proceedings needed to be issued
85% of the cohort removed from their parent's care were placed with a stranger foster carer
35% of cases held a Family Group Conference (FGC) and
55% of cases, parents were resistant to having an FGC
65% of cases parents did not contest to the local authority's care plan at final hearing
55% of cases had an expert family assessment and in
85% a father or another parent was included in that assessment.

Parental Feedback
77% of parents agreed their relationship with social worker was respectful 89% parents agreed with the social worker on what needed to change

Auditors found that care proceedings were the right decision for children in this category. So whilst the children looked after data appears to be high in comparison to statistical data, LBI CSC was able to evidence

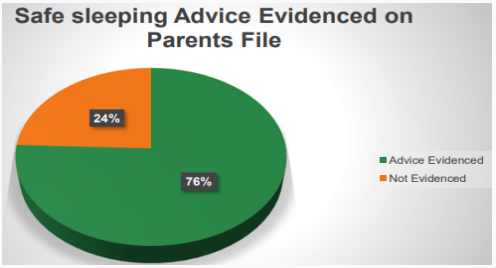
Assurances on Quality: Care Experienced Parents

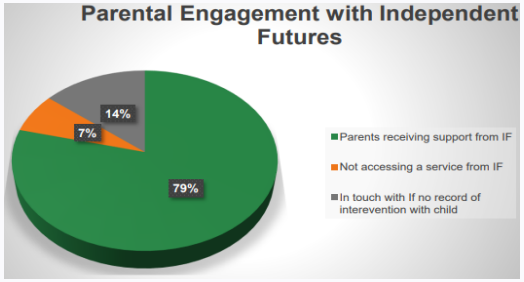
from their audit that decisions are being made on a proportionate basis. Also, while 45% of practitioners had evidence of understanding the children's culture and identity, only 25% effectively considered concerns about racism or discrimination in their assessments, possibly because most children in the audit were white British or white.

The audit evidenced a good working relationship between social workers and parents as well as with the children, this was demonstrated from 70% of children have a good rapport, trust and openness between them and their worker, 85% were visited on time and within statutory timescales.

Care Experienced Parents with children aged under 1

The LBI CSC has notified the ISCP of the death of 2 babies on separate occasions (in the last 3 years) who died suddenly and unexpectedly as a result of co-sleeping. Although, these deaths were not considered to result from neglect or abuse, there were indicators to suggest that co-sleeping arrangements had contributed to their deaths. In both occasions it was found that the parents were care experienced.
As part of their learning the LBI CSC sought to ascertain how practitioners worked with care experienced parents and explore how best to support parents who are often young and likely to have a limited amount of people they can rely on.
This audit looked at 41 (31 female and 10 male) care experienced parents with babies under the age of one years old and found the following:





The audit found that care experienced parents who are open to Independent Futures (Islington care leaver service for ages 16 to 25) do not have many children open to the Child in Need or Children Looked After service. Most parents had support with childcare, safe sleeping advice was recorded in 76% of cases, and 61% of children had a cot however only 41% of the children did not sleep alone. In some cases, information was not clearly recorded. Some children did not sleep in a cot, and 39% did not have a cot at the non-resident parent's home, indicating that they shared a sleeping space with a parent under the age of 1.
LBI CSC were able to demonstrate that their care experienced parents were being advised about safe sleeping arrangements with their babies, however although advised some parents chose to sleep with their babies.

Recommendations:
- Assistant Director for Corporate Parenting to agree a process or protocol whereby social workers and young people advisors are clear on what they need to explore with care experienced parents.
- Provide a clear steer to social workers and young persons advisors on what information about the child to include in parents' LCS record or pathway plan
- Hold safe sleeping sessions during team meetings and share information from the Lullaby Trust with all workers.

Care Experienced young people with children over 1

There were only 9 files audited for this cohort and a larger emphasis was made on the quality of the pathway plans to evidence how well it they address advice and support around parenting, help from family, the extended network and what role Independent Futures played in supporting them.
79% of the files were rated as Good.

Findings:
All audited plans had clarity on the services the parent received, and it was clear that the young person was a parent in all files. Non-resident parents were included in 66% of plans, but only 33% of plans had a rationale for not including them, indicating an area for improvement. Domestic violence or abuse (DVA) was not an issue in 22% of cases where it was not applicable, and in 45% of cases where DVA was present, it was included in the plan.
Parenting skills were partially considered in 55% of plans, and strengths in parenting were identified in 55% of plans. White British and other white backgrounds were the largest group of parents at 29% and 31%.

Assurances on Quality: Multi Agency Audit—CSCT/MASH Threshold

Multiagency CSCT/MASH Threshold Audit

Following a noticeable increase in the amount of contacts in the year 2021, this prompted a multi agency review of the contacts sent to Children Services Contact Team. April 2021 to March 2022 saw a high rise of contacts (12214) in comparison to previous years, the only year that had more contacts was from 2016 to 2017 (13671).

The multi agency audit looked at 100 children's cases to ascertain whether the appropriate threshold decision was made for : No further action | Targeted Services | Child and Family Assessment.

They found that 90 of the 100 cases, an appropriate decision was made regarding threshold.

A further 3 cases were considered appropriate on the available information however should have had further information to assist with the decision making and further information may have altered that decision.

The options within the audit asked did you agree with the decision – yes or no. A future audit could also ask the question "do you believe mash checks were required to make a decision?" - this coincides with a recommendation made following the Solihull JTAI ISCP comparison activity

Of the 7 cases where the outcome was disagreed 6 of these related to a decision of No Further Action where it was believed the family/child would have benefited from a service.

In 4 of these families CSCT agreed a service would have been beneficial however, the service offer was declined by the family and as such these families are required to be closed.

Findings

Further consideration should be given around the role of the Early Help practitioner in reaching out to families who are declining Early Help Services where it is felt that this may ultimately be of benefit to the child and prevent the delay in awaiting an escalation of need or crisis for the family.

This has demonstrated some of the difficulties in decision-making at CSCT when families have declined a beneficial service, while still having consent in place. Families have the right to decline services without interference with their fundamental rights to privacy and family life. This highlights the need for ongoing communication and information sharing among partner agencies and universal services.

Recommendations:

- Review of CSCT's framework which is required provide guidance around when MASH checks should be undertaken
- Feedback to CSCT workers around ensuring contact with alleged victims of domestic abuse ensures there is a discussion that victim is able to freely talk and this is case recorded. This may not address all situations where the alleged perpetrator may be present but will remind workers to be alert to this issue.
- Review in bi-monthly meeting this audit for further consideration around how to support families who decline offer of service.
- A further multiagency review to occur in 12 months.

Assurances on Quality: MPS Audit on S47s and Merlins

The Dedicated Inspection Team (DIT) is considered a critical role that provides the ability to independently conduct qualitative level 2 audit inspections of the MPS' work using the HMICFRS framework in 12 areas of Public Protection. Additionally, the DIT officers are part of the Aegis Team supporting Op Aegis by providing a bespoke auditing function for each BCU to provide both baseline, sustainability reviews and also inspects 12 core Public Protection theme MPS wide.

The DIT learning is shared with BCU's, Lead Responsible officers, policy makers, to improve safeguarding investigations and instil best practice within their teams. The audits main purpose is to understand and reinforce both policy, investigative compliance and to evaluate officers decision making and risk management. The DIT function has been praised as good practice by the HMICFRS and this relationship has been maintained to ensure we remain succinct and child centric.

Operation Aegis was created to support learning and embed the 'Improve model' to promote successful teams providing an operating rhythm. The Aegis team focusses on 6 Public Protection themes - Domestic Abuse, Child Exploitation, IIOC/YPSI, Child Abuse, Missing Children and SSO. The team are currently attached for 11 weeks to Central North BCU providing, mentoring, training and 121's for both Public Protection officers and response officers to share learning and best practice. The Aegis DIT team also provides snapshot audit for the 6 key Public Protection themes providing individual themed learning that is shared with the relevant Public Protection DI to support learning solutions for their teams.

Findings and Impact

In October 2021, the DIT audited Merlin reports (children coming to police notice). When comparing MPS results with Central North BCU (Camden and Islington Police), the good grad ed cases were comparable and positive, no inadequate cases were inspected. Across the Metropolitan Police, the main areas of learning, were officers not always speaking independently with children to obtain accounts, child exploitation not being explored where relevant and intelligence enquires to aid risk evaluation were not always being completed.

Findings and Impact

In December 2021, the DIT audited MPS wide Child Abuse investigations. The main MPS areas of learning found, wider safeguarding considerations for children placed with friends and family members were not always being considered and it is deemed good practice to conduct intelligence research to confirm there are no other apparent safeguarding risks with CSC, before placement is agreed, and concerns raised for suspects being spoken about the offence and not in accordance with PACE when conducting joint visits with CSC. Additionally, it is important that officers attend CP Medicals to brief the Paediatrician and obtain pertinent information as outlined by the LSCPs.

Impact

Locally, Central North BCU have implemented an Organisational Learning Board which allows for identified learning from DIT audits to be captured, disseminated and audited. The Board is chaired by a Senior Detective who has strategic oversight around the implementation of recommended learning which aims to improve the victim experience through the criminal justice process.

Early Help Subgroup

Social Progress Index

LBI are currently embarking on a similar journey to the London Borough of Barking and Dagenham in creating a social progress index at a locality level to allow them to understand the social well-being of the residents in Islington. The aim is to demonstrate how data can be used to help decision makers, businesses, charities and the general public understand how individuals are living and progressing within the borough and who is being left behind. In the context of the ISCP the early help subgroup would gain an understanding on how Early Help services could support those being left behind to make Islington more equitable by providing the necessary service from a multi-agency perspective.

LBI also wanted to develop a youth focussed version of a Social Progress Index for Islington. In order to implement this within Islington the data for LBBD was analysed in order to develop a proof of concept for Islington. One of the components chosen to attempt to explore was 'Personal Safety' given its background with "Stronger Families" and accessible data from LBI Community Safety team. This data could then be triangulated with:
LBI CSC child and family assessments involving domestic abuse – robbery offences by location of incident compared to resident population– rates of London Ambulance callouts for safety related reasons – Rate of incidents involving suspects who were (or thought to be) aged under 18 compared to under 18 population – rates of youth violence victims compared to resident population.
The data were able to demonstrate what this could potentially look like using the mentioned data points.

Possible Impact:

If successful, the Social Progress Index could be used by the statutory partners to have a better understanding of the children and families of Islington, subsequently being able to better meet their needs. This could potentially give scope in understanding the needs of each locality, therefore, being able to provide equitable resources to a specific area within Islington.

Youth & Play: Voice of the Child/Families:

LBI Play and Youth Commissioning Services brought evidence to the Early Help Subgroup A review conducted by the "Reflecting Reality" service included several case studies, one of which was a 16-year-old girl living with her mother and brother. Although the girl associated with males who joined gangs or were at risk of youth violence, she did not engage in these activities herself. She had limited experiences outside of the borough and was interested in studying creative subjects but planned to pursue a career in childcare based on her sibling's positive feedback. The girl lacked support and influences outside of her social peer group, limiting her cultural experiences and life expectations. Despite having no issues at school and good peer friendships, she faced challenges in achieving her full potential. The study provides insight into the experiences of young people in the borough and will influence how Youth Services can better relate to and engage with this cohort in the future.

Outlining of the Early Help Subgroup Priorities for 2022/24

Early Help System Guide

The Early help subgroup were able to gain feedback from relevant agencies using the Early Help System Guide formulated by Department for Levelling Up, Housing and Communities (DLUHC) in partnership with the Department for Education. The feedback informed the Early Help's sub group three priorities for the forthcoming year 2023.

Voice of the Family:

The incorporation of Family Voice into Let's Talk Islington data is considered a strength, with over 700 children included. Parents Champions, who have lived experience, contribute valuable insights. However, the current data does not fully represent the lived experiences of families who do not use the service. The need to hear their voices in regards to their experiences of inequality, necessary support in Islington, and how to access resources is highlighted. The goal is to make Family Voice a standard part of data presentation, and an application has been made to Research In Practice to be part of a Learning Network to strengthen Family Voice. It is a long-term project that will span over 5 years and will involve collaboration with Rees Centre.

Develop the Workforce

The focus is on developing the Early Help workforce across various sectors, including council, voluntary charity, health, education, police, probation, and youth justice, in order to align it with the workforce table. This will enable the workforce to identify needs early on and begin the early help process, or know how to link individuals to the appropriate services based on their role. Health Visitors and Midwifery are already completing early help assessments. The key questions being asked are how many early help assessments are being completed outside of council teams, and how often they are able to act as lead practitioners.

Data:

Recording system to enable partners to record their EH assessments and outcomes. Previously started but paused due to Covid 19. This priority is further elaborated in the next topic of the EHM Portal Project.

Liquid Logic Early Help Module (EHM) Portal Project:

The EHM Project provides a portal to allow partners to refer cases to Islington, replacing the MS Forms process. The project is in delivery and is nearing completion.

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. 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 ISCP's previous annual report stated that the EHM Portal would be ready for May 2022, however, this has not occurred as yet and it's inception and impact on services and subsequent families through effective information sharing will be reported on in our next reporting cycle.

Rees Centre Research:

In last year's ISCP annual report it described the beginnings stages of the proposal from Oxford and Sussex Universities: Rees Centre carrying out research with the aim to improve ways of evaluating impact, the LB of Islington commissioned a study: Children's Data, Coproduction and Use.

Effectiveness of impact: Rees Centre Research

They were able to provide some examples of tools or tool kits for gathering the views of parents. Evidence of the voice of the family across services has been gathered. Five families were interviewed as part of a small sample size – these were families whom had given positive feedback during the Local Authority's Children Services' week of auditing practice.

To test for reliability and consistency the families were asked the same questions by a 3rd party organisation to see if they gave answers consistent to the ones, they had supplied in practice week. All families were supported by Early Help services for approximately 6 to 9 months. It was positive the families did give answers consistent to the ones they had given in practice week, which were positive and showed that services worked well during Covid.

Early Help Auditing Activity

Audit of Early Help Assessments with an outcome of No Further Action (NFA) in Bright Start and Bright Futures

Bright Futures services (Early Help) set out to scrutinise the proportion of Early Help Assessments (EHA) that result in no further action (NFA).

They sampled 10% of the cases between Q1 to Q3 2021/2022 and wanted to observe indicators of good practice that may help to avoid an intervention ending with NFA before a family plan has been concluded.

The audit focused on:

5 families that disengaged

5 families that declined the service

6 families that stepped up to social care

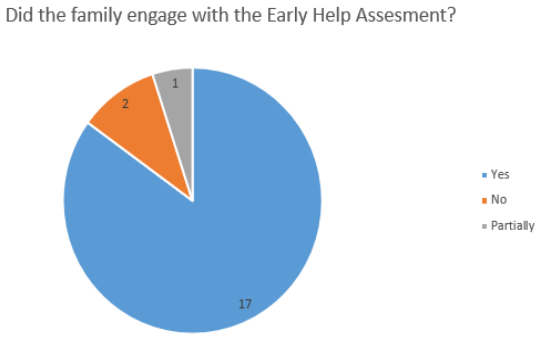
This was to examine the quality of practice and decision -making in cases where the intervention ended before a family plan was produced and concluded.

In addition, they audited 1 family that moved out of borough, 2 families that NFA'd after completing rapid response and 1 family where the outcome was 'service not available'.

Auditors were all Bright Start and Bright Futures manager (auditing cases outside their team)

Findings:

- Auditors agreed with the decision to NFA for all 20 cases
- Reasons for disengagement or declining the service included having unrealistic expectations, feeling that support was no longer required, minimal engagement with the service, and unclear reasons for disengagement in some cases.
- Auditors reported that the majority of families were engaged in the early help assessment (85%) and 63% of the children were seen in the family home as part of the EHA process.



- The majority of cases examined involved the professional network in the early help assessment, indicating effective collaboration among practitioners. Disengagement led to NFA outcomes in the 4 cases where the network was not engaged, and the auditors felt that engaging the professional network might have prevented disengagement in three of those cases. The professional network was consulted about NFA decisions in 40% of cases.

Recommendations:

- Case managers should provide support and direction to practitioners through supervision to ensure professional networks are involved in decision-making around NFA from EHA.
- Further work is needed with families who decline services or disengage after initial engagement to better understand engagement approaches, how services are promoted, and whether there is any variance in reaching different ethnicity groups.

This audit highlights the importance of having a team around the child as the auditor noticed that there was a possibility of disengagement when the professional network might not have been perceived as cohesive.

Case Review

Joint Targeted Agency Inspection (JTAI) Solihull

The Islington Safeguarding Children Partnership was tasked with compiling a report that highlighted the findings from the JTAI of Solihull and compared it to the multi-agency processes in Islington. A large proportion of the JTAI of Solihull findings relate to their MASH team and how under resourced it was, thus impacting their ability to make decisions in a timely manner. It should be noted that the JTAI of Solihull findings did not offer statistical data to emphasise the degree in which they fell short in some areas, however, they reported on what was not working well, what needed improvement and a few areas where they have observed positive practice such as multi-agency training provided to partner agencies.

The report highlighted 8 areas from the JTAI of Solihull that needed improvement. The ISCP's report concluded that a majority of the JTAI findings in Solihull would not pose the same problems in Islington, such as:

The timeliness and quality of the initial decision making in the MASH in relation to concerns received about children

All agencies' attendance at, and engagement with, child protection meetings, discussions and information-sharing forums needs improving.

However, there are some areas in Islington which needs further exploration, which formed the recommendations from the report as follows:

Recommendations:

LBI CSC to consider sample dipping their cases that are NFA or go to early help to ascertain if these cases were to go through the MASH process would there be a different outcome.

Progress: LBI CSC plan to conduct an audit (December 2022) on contacts made to CSCT to ascertain whether the outcome would change if cases went through MASH checks

Regarding Return Home Interview LBI CSC to ascertain what causes their statistics to be skewed, with specific attention to be paid to cases that are still in progress.

ICB NCL to consider how health information is disseminated for MASH purposes and whether there is any scope for primary care information (information from GP using EMIS) to be accessible to on routine health checks.

Progress:

ICB had responded to this stating that due to the complexity of the health landscape and multiple record keeping systems there is not a single health record that the MASH Health practitioner is able to access. There are local systems and processes in place to ensure that heath information is provided in a timely and effective manner.

ISCP has started to explore how the voice of the child can be obtained more throughout partner agencies.

ISCP has started implementing training for partner agencies that are aligned with their identified learning and training needs gathered by audits brought forth to the Partnership

Rapid Reviews / LCSPRs

Child U

This case initiated as a Rapid Review and involved a tragic suicide of a 17 year old. The Child Safeguarding Practice Review Panel (CSPRP) agreed with the ISCP's recommendation to progress with a LCSPR. The key line of enquiries wanted to ascertain the key junctures in Child U's lived experience of being a young carer to his mother, contextual safeguarding concerns, being subject to adultification by being taken directly to the morgue as opposed to A&E and concerns around his risky sexual behaviour and drug use.

Other factors involve the power dynamic between his step father towards his mother regarding her disability due to health reason and not being able to be the primary carer for her daughter, Child U's half sibling. Child U also faced difficulties he faced with his step father by also being physically assaulted by him on one occasion.

The findings highlighted a learning gap in how Adults Social Care and Children Social Care conducted their joint supervision and planning.

Learning and Impact:

Adult Social Care are currently in the process of devising a joint protocol to stipulate the frequency of joint supervision and planning when they have a case open to both services.

Another relevant recommendation was to ensure that ISCP incorporates appropriate training pertaining to adultification, how to support young carers and training around LGTBQ.

Whilst the LCSPR highlighted other concerns surrounding contextual safeguarding these findings were already being taken up by previous action plans relating to other LCSPRs.

Child V

This case involves the tragic death of a 11 week old girl (Mixed Parentage, white and black Caribbean and Black African Somali) whose death was consistent with accidental suffocation. The ISCP recommended that a Rapid Review was undertaken, however, the National Panel recommended we reconsider the need for a Rapid Review, as the criteria was not entirely met. The ISCP did agree that an internal management review would provide the necessary learning.

The internal management review made recommendations regarding the record keeping from health services used by mother and the development of a local multi-agency discharge planning meeting procedures. Other recommendations for the Local Authority to have clearer guidelines around information sharing between services, importance of observing sleeping arrangements as part of the assessment process and a review of the supervision order protocol.

Impact:

The ISCP business unit placed more emphasis on the importance of information sharing within their existing training programmes. Which has been received well by relevant agencies who attended.

Primary Care in Islington and Haringey created 7 minute learning sessions to mitigate risks of de-registration of vulnerable adults and children and hospital discharge of babies, children and vulnerable adults

Child V's parent were care leavers so an action involved the LBI CSC to conduct brief audit on care leavers who are parents of under 1 babies and ascertain their sleeping arrangements and understand whether parents know the dangers.

Whittington Midwifery also reviewing how their digital processes for receiving "outborn" postnatal discharges from other hospital Trusts to provide midwives with a framework to support the digital documentation of safeguarding concerns

Rapid Reviews / LCSPRs

Child W

This case involves a young person of Black Caribbean descent being a victim of serious youth violence by being stabbed to his torso and limb, this resulted in life long impairment to one of his limbs. This progressed to a rapid review and concluded with the ISCP recommending that there was no apparent threshold for proceeding to a LCSPR. The Child Safeguarding Practice Review Panel did not share the same view and believed there were compelling reason for this to progress to a LCSPR.

ISCP were able to learn from their rationale because it demonstrated a need for the ISCP to take into account issues relating to equality, diversity, and inclusion, including the possible impact of 'adultification' and transitional safeguarding arrangements given their age. The ISCP has progressed with the LCSPR which will be reflected in the next annual report.

Child Q (Hackney)

City and Hackney's local child safeguarding practice review (LCSPR) for the case of Child Q has been the subject of much disturbing details due to her treatment which causes for much needed analysis and reflection within the safeguarding community. The details of the LCSPR regards concerns being raised about a 15-year-old black female student, referred to as Child Q, who appeared to smell strongly of cannabis and may have been in possession of drugs. Despite prior searches of the child's bag and outer clothing by school staff that turned up nothing, two female police officers were called to the school and conducted a strip search of the girl in the medical room, using Section 23 of the Misuse of Drugs Act as justification. The search involved exposing Child Q's intimate body parts and was carried out on school premises without an appropriate adult present, despite the fact that the child was menstruating at the time. The search did not yield any drugs. Child Q later returned home and shared what had happened, seeking medical help due to her distress.

Learning and Impact:

This case highlighted several critical issues related to multi-agency working, communication, and decision-making in cases of child abuse and neglect. By examining the case in depth, we can gain valuable insights into the strengths and weaknesses of current safeguarding practices and this has been demonstrated by recommendations made by the LCSPR and where it applies to local changes the ISCP has formulated responses and an action plan to provide assurances:

The ISCP Business unit has incorporated learning from Child Q regarding professionals advocating for the safeguarding of children and how this is informed by legislation in the Children's Act 1989 /2004, into its Safeguarding Refresher and Practice review training The Central North Basic Command Unit also gave assurances to the ISCP from a briefing that included intensive and thorough data for stop and searches – where no strip searches (MTIP) were performed on children.

They also gave assurances to parents through schools acknowledging the regrettable incident and the learning taken from Child Q and their pledge to emphasise that Schools Officers are aware of the impact they have to ensure young people are not criminalised in circumstances they otherwise would not be if a police officer did not work in a school.

Safety School Officers began focusing on secondary schools to deliver workshops on young people's rights and reasons behind stop and search termly and 'know your rights cards' are shared with young people to understand this area further.

MPS re-focussed in delivering MTIP practical training for police officers.

Chief Inspector for Neighbourhood Policing Teams, Safer Schools already liaises with CHOICES a Stop and Search Community Monitoring Group.

Relevant agencies within the ISCP have already began to incorporate adultification training – through the ICB. The ISCP Business Unit have begun enquiries in providing this training to other relevant agencies in the ISCP.

ISCP Training Needs

ISCP Training needs:

The ISCP Business Unit currently has a vacant post for a Training and Quality Assurance manager that will be filled in the next reporting period. This vacant post has impacted the deliverance of bespoke training that would support in filling the ISCP's development needs as analysed through themes and patterns.

The ISCP Business Unit have continued to run the following core training:

Multi-Agency Foundation Safeguarding & Information Sharing

Request for training	Candidates trained	Percentage trained	Number of courses
223	162	73%	5

Multi-Agency Safeguarding Refresher Training

Request for training	Candidates trained	Percentage trained	Number of courses
283	227	80%	6

Multi Agency Designated Safeguarding Lead Training

Request for training	Candidates trained	Percentage trained	Number of courses
294	260	88%	9

Multi Agency Practice Review

Request for training	Candidates trained	Percentage trained	Number of courses
23	15	65	1

Throughout the reporting period of this annual report the ISCP training sub-group organised to use the skills from relevant agencies to deliver training for the ISCP.

The CSE Team within LBI CSC has delivered: Harmful sexual behaviour training – Child Sexual and Criminal Exploitation Training

Request for training	Candidates trained	Percentage trained	Number of courses
15	15	100%	1

The VAWG from LBI Young Islington have carried out domestic abuse and violence awareness training

Request for training	Candidates trained	Percentage trained	Number of courses
30	24	80%	2

Family Group Conference – Early Help Workshop

Request for training	Candidates trained	Percentage trained	Number of courses
31	23	74%	3

External training for the ISCP:
Reducing Parental conflict

Request for training	Candidates trained	Percentage trained	Number of courses
22	19	86%	1

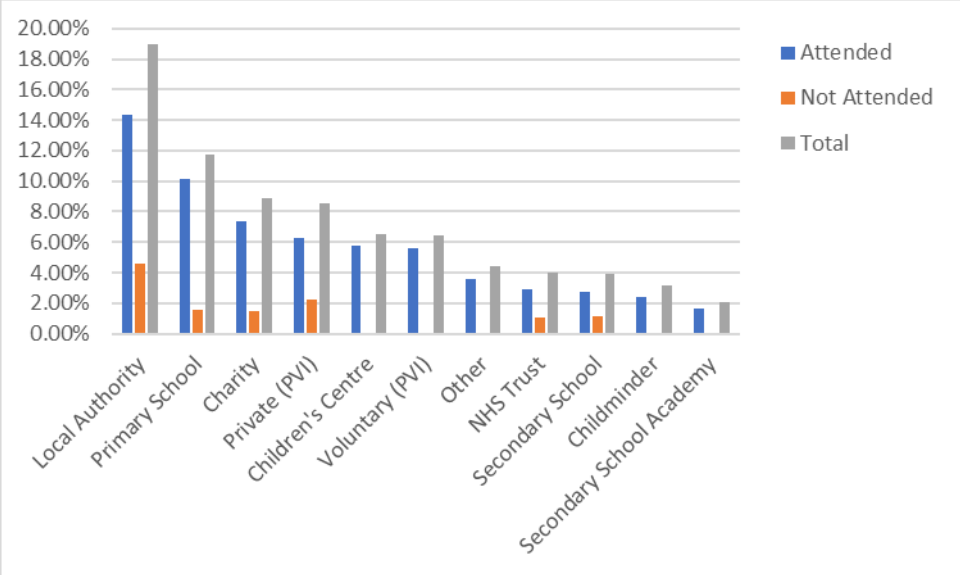
ISCP Training Needs

Workshop based on joint agency work around Camden and Islington, raising awareness around modern slavery, child exploitation and NRM, identifying themes between each agencies and is trauma informed practice. This was specific training statutory partners including Police, LBI CSC and Health partners. This gained positive feedback to better understand the NRM process especially as LBI CSC has pilot scheme

Impact

Request for training	Candidates trained	Percentage trained	Number of courses
953	766	80%	29

This demonstrates that overall we have maintained a 80% attendance rate from multi agencies attending our training. This is likely to be increased when the vacant Training Manager post has been filled



Feedback evaluation

To what extent did the training course meet YOUR learning objectives?	Excellent	366	44.1%
	Good	406	49%
	Average	57	7%

To what extent did the course meet its published objectives?	Excellent	397	48%
	Good	394	47%
	Average	38	5%

The course has helped your awareness of the subject area.	Strongly Agree	396	47.8%
	Agree	425	51.3%
	Disagree	8	1%

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ISCP Training Needs

Take into account the 6 lawful bases for information sharing before I share information, and being aware of private fostering in case it is happening to a child in my care

I have more confidence to report and keep reporting if i think something is wrong or not quite right

Take into account the 6 lawful bases for information sharing before I share information, and being aware of private fostering in case it is happening to a child in my care.

My awareness has increased in terms of thinking about the consent of children and how to keep this in mind when making decisions or sharing information; particularly where they don't have the capacity to do so themselves."

Found updates in legislation useful and legal bases for information sharing

Have more empathy and understanding for children who are criminally exploited. Be much more aware of the adultification of children being criminally exploited

My awareness increased in understanding thresholds and levels of intervention

Liaise with others in regard to e.g. nothing is to insignificant, to small and any information/ concerns will be shared with the correct agencies. I now have more confidence to make a referral.

Better understanding of LADO referrals and confidence in raising concerns to discuss ways forward.

As a new early years practitioner I have learnt a lot from this course and what to look out for but also how to support families before safeguarding may become a concern

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ISCP Membership

Chance UK, Voluntary Sector

Corporate Director Children's Services, London Borough Islington

Assistant Director of Public Health, Public Health (Camden and Islington)

Assistant Director of Safeguarding, London Borough of Islington

Business Manager, Islington Safeguarding Children Partnership

Consultant Community Paediatrician, Designated Doctor, Whittington Health NHS Trust

DCI, CN BCU Police

Designated Nurse, Safeguarding Children NHS North Central London Integrated Care Board

Detective Superintendent, CN BCU Police

Director - Housing Needs and Strategy, London Borough of Islington

Head of Pupil Services, London Borough of Islington

Director of Early Intervention and Prevention, London Borough of Islington

Director of Safeguarding, NHS North Central London Integrated Care Board

Director Young Islington, London Borough of Islington

Director, Safeguarding and Family Support, London Borough of Islington

GP, Named GP, NHS North Central London Integrated Care Board

Principal Officer Safeguarding in Education

Head of Safeguarding, Arsenal Football Club

Head of Safeguarding, Whittington Health NHS Trust

Head of Safeguarding & Mental Capacity Act, London Borough of Islington

Head of Safeguarding and Mental Health Law, Camden and Islington NHS Foundation Trust

Head of School Improvement, London Borough of Islington

Head of Service and Operations Designated Safeguarding Lead, Chance UK, Voluntary Sector Representative

Head of Service Camden & Islington LDU and Enforcement, National Probation Service

Headteacher, Newington Green School

Lay Member, Independent

Lead Member, Childrens, London Borough of Islington

Named Nurse, Whittington Health NHS Trust

Named Nurse for Child Protection and Safeguarding Children and Young People, Moorfields Eye Hospital NHS Foundation Trust

Palace for All, Voluntary Sector

Service Manager Private Law Team, CAFCASS

Budget

INCOME	
Agency contributions	
London Borough of Islington	£132,200.00
DSG Grant	£50,000.00
NCL ICB	£10,000.00
Camden & Islington NHS Trust	£7,500.00
Whittington NHS Trust	£15,000.00
Moorfields NHS Trust	£7,500.00
National Probation Trust	£2,500.00
MPS (MOPAC)	£5,000.00
Subtotal	**£229,700.00**

Expenditure	2022/23
Salaries including 0.5 Workforce Development post	£150,887.38
Independent Chair and Scrutineer (Projected)	£18,000.00
Part-time Training Administrator (approx.)	£18,000
Audits	£ 2,800.00
LCSPRs and Rapid Reviews	£ 8,337.50
TASP Membership Fee	£ 875.00
Miscellaneous Costs	£ 973.98
Subtotal	**£199,873.866**

Glossary

ASD	Autism Spectrum Disorder
ASIP	Adolescent Support intervention Project
ASV	Allegations against Staff/Volunteers
BCU	Basic Command Unit
CAMHS	Child Adolescent Mental Health Service
CCE	Child Criminal Exploitation
CYP	Children and Young People
CIN	Children in Need
CP	Child Protection
CQC	Care Quality Commission
CSC	Children Social Care
CSCT	Children Services Contact Team
CSE	Child Sexual Exploitation
DCI	Detective Chief Inspector
DIT	Dedicated Inspection Team
DSL	Designated Safeguarding Lead
FGC	Family Group Conference
FGM	Female Genital Mutilation
GP	General Practitioner
HSB	Harmful Sexual Behaviour
HMICFRS	His Majesty's Inspectorate of Constabulary and Fire & Rescue Services
ICB	Integrated Care Board
ICPC	Initial Child Protection Conference
IDVA	Independent Domestic Violence Advocate
ISAB	Islington Safeguarding Adults Board
IIOC	Indecent Images of Children
IMHARS	Islington Mental Health and Resilience in Schools
LADO	Local Authority Designated Officer
LBI	London Borough of Islington
LCSPR	Local Child Safeguarding Practice Review
MASH	Multi Agency Safeguarding Hub
MPS	Metropolitan Police Service
NCL	North Central London
NFA	NFA
NHS	National Health Service
NRM	National Referral Mechanism
QA	Quality Assurance
SEMH	Social Emotional Mental Health
SEND	Special Educational Needs/Disability
SSO	Safety School Officer
UASC	Unaccompanied and Separated Children
VCS	Voluntary and Community Sector
YJSMB	Youth Justice Service Management Board
YPSI	Youth Produced Sexual Imagery